

Commissioning World Class Dentistry in Kensington & Chelsea and Westminster



A race equality impact assessment of how the current approach to the provision of dental services is affecting BME communities

A Report by the BME Health Forum - July 2009

Cover image: courtesy of Terrence Higgins Trust

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Executive Summary

This is a study about the experience of dental services by BME communities in Kensington & Chelsea & Westminster (KCW). It aims to capture and analyse the experiences and views of the community and the relevant health professionals in order to recommend how existing services may be improved.

This study also forms a race equality impact assessment designed to assess how the current approach to the provision of dental services is affecting BME communities.

In this study, 51 interviews were conducted with residents in KCW. The sample of those interviewed is not representative of BME residents in KCW in general but consists of a group who are most likely to experience deprivation. The sample consists of high proportions of women, people on benefits, and people who are not fluent in English. However, most of the group have been living in the UK for sometime and are familiar with the benefits system and other entitlements.

In addition, 7 dentists and 2 commissioners were interviewed.

Main findings:

- **The majority of our sample visit the dentist frequently**
In total, 39/49 people have been to a dentist within the last two years.¹ Furthermore, 31/49 people attended their last appointment with an NHS dentist within the last two years (the other appointments were abroad or private). This figure (63.3%) compares well with the national average in England for adults having attended an NHS dentist within the last two years (49%) or the average in Westminster (37.1%) and in Kensington & Chelsea (19%).² In addition, 21/49 people have attended a dentist within the last six months.
- **The BME groups surveyed have a much higher rate of extractions than the general population**
Amongst those whose last dental visit in the UK was to an NHS dentist, 12 had an extraction at their last appointment. (12/39 or 30.8% compared to 1/5 or 20% for those who saw a private dentist at their last appointment). In comparison, the percentage of courses of treatments that contain an extraction amongst adults in England is 7.9%.³

¹ Two people did not answer the question.

² NHS Dental Statistics for England: Quarter 3, 31 December 2008, Annex 2a: Primary Care Trust (PCT) factsheet. However, our sample contained many women who according to some studies visit the dentist more frequently than men, see Health Survey for England –The health of minority groups '99, 11.3 Pattern of Use of dental services, <http://www.archive.official-documents.co.uk/document/doh/survey99/hse99-11.htm#11.3>

³ Dental Treatment Band analysis, England and Wales, 2007-2008, p. 5. In drawing these comparisons, we need to remember that our survey asked about the patients' 'last appointment' regardless of timeframe, while the national statistics are about entire courses of treatment within a year.

In contrast, our sample seem less likely than the average KCW resident to have band 3 treatments such as crowns, bridges or dentures (4/39 or 10.3% compared to 3/5 or 60% band 3 treatments in those who had private treatment) while in Westminster the proportion of band 3 treatments is 13.5% and in Kensington & Chelsea it is 14.3%. There were no recorded cases of root fillings in our sample.⁴

The issue of why this section of the community is having a disproportional high rate of extractions but a correspondingly low rate of band 3 treatments that could prevent or ameliorate an extraction needs to be investigated further. It may be that the communities represented in our sample are less assertive than the general population or are less able to communicate their preferences and are therefore more likely to accept the option of an extraction over other more time-demanding treatments. Furthermore they may be less likely to ask for a bridge or dentures or may be more susceptible to the suggestion that such treatments should be done in the framework of private treatment. It is important to note that a scoping report for NHS Kensington & Chelsea stated that the proportion of band 3 treatments varies dramatically between practices without any discernible geographical link for this. The issue of whether there are financial or other disincentives for dentists carrying out complex treatments as suggested by the survey for the London Assembly in 2007 also needs to be investigated.⁵

- **Over 40% of our sample who have had NHS treatment at their last UK appointment are not happy with the treatment they received (15/37) and a third would not go back to the same dentist (13/39)⁶**
This compares to 1/5 not being happy with the treatment they received at their private dentist but 4/5 not being happy to attend the same dentist, mostly because of expense. Some of this discontent with NHS treatment is attributed by patients to inadequate clinical treatment such as fillings falling out soon after they have been placed, mistakes (e.g. a bridge being accidentally removed, a wrong injection being administered), experiencing pain, teeth being extracted too soon without the dentists trying to save them and generally rushing treatment and not being interested in treating the underlying causes of their problems. Some patients thought that these problems were caused by poor communication, more specifically that the dentists did not listen to them. Others thought the problem lay with the dentist's attitude towards them – that they were rude, did not explain the treatment properly and treated them without respect.

⁴ NHS DENTAL STATISTICS FOR ENGLAND: Quarter 3, 31 December 2008. In drawing these comparisons we need to remember that the data on KCW includes children. The national proportion of band 3 treatments is much lower at only 5.2%.

⁵ NHS Kensington & Chelsea, 'Initial Scoping Report: Increasing Access to Dental Services in Kensington & Chelsea', p. 34; London Assembly, Health and Public Services Committee, *Teething Problems; A review of NHS Dental Care in London*. December 2007, p. 26. <http://www.london.gov.uk/assembly/reports/health/dentistry.pdf>

⁶ Two residents who had had NHS treatment at their last appointment did not answer the question about whether they are happy with treatment they received.

- **Although dentists say that they do not use interpreters because they do not need them, the evidence suggests that they need interpreters but do not use them because they do not know how to do so**

All the dentists said that interpreting by friends and family was usually satisfactory and 6/7 dentists said that they had never used interpreting services because they had never needed to. Nevertheless, 3 dentists mentioned that there had been occasions when treatment had to be postponed and the patient turned away because the patient was not able to understand what the treatment would involve. Among the interventions required to communicate with patients were a dentist ringing other patients and asking them to interpret over the phone, a dentist ringing her own father and asking him to interpret and patients ringing friends to provide telephone interpreting. Two dentists said that interpreting by friends and family occasionally caused difficulties such as when the interpreter's English was not good enough to do the job and when the person interpreting interfered with the patient's decision-making process.

Six out of seven dentists agreed that less than perfect communication inhibits the service patients receive. They said that communication was essential for informed consent, for reaching a correct diagnosis and for the patients to understand the treatment plan so that they come back to complete the course of treatment. Patients also needed to realise how serious their problems were, so that they did not underestimate or overestimate the severity of their condition.

It was initially assumed that the staff at dental practices knew how to book interpreters, so this was not an interview question. However, during the course of the interviews and from the shadowing results, it became apparent that dental practices do not know how to book interpreters. In 2 practices, the receptionists said they did not know how to book interpreters and asked for the information. In another, the practice manager said she had tried to book an appointment but she had been told by the service provider that the practice would have to pay the costs. In another practice, the dentist said he used to book interpreters in the past but that the last few times he had tried, no interpreter had been available.

- **Patients prefer using formal interpreters to having friends and family interpret for them**
In both focus groups, all the people who use friends and family to interpret for them or who speak to the dentist in English but struggle when doing so said they would prefer to use official interpreting services.
- **Our sample underestimated the importance of giving up smoking for maintaining good oral health and overestimated the importance of using mouthwash and avoiding tea and coffee**

When asked which were the top 5 priorities for maintaining good oral health 26/50 included using mouthwash, 21/50 included avoiding tea and coffee and only 15/50 included quitting smoking.

Recommendations:

What the local NHS can do:

Interpreting

Dentists and practice managers should be shown how to book interpreters. Such information should be communicated in person since the local NHS have already sent this information to the practices but the practices are still unable to use it. Practices should be told to ask patients whether they need an interpreter and the local NHS should make it clear that interpreters should be provided in order to meet the legal requirement to provide equitable access. This may help reduce oral health inequalities and support the local NHS in achieving the requirements of World Class Commissioning.

Ethnic monitoring

The local NHS should provide training to dental practices to record ethnic monitoring statistics properly and ensure that this is done. Information about which communities are more likely to have their teeth extracted and which communities are least likely to have time consuming treatments including crowns, bridges, dentures and root canals needs to be collected and analysed.

The local NHS should also review this information by taking into account that Band 2 treatments should not be automatically regarded as better than band 3 treatments, since a crown may be a more positive outcome than an extraction from the patient's perspective.

Ethnic monitoring statistics will aid the local NHS in commissioning evidence-based services and reduce health inequalities as directed by the World Class Commissioning Programme.

Private treatment

There should be tighter regulations about practices suggesting to patients that private treatment is better (from a non-cosmetic perspective) or that it is their only suitable alternative. Dentists should be asked to show that before performing a private treatment, they offered an NHS alternative.

Capacity

This report welcomes the plans to increase the capacity of dental practices in both boroughs. The local NHS should continue in its efforts to commission sufficient capacity to meet the needs of its populations and ensure year-on

year improvements in the number of patients accessing NHS dental services. This is necessary to meet the NHS operating framework objectives.⁷

Information

An information campaign to KCW residents in different languages and formats which should include:

- A list of local NHS dentists
- Information that registering with a dentist is not required and that NHS dentists are accepting new patients
- Preventive Advice
- Information on entitlements (free treatment if on benefits, reduction in costs with certificate if on a low income, band system)
- Similarities between NHS and private treatment with emphasis on the facts that
 - All clinically necessary treatment can be had within the NHS framework; including root fillings, crowns and bridges. Private treatment is required only for cosmetic treatment
 - You can have your teeth cleaned by the dentist within the NHS framework, and do not need to see a hygienist privately for this treatment
 - If you require specialised treatment for gum disease this can be provided within the NHS by a specialist
 - There is no difference between private and NHS practices in terms of the dentists' qualifications or the hygiene arrangements at the practice
 - Amalgam fillings are not dangerous and are of equal quality to white fillings

Further research

Further work is required to assess the oral health needs and access issues of BME communities who are not exempt from NHS charges as it is likely that they have different access and treatment issues from exempt patients.

Also, further research should look at patients' treatment history rather than just 'last appointment' as was the case in this study.

Such research will enable the local NHS to commission evidence-based services as required by the World Class Commissioning programme.

What the local dentists can do:

- Offer and book interpreters when needed
- Complete ethnic monitoring
- Ensure provision of information in the appropriate languages and formats

⁷ *Dental Commissioning in Context*, <http://www.pcc.nhs.uk/353#WCC>; *Commissioning NHS primary care dental services: meeting the NHS operating framework objectives*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082104

What the BME Health Forum can do:

Complaining & feedback

Further work is required to examine the complaints system and enable successful complaining by people who are not fluent in English.

Information

The BME Health Forum needs to support and facilitate the dissemination of information with regard to preventive advice, finding a dentist and entitlements as described above.

Working with dental practices

The BME Health Forum is committed to working with two dental practices in the following year. Within this work the Forum should encourage the use of interpreters and gather evidence whether the use of official interpreters can lead to increased health outcomes for people who are not fluent in English.

Current Study

How it came about

Issues concerning oral health and dental services have been raised within the BME Health Forum for a number of years in meetings and projects. In particular, the BME Health Forum meeting on dentistry in March 2008 raised a number of concerns from the local community.

The feedback the Forum has received from its members has generally been that people find it difficult to be accepted by an NHS dentist as practices often tell them that they are no longer accepting NHS patients. Furthermore, some people feel pressured by dentists to move from NHS to private care because the dentists suggest they would be able to provide a higher standard of care if they were not confined by the limits of NHS treatment. This issue is raised particularly with regard to amalgam fillings and treatment by hygienists.

Other problems include lack of information about NHS dentistry, in particular entitlements, system for referrals and charges. This is particularly difficult for people who have no access to the internet. Limited weekend opening and long waiting times also cause concern, as do a perceived lack of interpreting services, and walk-in and emergency facilities.

The aim of this project was to move beyond the level of anecdotal information to investigate access to NHS dental services and to whether services are meeting the needs of minorities.

Steering group

The Steering group members are:

Judith Blakeman, Councillor for Notting Barns Ward, Kensington & Chelsea

Brian Colman, Head of Equality, Diversity and Human Rights, NHS Westminster

Vivien Davidhazy, BME Health Forum Administrator, Migrants Resource Centre

Fiona Erne, Head of Service Development (Dental, Pharmacy and Ophthalmic), NHS Westminster

Yvette Marks, Dental Commissioning Manager, NHS Westminster

Claire Robertson, Consultant in Dental Public Health

Amjad Taha, BME Health Forum manager

Nafsika Thalassis, Project manager

Edward Ward, Commissioning Manager for Primary Care services, NHS Kensington & Chelsea

Community researchers

The BME Health Forum community researchers are a group of volunteers recruited in 2005 and 2007 to carry out interviews with community organisations, health professionals and KCW residents. They have contributed to a number of BME HF projects including 'Minding the gaps Are BME groups partners or substitutes in health provision?', 'Primary Concern, Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster' and the circumcision services

project.⁸ The researchers were recruited from BME community groups in KCW.

For this project the community researchers were given particular training about the issues relating to oral health, dental services and the BME communities, as well as training relating to the shadowing technique used in this project. During the training, the volunteers piloted the questionnaire for the KCW residents and identified questions which were unsuitable. They were therefore instrumental in producing the final version of this questionnaire.

Methodology

The project was managed by Nafsika Thalassis who worked under the supervision of the BME Health Forum Manager, Amjad Taha and the Project Steering group. The steering group met every month to discuss the progress of the project and to give advice on how the project should proceed.

The research took the form of semi-structured qualitative interviews, focus groups and shadowing.

Semi-structured qualitative interviews

The questionnaires were put together by Nafsika Thalassis and were then amended according to the advice of the steering group and the community researchers. Three different questionnaires were put together for the following groups of interviewees:

BME residents in KCW

Fifty one interviews were conducted. The sample was not random as particular efforts were made to interview people who were living in the UK for over a year and to interview a substantial number of people who were not fluent English speakers. In the later parts of the project, when it was realised that the overwhelming majority of those interviewed were entitled to free dental healthcare an attempt was made to interview more residents who were not exempt from NHS charges. A small payment was made to each resident for taking part in the survey.

The residents interviewed are mostly women (42/51). Many are not fluent in English (15/51 identified language as a barrier to accessing services while a further 15/51 have used friends to interpret for them or have been attending a dentist who speaks their own language). Most people in the sample have been living in the UK for some time (43/51 have lived in the UK for longer than 2 years). From those who have attended an NHS dentist at their last UK appointment, most are exempt from NHS charges (33/39 did not pay for NHS treatment at their last appointment). Therefore, this group is not representative of all BME communities but of a subgroup of BME communities who are multiply disadvantaged in socio-economic terms and in terms of the language

⁸ BME Health Forum, 'Minding the Gaps, Are BME groups partners or substitutes in health provision?' June 2006, <http://www.westminster-pct.nhs.uk/pdfs/MindingTheGaps.pdf>; BME Health Forum, 'Primary Concern, Access to GP Practices for Black and Minority Ethnic communities in Kensington, Chelsea and Westminster', June 2008, http://www.westminster-pct.nhs.uk/pdfs/bme_Primary_Concern.pdf

barrier but who are also familiar with how health services and the welfare state work and are able to claim for the services to which they are entitled.

Dentists

Seven dentists practising in KCW were interviewed. They were paid for their time.

Commissioners

Two commissioners from NHS Kensington & Chelsea and NHS Westminster were interviewed.

Focus groups

Two focus groups were conducted. The first focus group consisted of Somali women organised by Midaye, Somali Development Network. Most of the women present were unable to speak fluent English and spoke through interpreters.

The second focus group was a mixed group both in terms of ethnicity and gender. This group worked less well because it appeared to be difficult for the interpreters to manage the different language needs present. It also appeared that some members were not residents in KCW, were recent arrivals and some were members of the same family.

Shadowing

The shadowing project consisted of identifying KCW residents who had not been to a dentist in the UK for the last 5 years and those who were unhappy with their last dentist and documenting the difficulties they faced in finding a new dentist and receiving treatment. The community researchers who carried out the shadowing were briefed not to help the residents unless they became stuck at a particular barrier. The purpose of this exercise was to document the barriers faced by residents in their efforts to find a new dentist rather than simply help residents find new dentists.

The most overt difficulty with the shadowing project was that the time frame of the project was not sufficient to conclude the process. Furthermore, the people who were shadowed were the subjects more likely not to be interested in treatment and most likely to have an unstable home life which made the process of trying to shadow them difficult for the volunteers.

Nevertheless, where successful, the shadowing project revealed a lot of useful information about the barriers to healthcare faced by a population who is disadvantaged not only by the language barrier but also by temporary accommodation and by the fear of providing information to health services in case it jeopardises their stay in the UK. Furthermore, the shadowing project demonstrated that a number of people were able to find a dentist so long as they received support over an initial hurdle – a practice that refused to accept them, or a practice that refused to book an interpreter. For others however, the disillusion with services was far more profound and could not be so easily overcome.

Context

The band system and dentists' payment

Patients pay NHS dentists according to a system of bands. Band 1 includes a check up, cleaning, diagnosis, x rays, prescriptions and advice. Band 2 includes everything in band 1 as well as fillings, root fillings and extractions. Band 3 includes everything in bands 1 and 2 as well as crowns, bridges and dentures.

Charges are the same for single and for multiple treatments. So for example, the charge for a single filling will be the same as that for 3 fillings, a root filling and 2 extractions so long as they are part of a single course of treatment (which spans from unhealthy to healthy) because they all fall under Band 2 treatment. However, if the same patient had a crown instead of an extraction the entire course of treatment would be charged at the higher rate of a band 3 treatment.

Dentists are paid according to Units of Dental Activity (UDAs) that correspond to the band system. Band 1 corresponds to 1 UDA, Band 2 corresponds to 3 UDAs and Band 3 corresponds to 12 UDAs. The value of each UDA was negotiated separately with each practice at the initiation of the contract in order to ensure that the new contract did not diminish the income of any practice. The value of the UDAs has been available for renegotiation since April 2009.

Local context

Kensington & Chelsea

Kensington & Chelsea has the lowest number of NHS patients in the country. NHS dentists in Kensington & Chelsea saw 28,187 adult patients in the two years preceding 31st December 2008 (19% of the adult population). K&C have a very high proportion of band 3 treatment (14.3%) and very low proportion of band 1 treatments (33.3%). Furthermore, the number of patients visiting NHS dentists has been in decline although they have recently begun to rise.⁹

Westminster

In Westminster, the number of NHS adult patients (74,351 patients, 37.1% of the population) is considerably higher than Kensington & Chelsea although considerably lower than the English average (49% of the adult population). Their proportion of band 3 treatments (13.5%) is lower than Kensington & Chelsea although much higher than the national average (5.2%). Their proportion of band 1 treatments (33.1%) is even lower than that of Kensington & Chelsea and much lower than the national average (52.2%).¹⁰

A recent social marketing report in Kensington & Chelsea has identified low perception of need as a key behavioural challenge among the residents. Residents equate absence of pain or trauma with good oral health and

⁹ NHS Dental Statistics For England: Quarter 3, 31 December 2008; NHS Kensington & Chelsea, *Initial Scoping Report: Increasing Access to Dental Services in Kensington & Chelsea*, p.11.

¹⁰ NHS Dental Statistics For England: Quarter 3, 31 December 2008.

therefore only attend the dentist when something is wrong. Use of NHS dentistry is higher in the most deprived areas of the borough indicating that those living in the most affluent parts of the borough represent the bulk of the approx 40% who use private dentistry. According to the scoping report, the behavioural barriers affecting the majority of BME communities appear to be the same as those affecting the general population: low perception of need reinforced by phobia or fear, memories of unpleasant experiences and a lack of child friendly practices. The proportion of band 3 treatments varies dramatically between practices with no discernible geographical link.¹¹

A recent study on Dentistry in the Church Street Area (the most deprived area in Westminster and one of the most deprived areas in the country) found that 77% of respondents said they were registered with a dentist in the Church street area, while a third of those who were not said that they were registered with a dentist somewhere else in London (did not say whether or not this was NHS). Furthermore, the majority (39%) said they visited the dentist every 6 months, while 88% said they were satisfied with the service they received last time they went to the dentist. When asked how services could be improved, 30/169 people commented on the current service and of those 6 cited poor treatment and 7 cited poor communication. In this survey, only 35% of the respondents described themselves as white. The survey did not distinguish between patients who were exempt from dental charges and those who were not.¹²

World Class Commissioning

The World Class Commissioning programme is committed to commissioning services, with a clear focus on delivering improved health outcomes. This includes reducing health inequalities dramatically, and ensuring that people have choice and control over the services that they use.¹³

BME groups and access to services

Reports on BME groups' access to dental services show mixed results. Some studies have shown that BME groups have lower than average access to dental services and that people who do not speak English or who have recently arrived in the UK are likely to lack knowledge about their entitlements to free or reduced cost dental care.¹⁴

¹¹ NHS Kensington & Chelsea, *Initial Scoping Report*, pp. 9-10, 34.

¹² *Church Street Dentistry & Healthcare, A survey of Residents in Church Street, A consultation undertaken by DOC Associates in association with the PDT Community Research Project*, February 2008, p. 8-10.

¹³ The vision for world class commissioning.

<http://www.dh.gov.uk/en/Managingyourorganisation/Commissioning/Worldclasscommissioning/Vision/index.htm>

¹⁴ *Health Survey for England –The health of minority groups '99*, 11.3 Pattern of Use of dental services, <http://www.archive.official-documents.co.uk/document/doh/survey99/hse99-11.htm#11.3>; *Teething Problems; A review of NHS Dental Care in London*. December 2007, p. 15 & p. 17.

On the other hand, some studies have shown increased access by BME groups and increase likelihood of being dentate.¹⁵ A recent survey in Kensington & Chelsea found that 50% of BME respondents had visited an NHS dentist within the last year compared to 28% of white correspondents.¹⁶ One survey found no inequalities of access for minority groups but found a link between attendance and decayed, missing and filled teeth, arguing that because this group has a high degree of perceived (and actual) oral health problems, dental attendance is associated with treatment rather than prevention and that this leads to mistrust of dentists and concern with over treatment.¹⁷ A study examining barriers to access for minority groups in East London found that these barriers were similar to those faced by white populations.¹⁸ Similar results were found by a study exploring attitudes towards dental-care among second generation ethnic groups which reported that the perceptions among the different second-generation minority ethnic groups fit with current general population trends.¹⁹

BME groups and satisfaction with services

A recent survey in Kensington & Chelsea found that white respondents were more likely to agree compared to BME respondents that they were treated with dignity and respect by practice staff (86 per cent compared to 80 per cent), the information given was easy to understand (92 per cent compared to 87 per cent) and that they had a say in the planning of their care (72 per cent compared to 65 per cent of BME respondents).²⁰

Access for exempt and non-exempt patients

Furthermore, issues around access are complicated by the fact that exempt patients may find it easier to find an NHS dentist than non-exempt patients. According to a survey for the London Assembly in 2007 a number of NHS dentists were only accepting new patients if they were exempt. While in Kensington & Chelsea all 21 practices were accepting new patients regardless of their exemption status in Westminster, 9 practices were accepting only exempt patients and 12 practices were not accepting any new patients altogether.²¹

¹⁵ J.E. Todd & D. Lader, *Adult Dental Health 1988, United Kingdom*, 1991, London OPCS cited in NHS Kensington & Chelsea, 'Initial Scoping Report', p. 74.

¹⁶ *Residents' Panel Survey: Health Care Report – Extract relating to Dentistry*, 2009, Royal Borough of Kensington and Chelsea p. 7.

¹⁷ Gibbons DE, Gelbier S & Newton T (2000) *The oral health of minority ethnic groups in contemporary Britain: A case study of the South Thames region*. London, GKT Dental Institute pp ix + 84 cited in NHS Kensington & Chelsea, 'Initial Scoping Report: Increasing Access to Dental Services in Kensington & Chelsea', pp. 78-79.

¹⁸ R. Croucher & R. Sohanpal, 'Improving access to dental care in East London's ethnic minority groups: community based, qualitative study', *Community Dental Health* (2006) 23, pp. 95-100.

¹⁹ K. Mullen, R. Chauhan, R. Gardee & L. Macpherson, 'Exploring issues related to attitudes towards dental care among second-generation ethnic groups,' *Diversity in Health and Social Care*, 2007, 4, pp. 91-99.

²⁰ *Health Care Report*, 2009, Royal Borough of Kensington and Chelsea p. 11.

²¹ *Teething Problems; A review of NHS Dental Care in London*. December 2007, p. 19.

Treatment outcomes for exempt and non-exempt patients

A survey for the London Assembly in 2007 was given evidence from some NHS trusts that non-exempt patients may be opting for a band 2 treatment such as an extraction over a more expensive band 3 treatment such as a crown. In addition, according to this survey, dentists in some parts of the country have decided not to treat people who require multiple or complex treatments because they do not believe they get properly compensated for such work. These issues were identified in the report as factors likely to affect BME groups in particular.²²

²² The evidence came from Lewisham, Tower Hamlets and Richmond and Twickenham PCTs. *Teething Problems; A review of NHS Dental Care in London*. December 2007, p. 26.

Discussion

Residents' questionnaires

About the sample (See also pp. 41-43 & 45)

The residents group is very diverse originating from twenty different ethnicities. Thirty-one people live in Westminster and 20 live in Kensington & Chelsea. There are many more women than men in the sample (42:9).

Most people surveyed are exempt from dental charges on account of receiving benefits (33/39 of those whose last UK visit was to an NHS dentist did not pay for treatment). It is likely that 2 more people from this sample are exempt. Furthermore, from the 5 people who had private treatment, 2 are probably exempt because of the benefits they receive.

In total, 30/51 indicated that they are not fluent in English in one or more of the following ways:

- Identified language as a barrier in accessing services
- Have used someone to interpret for them
- Are attending a dentist who speaks their language
- Said that they have difficulties speaking English to their dentist

The ages in the sample ranged from 20-70 (37/51 are aged 30-59). Eight people said they were disabled. While a handful of people were newcomers (3/51 have been in the UK less than a year), by far the biggest group had been in the UK over 10 years (30/51).

Access (See also pp. 41-43, 45-47, 50-51.)

Access to the dentist does not seem to be a problem for the majority of the sample. In this group there were 7 people (5 from Westminster, 2 Kensington & Chelsea) who had not been to the dentist in any country for longer than two years (only 1 of whom had not been to the dentist for longer than 5 years) and 3 additional residents (all Westminster) who had never been to a dentist.

The majority of people in our sample visited the dentist frequently. In total, 39/51 had visited a dentist within the last two years, of whom the majority (21/39) had visited the dentist within the last 6 months. Moreover, 12/45 of those who answered said that they are planning to go to the dentist again within a month, 2/45 are planning to go within two months and a further 10/45 are planning to go 'soon' or 'as soon as possible'. In total, 27/45 patients want to go to the dentist 'soon' or within a period of 6 months or less, while 18/45 want to go 'when needed'. Six people did not answer.

There appear to be 5 subgroups of attendance among the residents:

- One group 13/51 have been to the dentist recently (less than 6 months ago) but are planning on going again soon (less than 6 months since their last appointment). Only in 3 of these cases were the two appointments within a month of each other suggesting that they may be in the middle of a course of treatment. In the other 10 cases, the gap

between appointments was longer than two months suggesting that these people feel they need to visit a dentist either because a new problem has come up, a previous problem was not rectified or because they feel this is how often one should visit the dentist

- Another group (9/51) have been to the dentist within the last six months but do not intend to go to the dentist again until they need to
- A third group, (12/51) have not been to the dentist recently (longer than 6 months since their last visit) but would like to go again soon (within the next six months, or 'soon')
- A fourth group have been to the dentist sometime ago (longer than 6 months) and do not intend to go to the dentist again until they need to (14/51)
- A fifth group (3/51) have never been to the dentist and don't feel they need to go until it's needed

The issue of what prompts people to go to the dentist has been investigated in a number of questions. In response to the question "Why did you go to the dentist?" only 6 people exclusively mentioned having a check up or having their teeth cleaned, compared to 31 people who mentioned a specific problem (pain was the most common problem mentioned).²³

However, when asked "How often would you like to get your teeth cleaned?" 14 patients said they would like to have their teeth cleaned every 3-4 months or more frequently, 22 patients said every 6 months while only 1 patient said they would like to have their teeth cleaned yearly and 1 patient saying "whenever needed."²⁴ In response to the question "How often would you like to get your teeth checked?" 8 patients responded that they would like to have their teeth checked every 3-4 months, 22 said every 6 months, 7 said yearly, 1 said every two years and 1 said 'whenever needed'.²⁵ A similar question "How often should you have your teeth cleaned by a dentist or hygienist?" produced similar results (Every month =3, Every 2 months =1, Every 3-5 months=14, Every 6 months=20, Every 9 months=1, Once a year =4, When needed/ advised =2, No answer =6). In addition when asked what are good reasons to go to the dentist 31/46 suggested oral health or related reason (oral hygiene, to prevent decay etc) and only 15/46 mentioned specific problems only.²⁶

These results suggest that while problems with access to services do exist, they affect a small proportion of people. The majority of our sample attend services regularly but nevertheless aspire to attend even more frequently. When they were asked why they went to the dentist, the majority of patients (31/37) mentioned specific problems, however, this seems to be indicative of the fact that they have such poor oral health that they develop symptoms (real or perceived) frequently enough to warrant regular attendance to the dentist,

²³ This question only applied to the sample of 48 who had been to a dentist. Only 37 people replied.

²⁴ This question only applied to people who had been to a dentist in the UK within the last 5 years (n=43). Thirty eight people responded to the question.

²⁵ This question only applied to people who had been to a dentist in the UK within the last 5 years (n=43). Forty people responded to the question.

²⁶ Five people did not answer this question.

rather than that they think that there is no reason to go to the dentist unless there is something wrong. Most people (27/45) have a specific timeframe in mind about when they need to go to the dentist again which generally means a gap of less than 6 months, while the minority (18/45) say they will go again “when needed”.

In terms of the factors that stop or delay people going to the dentist, fear of pain and anxiety about treatment were the most important for the majority. However, when asked to select all the factors that could stop them from going to the dentist or postpone their visit, 16 said difficulty in getting a suitable appointment and 15 said being unable to communicate in English. (For 14 people, difficulty in getting a suitable appointment was amongst the top 3 most significant barriers and for 13 people being unable to communicate in English was amongst the top 3 most significant barriers). It appears that while most people do not think that these are the most significant barriers to access, they are a barrier nonetheless. Among the people who had not been to the dentist there was no particular pattern of barriers experienced.

Perceptions of access (See p. 46)

To the question “Do you think it’s easy to find an NHS dentist?” half the sample (23/45) said “Yes” and half (22/45) said “No”.²⁷ From those who said “No”, a substantial portion seem to think that the difficulty lay in finding a good dentist rather than an NHS dentist as such. From the patients that had not been to the dentist, many said that it was difficult to find an NHS dentist (5/8) but again the problems often related to quality and language issues rather than pure availability. Of these, 6/9 had taken steps to find an NHS dentist.

Treatment (See pp. 43 - 45)

The treatment received by this group of residents at their last appointment with a dentist in the UK was considerably high grade²⁸. Only 6/44 residents had cleaning and a check up. Four were prescribed antibiotics, 18 had fillings, 13 had extractions (11 of these patients were exempt from charges, 1 was a non-exempt NHS patient and 1 was a private patient), 5 had bridges or teeth implants (3 NHS, 2 private), 1 had a crown replaced (private), 1 had new dentures fitted and 1 had old dentures repaired (NHS).

Nine residents had private treatment at their last appointment. For 5 residents the treatment was exclusively private and for 4 residents their private treatment was combined with NHS treatment. Exclusively private treatment consisted of replacing a crown, antibiotics, fixing a chipped tooth, implanting teeth, extracting teeth and replacing them. Combined treatment included two cases of whitening, one treatment by the hygienist and fillings.

The severity of the treatment correlated to how recent the last appointment was. So in the cases of the 6 people who only had a check up and cleaning, 5 had been to the dentist within the last 6 months and 1 had been to the dentist a year ago. In contrast with the 13 patients who had an extraction in their last

²⁷ Six people did not answer the question.

²⁸ Forty-four have had dental treatment in the UK. Six people have never had dental treatment in the UK and 1 person did not answer the question.

appointment 5 had their last appointment less than 6 months ago, 2 had their appointment between 6 months-1 year ago, 1 had an appointment between 1-2 years ago; 4 had appointments 2-5 years ago and 1 had an appointment over 5 years ago. Put another way, from the people who were at the dentist within the last 6 months 5/21 had extractions and 5/21 had just a check and a clean, whereas from the 7 people who had not been to the dentist for over two years, 5 had extractions and none had just a check up and cleaning.

Nevertheless, it cannot be inferred from these results that the people who went to the dentist more frequently had better oral health or were less likely to have their teeth extracted. Since over a quarter of the people who went to the dentist within the last six months had a tooth extracted it is possible that over the course of two years the majority would have a tooth extracted which would place them in no different situation than the group who went to the dentist 2-5 years ago, the majority of whom had a tooth extracted in their last appointment. In other words, while going to the dentist frequently obviously diminishes the chances that a person will have had an extraction at his or her last appointment it does not necessarily decrease his/her chance of having an extraction within a given time period. More research needs to be done to assess whether frequent appointments protect people from having more severe treatment.

In addition, our sample seems less likely than the average KCW resident to have band 3 treatment such as crowns, bridges or dentures (4/39 in our sample compared to 13.5% Westminster and 14.3% in Kensington & Chelsea).²⁹

This raises an important question: Why does this group of people whose oral health is so poor that they have so many more extraction than the general population, have fewer than average treatments that prevent or ameliorate extractions (crowns, bridges, dentures)? In contrast, among the people who had private treatment 1/5 had a crown replaced, and 2/5 had bridges or tooth implants even though the later two patients are in receipt of benefits and could have had bridges or dentures for free on the NHS. Another patient who was on income support was offered private treatment to have 'artificial teeth' but she could not have the treatment because it was too expensive.

A large number of people who had NHS treatment at their last appointment are not happy with the treatment they received (15/37) and many would not go back to the same dentist they saw at their last appointment (13/39). This compares to 1/5 not being happy with the treatment they received at their private dentist but 4/5 not being happy to attend the same dentist, mostly because of expense.

Only half of those who responded reported being given a treatment plan (18/36).

²⁹ NHS Dental Statistics For England: Quarter 3, 31 December 2008.

Twelve people said that their dentist had discussed with them the possibility of getting private treatment. Amongst the reasons given for the suggestion were to obtain quicker and better quality service and because of the condition of the patient's teeth.

Perceptions of private treatment vs NHS treatment (See p. 50)

When asked if you could get the same quality of care in NHS and private practice, only 8/37 said you could, while 29/37 said you could not. When asked the reasons for this, 14 people said that private treatment was better, 10 said that you could get quicker appointments in private practice, 7 said that in private practice, you got better care and that the staff was friendlier, six said that the dentists who worked in private practices were more professional and better qualified. Six said that private practice was more expensive.

Treatment abroad (See p. 51)

From the 11 people who had treatment abroad within the last 5 years only 3 said they did so as a matter of choice (because they know their dentist and do not want to change, because treatment abroad is cheaper and better), while the others simply needed treatment while they were abroad.

Self-perceptions of oral health (See p. 45)

The residents whose last visit to the dentist was in the UK were asked if they thought they had healthy teeth and mouth and 23/44 said they did and 21/44 said they did not.

Experience of going to the dentist (See pp. 50, 42 & 43)

The majority of those who had been to a UK dentist within the last five years (n=43) said that at their last appointment they had been given a convenient appointment (32/43) and that the practice was clean (35/44). However, when asked to select all the factors that has ever stopped them from going to the dentist or made them postpone their visit, 16 said difficulty in getting a suitable appointment (for 14 people, difficulty in getting a suitable appointment was amongst the top 3 most significant barriers).

The dentists' gender (See p. 47)

The dentist's gender is not important for the majority of patients (39/49)³⁰. Six women said they preferred a female dentist, 2 women said they preferred a male dentist and 2 men said they preferred a male dentist.

Knowledge (See pp. 47-49)

When asked an open question about whether there was anything they can do to prevent tooth decay and gum disease, none of those asked mentioned quitting smoking. In contrast, 35/46 mentioned brushing their teeth, 11/46 mentioned having regular check ups, 6/46 said to avoid sweets or chocolate.

When given a list of options to select the top five priorities nearly all the patients selected brushing your teeth twice a day (46/50). A majority of respondents selected avoiding sugary foods and drink (35/50), using

³⁰ Two people did not answer the question.

toothpaste that contains fluoride (28/50) and having your teeth checked by the dentist or hygienist at least once a year (27/50). However, only 15/50 selected quitting smoking whereas 21/50 selected avoiding tea and coffee and 26/50 using mouthwash. We do not know how many of our sample are smokers.

Furthermore, out of 33 patients who answered the question, 19 thought that amalgam fillings were unhealthy. Also 15/41 said you could catch a disease from the dentist while another 5/41 said it was possible. Of the 19 people who answered the question, 15 people thought that London water contained fluoride.

Discussion from the Shadowing results (See pp. 52-54)

The barriers faced by this group of people were language, lack of information, cost, dissatisfaction and mistrust of dentists, worries about the home office due to visa status, unstable housing and lack of support. Having never been to the dentist and not being interested in getting treatment were also considered to be barriers.

The volunteers were most successful in supporting patients where the barrier e.g. cost or not having been to a dentist before, could be overcome in a straightforward manner within the timeframe of the project. So for example A.D. who was not in paid work was able to get an HC11 certificate easily and get the treatment she needed. In contrast, J.C., R.E., P.S. and M.F. who were working longer hours than those permitted by their student visas were worried about sending their payslips to the authorities. We know that one of these women did get an exemption certificate eventually.

Having never been to the dentist, lacking information, and being unable to speak English were significant barriers but these could be overcome if there was sufficient support from the family or from the volunteer. For example, in T.B.'s case, the volunteer could not talk to T.B. directly because T.B. did not speak English but she contacted T.B.'s husband and he took her to the dentist. In contrast, M.A.'s family had no interest in taking her to the dentist so she did not go. A.S. was turned down at the first dentist she visited but the volunteer took her to a second dentist where she was accepted. J.S. was taken to her old dentist by the volunteer but the dentist refused to arrange an interpreter for her so the volunteer took her to a Farsi speaking dentist.

In certain cases, where the patient was dissatisfied with his or her own dentist but had not lost faith in the system altogether, it was also possible for the volunteers to help by encouraging them to go to a new dentist. So, for example, after some encouragement, I.S., N.G. and A.H. who were all unhappy with their previous dentists, found new dentists. By contrast, R.D., I.H., Z.K. and M.J. did not. These patients were disinterested about getting treatment and mistrustful of dental services altogether. R.D. initially said she needed to go to the dentist urgently but she subsequently appeared to lose interest. She spoke good English and should be able to get an appointment by herself if she chooses. M.J. had previous experience of very expensive treatment and no longer wished to go to the dentist –he felt it was not worth it as he had only a few teeth left. Z.K. had been to the dentist recently and was not happy with the treatment and then her experience of not being given an emergency appointment while she suffered through the night has put her off the idea of having a dentist altogether.

Discussion from the Focus Groups (See pp. 55-57)

Finding a dentist

Finding a dentist was done through either recommendation or by spotting a local dental practice while walking around. There was only one instance of a person using the internet for this purpose. The yellow pages were not used. The gender of the dentist was not important and getting suitable appointments was not difficult. The language and background of the dentist were significant in choosing a dentist.

In the women's group everyone had been to the dentist while in the mixed group 6/12 had not been to the dentist for at least 5 years.

None of the people who had not been to the dentist in the last five years, had tried to get an appointment. Their reasons for this included: a previous bad experience, feeling there was no need, having no information, having been told that most dentists are private and being unable to go by oneself because of the language barrier. One also expressed the concern that if he made an appointment and then did not go he would still have to pay for the appointment.

Treatment

In total more than a third of patients (6/17) were not happy with their dentists. In the Somali women's group the numbers were higher (5/11 were not happy) while in the mixed focus group 1/6 was not happy.

Seven women said they were unhappy with the treatment they had received and had suffered from ongoing pain after the treatment. One said that she thought the dentist lacked the sufficient skills, while six said that the dentist was unwilling to investigate underlying problems. Many women felt their teeth had been extracted too soon, and that dentists didn't try and save them. Only one woman said that she'd been given any preventive advice. The women who felt that they had been given poor quality medical treatment thought that this may be partly attributable to poor communication (that the dentist didn't listen to them).

The women also felt that because they are from a BME or refugee background, they were received with a less welcoming attitude, and the dentists were not caring, did not listen to them, did not treat them equally or fairly, and were not respectful. Some women also expressed the view that their dentist was not professional and made BME patients wait longer than other patients.

The women who were happy with their dentist felt that their dentist gave them a lot of information and advice and took time and responsibility over their treatment.

In the mixed group, one patient complained that he had to wait 6 months for a hospital referral and another felt that the dentist had been rude.

Five people were worried about the sanitary conditions at the dental practice, how often equipment was changed and how the hygiene of the practices is supervised.

Communication and interpreting

Although nearly all the women needed someone to interpret for them when they attended the dentist, they all felt that the communication problems they had with the dentist were not attributable to the language barrier but to the dentist's reluctance to listen to them.

In the mixed group, one person felt they had been given inappropriate treatment (a wrong injection). This patient was unable to speak English and while her daughter had initially interpreted for her, she had then left and the patient was unable to communicate with the dentist. Nevertheless she did not feel that this difficulty in communication was responsible for the problems with the treatment.

In both groups everyone said that they would prefer an official interpreter to a friend interpreting. At the moment most people use their children or friends to interpret. They have not been offered interpreting and did not know that they can ask. They would like to ask but are hesitant about doing so.

Complaints

Three women would like to complain about the treatment they received. None know how to complain but they would prefer to do so by talking to someone in person or on the telephone in their own language.

Discussion from the dentists' results (See pp. 59-63)

Increasing the number of NHS patients

The Kensington & Chelsea practices had a more positive attitude towards increasing their NHS patients than their Westminster colleagues and did not seem to be concerned about exceeding their contract. One dentist in Kensington & Chelsea even described the contract as 'unlimited'. This seems to be partly the result of the fact that the commissioner in Kensington & Chelsea had provided reassurances that any excess work would be paid. In addition, it is possible that the practices in Kensington & Chelsea were not likely to fulfil their contract and therefore had less to worry about in terms of excess.

Increasing the number of private patients

From the seven practices, only two said they were not interested in increasing their number of private patients. One of these suggested that NHS patients were more stable.

From the other five practices, two were explicit in how they would increase the number of private patients. The dentist from the Westminster practice with the 50% abatement value said that 90% of their private work comes from NHS patients and that therefore by increasing the number of NHS patients they would also increase their private work. This raises a question mark about why so many NHS patients in this practice choose to have private treatment and whether it is suggested to patients that private treatment is their only suitable option. From our patients' results we know that one patient who received private treatment worth £500 in this practice for having his teeth extracted and replaced (we do not know if he had bridges, dentures or implants) is in receipt of disability allowance and would probably have been able to receive dentures or implants free of charge on the NHS.

The dentist from the Kensington & Chelsea practice which was explicit about how the practice tried to increase the number of private patients said that they did so by giving options for private treatment to all patients, providing opportunities for further training to dentists so they could perform specialised, cosmetic procedures and by advertising new instrumentation and rejuvenation procedures through posters in the waiting room. Although this practice has a 95% abatement value, the dentist interviewed originally suggested that the abatement value was around 80%. When she realised that her original estimate reflected her own work rather than that of the practice she said 'I guess I'm just lucky' indicating that in this practice private patients were considered a better investment than NHS patients. In addition, prior to the interview the researcher heard the practice manager tell a patient who was inquiring about the cost of having his teeth cleaned that he would have to be seen by a dentist who would assess the situation and if the cleaning was something the dentist could do by himself it would only cost £16.40 but if it had to be done by the hygienist it would cost £45. The same patient inquired after having a root canal and the practice manager told him that the dentist would have to assess him and see whether the root canal could be done on the NHS or whether it had to be done privately because currently there was a

very long waiting list for NHS treatment. This suggest that despite the 95% abatement value, at this practice there is a deliberate attempt to entice patients away from NHS treatment to private treatment.

Barriers

As far as the dentists were concerned the most significant barriers for patients were anxiety about treatment, fear of pain and fear of cost. Being unable to communicate in English and the perception that it is difficult to find a good dentist were identified as barriers by 4 dentists but they were mostly given a low priority –only 1 thought that the former was one of the most important barriers (he said it was the most significant) and two thought the latter was of significant importance (amongst the top 3). In contrast, difficulty in getting a suitable appointment was identified as a barrier by only 2 dentists, both of whom marked it as having relatively a low importance. In addition 3 out of 7 dentists thought that the inconvenience of travel and the perception that treatment would do more harm than good were barriers (but not amongst the top 3 most significant barriers).

In contrast, while this group of patients did indeed identify fear of pain (20) and anxiety about treatment (15) amongst the top 3 barriers that stopped them going to the dentist, they also identified difficulty in getting a suitable appointment (14), and being unable to communicate in English (13) as significant barriers. Fear of cost was also significant (12). In contrast, the perception that treatment would do more harm than good was only perceived by two patients as significant.

Dentists' gender preference

Four dentists said that some of their patients wanted to see a dentist of a particular gender. 3 said some women (particularly Muslim women) wanted to see a female dentist and two dentists said that some patients asked to see a male dentist because they did not trust female dentists. Only 10/49 patients said they had a gender preference. 6 said they preferred a female dentists (all these patients were female) while 4 patients said they preferred a male dentists (2 of these patients were female). The reasons offered for preferring a female dentist were religion, that women had a softer touch, they were easier to talk to, and that the patients felt less shy with a woman dentist. The reasons offered by female patients for preferring a male dentist were a bad previous experience with a female dentist, and the belief that male dentists are better. Male patients did not offer an explanation for preferring a male dentist. Overall this suggests that the issue of the dentist's gender is not very important for the majority of patients.

Communication & interpreting

The results from this section present a contradictory message. On the one hand, nearly all the dentists accept that good communication with patients is very important to the extent that 3/7 reported having to refuse to carry out treatment because they felt that the patient did not understand them sufficiently. On the other hand, nearly all the dentists said that they had no need for interpreting services. Since the same dentists who reported having no need for interpreting services also reported resorting to extreme alternatives to communicate with patients (one dentist reported ringing her

father in the hope he would be able to interpret for a patient, while another said that the patients ring their friends while in the surgery to provide telephone interpreting) it is likely that the real barrier towards using interpreting services is lack of information about how to book the service rather than a genuine perception that there is no need.

In addition, when asked about causes for dissatisfaction among BME patients 2 out of 7 dentists identified difficulties in communicating with the practice staff as the most significant cause.

Furthermore, while all the dentists said that interpreting by friends and family was usually satisfactory, 2 dentists highlighted that interpreting by friends and family occasionally caused difficulties. 1 said that problems were caused when the interpreter's English was not good enough to do the job and the second 1 said that sometimes the person interpreting interfered with the patient's decision making process. Similarly, while 6 dentists said that they were able to communicate with their patients in a number of different languages because they spoke different languages personally and because they could use other staff members including nurses and practice managers as interpreters, 2 dentists admitted that this process was problematic. 1 dentist mentioned that when she did consultations in Greek she occasionally ran into difficulties because she did not always know the technical vocabulary in Greek (she had been trained in English). Another dentist said that although he was fluent in Hindi and Bengali he did not conduct consultations in those languages for legal reasons – he thought it was better to let the patients bring their own interpreters because that way it was the patient who was responsible for the quality of the interpreting rather than the dentist himself. This is a misinterpretation of the legal situation as the legal responsibility to ensure informed consent always falls with the healthcare professional regardless of which party provides the interpreter.

While a number of practices had posters up explaining that interpreting in different languages was available, it gradually became clear that in the practices which had never used the interpreting services (6 out of 7), the receptionist and/or practice manager did not know how to book such an appointment. While the survey did not ask any members of staff directly if they knew how to book an interpreter, staff brought up this issue with the researcher by themselves. For example, in one practice (Westminster) the practice manager said that within the last year she had tried to arrange for an interpreter with language line but had been told that the service would cost £75-100 and she therefore did not pursue it. In another practice, (Kensington & Chelsea) the receptionist (who may also have been the practice manager) told the researcher she did not know how to book an interpreter and asked her for information because she had a patient who needed an interpreter coming into the practice the following week. Also the dentists, while being aware of the theoretical possibility of getting an interpreter, did not know that it was at no cost to the practice or how to go about arranging it. The only dentist who had used interpreting services said that interpreting services had been good in the past. However, the last 3-4 times he had tried to use them more recently

no interpreter had been available and therefore he had given up trying to use them.

Furthermore, 5 dentists mentioned they would like to have more leaflets in different languages. One dentist said that he would like a translated leaflet encouraging parents to bring their children to the dentist as soon as they have all their teeth. This material should also explain to parents that they should not give their children sweets and should not use going to the dentist as a threat to the child. Another dentist said that leaflets in different languages should explain that there are NHS dentists and that if you are on benefits, treatment is free. Such leaflets should be available in GP practices, and job centres. One dentist said that leaflets on the issue of betel chewing in Bengali and other languages would be useful.

Most dentists were not enthusiastic about receiving information screens in different languages or support with interpreting services although leaflets in different languages were requested. Arguably, this is because practices are already familiar with leaflets and know how to use them.

Oral health & treatment by hygienists

A number of dentists reported that they found it challenging to explain oral health issues to BME patients and convincing them that these were important. However, there were also examples of good practice. For example, one dentist said that although it was not easy to convince BME patients of the need to treat gum problems because the explanation was not as straight forward as showing them that they have a hole in their tooth, he showed patients a diagram of how gum problems can lead to teeth becoming loose. He said that the challenge was engaging patients to contribute toward their own oral hygiene as the top priority to achieving good oral health. Another dentist said that the practice has computer programs and books to show people the consequences of poor oral health. Another dentist said that they employ a hygienist who sees patients on the NHS, have oral health promotion days, and that they are currently training an oral health promoter. He said that the effectiveness of these methods depended on the individual patient and to what extent they took responsibility for their oral health. Another dentist said that if patients stayed with the practice for years the advice would gradually work and the patients' oral health would improve but that some patients are not interested –they say that everyone in their family has lost their teeth and that it was not important. One dentist said that oral health advice was more effective with young people and that older people often didn't care but that overall BME groups are more worried about having clean and healthy teeth than the average native British person. By contrast another dentist said that oral health advice was less effective with BME groups because they didn't care about it and didn't listen to the dentist's advice.

Most practices employ hygienists but usually patients can only be treated by hygienists under private treatment. If the patient does not want to pay extra for a hygienist then the dentist can clean his or her teeth within the NHS framework. One dentist commented that in his opinion the dentists do at least as good as good a job cleaning teeth as hygienists, but that hygienists are

able to offer the patient more time. Presumably, the issue of time is related to the fact that treatment with the hygienist falls under private practice.

Problems with the contract and support from the local NHS

Two dentists (one Westminster, one Kensington & Chelsea) said that the NHS could help improve NHS dentistry services by increasing the number of units they are allocated. Other problems with the contract mentioned were that sometimes a patient needs very simple treatment which is nonetheless classified as band 3 and was therefore very expensive for the patient. Another dentist said that for patients with multiple needs who required very expensive treatment, the banding system was too rigid and that multiple band 3 treatments should be permitted. Another dentist (Kensington & Chelsea) said that the PCT's priorities interfered with clinical practice such as when the PCT told a practice that they were having too many band 3 treatments or were not seeing enough children. He said that the new contract was not supposed to require dentists to record every aspect of treatment, but increasingly, this was requested. He said that practices need security, and long-term contracts that did not change. One dentist suggested that the contract should do more to encourage preventive work and another suggested that one way to ensure equal access to BME patients would be to increase the contract for practices which accept above a certain number of patients so that the practices can accept new patients at all times.

Other suggestions were that PCTs should do outreach work with regard to children, advertise the fact that NHS dentists are available, promote dental health in the population and support staff training. Also specialist referrals were thought to be problematic because they take a very long time to come through and occasionally don't come through at all. It was suggested that many patients are confused about the differences between NHS treatment and private treatment.

Discussion from Commissioners results (See pp. 64-65)

Access

There are plans for two new practices in Westminster and three in Kensington & Chelsea. There will also be expansion of existing practices in both boroughs. Expansion will be based around a number of criteria, which are not published but include access, quality, capacity, tools, opening hours, and infection rates.

Interpreting services

Interpreting services, commissioned by local PCTs, are available for dental practices to use free of charge. Dentists have a similar duty of care as doctors to ensure that their patients can fully understand what treatment they are about to receive and any additional advice the dentist has to offer. The commissioners said that interpreting by friends and family is not desirable but it has to be acceptable in certain circumstances, if for example, the patient prefers a family member and it is possible to establish the patient's informed consent in this matter. Interpreting by children is not acceptable.

Private dentistry

There are no new contracts offered to practices that do mainly private work. It is difficult to combine a large NHS practice with a large private practice, and each practice should be either private or predominantly NHS (Some private cosmetic treatment has to be available to NHS patients).

Conclusions

Access

The majority of the sample have visited a dentist within the last two years. The fact that this sample do not seem to find it difficult to access dental services may be partly due to the majority being exempt from NHS charges. That BME communities in general probably do not face difficulties with accessing dental services is corroborated by the fact that dentists reported that 60-70% of their patients come from BME communities and by other local studies showing BME groups are more likely to visit the dentist than those who identify themselves as white.

While patients are going to the dentist, this does not necessarily mean that they have access to appropriate treatment. In the focus groups, very few patients reported receiving advice on prevention. Furthermore, even though the number of extractions in this group suggests that their teeth are in very poor condition, very few of them seem to have access to expensive and time consuming band 3 treatments such as crowns, bridges and dentures or to root fillings. The fact that some patients who are on benefits are choosing to receive such treatments privately, suggests that it is lack of availability rather than lack of need that is stopping them receiving these treatments.

These findings indicate it would be relevant to investigate whether there are any disincentives for dentists providing these treatments as suggested by the London Assembly Report and whether there are widespread difference in the provision of band 3 treatments between practices as suggested by the Initial Scoping Report For NHS Kensington & Chelsea.³¹

For the group of residents who do have difficulties with accessing dental services, the problems identified from the shadowing exercise are varied. There is a Latin American population of recent arrivals who want to go to the dentist but find it difficult due to costs and face difficulties in obtaining an exemption certificate because they frequently change address and because they are concerned about revealing how many hours they are working. Other recent arrivals who cannot speak English, and are either quite young or quite old, appear to be completely reliant on their families to take them to the dentist and whether they go or not depends on the priority these family members give to this issue. (Other people who have difficulties speaking English but who have lived in the UK for a long time, go to the dentist frequently). In other cases, the issue seems to be that people have had a bad experience at their dentist, want to change practice but they are not sufficiently motivated to do so and therefore postpone going to the dentist altogether. In some cases, their previous experience was so negative that the person is not willing to go to the dentist again unless s/he is forced to do so by pain or other symptoms.

³¹ Initial Scoping Report: Increasing Access to Dental Services in Kensington & Chelsea', p. 34; *Teething Problems; A review of NHS Dental Care in London*. December 2007, p. 26.

Treatment

As discussed above, our sample contains people who have extractions far more frequently than the average person. The data from the focus group suggested that people are not happy about this and said that they are concerned that dentists remove their teeth too quickly without trying to save them. In addition, they are less likely to receive treatments such as root fillings, bridges, crowns and dentures and some patients appear to be seeking private treatment in order to do so.

Many people are not happy with the treatment they received at their last appointment with an NHS appointment (15/37) and a third would not go back to the same dentist they saw at their last appointment (13/39).

Interpreting & communication

Dentists are not using interpreters, and say that this is because they do not need them. In practice, it is obvious that they do need them –some practices have gone to tremendous lengths to provide informal interpreting, some have had to turn away patients when communication is insufficient and some have tried to book interpreters but have failed to do so. The real barrier from the dentists' point of view towards booking interpreters seems to be that they do not know how to do so and when they try to do it they are unable to book an interpreter.

Furthermore, the residents say they need and want formal interpreters. The focus groups revealed that people preferred formal interpreters to having friends or family members interpret for them.

Finally the commissioners say that they are committed to providing interpreters.

However, it should not be assumed that interpreting would solve all the difficulties between patients and dentists. During the focus group, the residents told us that even though they are unable to communicate with the dentist without an interpreter and even though they feel they have many communication difficulties with their dentists, they did not ascribe these problems to the language barrier but to the fact that the dentist did not listen to them.

Oral health messages

Our sample underestimated the importance of giving up smoking and overestimated the importance of using mouthwash and avoiding tea and coffee.

Difficulties with implementing some of the recommendations

Our study suggests that the local NHS would meet the needs of exempt BME groups better by encouraging the use of interpreting facilities, and discouraging extractions in favour for other treatments including root fillings, and crowns and encouraging the use of bridges and dentures for those who have already lost their teeth.

The PCTs currently have multiple financial incentives not to do this. Increased interpreting services and increased band 3 treatments for exempt patients are both costly options. In addition, such improvements would not improve the PCTs' standing in the short term in national performance measures which aim to reduce band 3 treatments.

Nevertheless, in the long run, using interpreting services where necessary and providing patients with more treatment options than appear to be currently available, will improve communication and the overall relationship between dentists and exempt BME patients. This should lead to increase access and improved oral health outcomes and ultimately decrease both band 2 and band 3 treatments particularly bridges and dentures. Since reducing health inequalities is a key tenet of the World Class Commissioning Programme, it is in the interest of the local NHS to promote these options.

Recommendations

What the local NHS can do:

Interpreting

Dentists and practice managers should be shown how to book interpreters. Such information should be communicated in person since the local NHS have already sent this information to the practices but the practices are still unable to use it. Practices should be told to ask patients whether they need an interpreter and the local NHS should make it clear that interpreters should be provided in order to meet the legal requirement to provide equitable access. This may help reduce oral health inequalities and support the local NHS in achieving the requirements of World Class Commissioning.

Ethnic monitoring

The local NHS should provide training to dental practices to record ethnic monitoring statistics properly and ensure that this is done. Information about which communities are more likely to have their teeth extracted and which communities are least likely to have time consuming treatments including crowns, bridges, dentures and root canals needs to be collected and analysed.

The local NHS should also review this information by taking into account that Band 2 treatments should not be automatically regarded as better than band 3 treatments, since a crown may be a more positive outcome than an extraction from the patient's perspective.

Ethnic monitoring statistics will aid the local NHS in commissioning evidence-based services and reduce health inequalities as directed by the World Class Commissioning Programme.

Private treatment

There should be tighter regulations about practices suggesting to patients that private treatment is better (from a non-cosmetic perspective) or that it is their

only suitable alternative. Dentists should be asked to show that before performing a private treatment, they offered an NHS alternative.

Capacity

This report welcomes the plans to increase the capacity of dental practices in both boroughs. The local NHS should continue in its efforts to commission sufficient capacity to meet the needs of its populations and ensure year-on-year improvements in the number of patients accessing NHS dental services. This is necessary to meet the NHS operating framework objectives.³²

Information

An information campaign to KCW residents in different languages and formats which should include:

- A list of local NHS dentists
- Information that registering with a dentist is not required and that NHS dentists are accepting new patients
- Preventive Advice
- Information on entitlements (free treatment if on benefits, reduction in costs with certificate if on a low income, band system)
- Similarities between NHS and private treatment with emphasis on the facts that
 - All clinically necessary treatment can be had within the NHS framework; including root fillings, crowns and bridges. Private treatment is required only for cosmetic treatment
 - You can have your teeth cleaned by the dentist within the NHS framework, and do not need to see a hygienist privately for this treatment
 - If you require specialised treatment for gum disease this can be provided within the NHS by a specialist
 - There is no difference between private and NHS practices in terms of the dentists' qualifications or the hygiene arrangements at the practice
 - Amalgam fillings are not dangerous and are of equal quality to white fillings

Further research

Further work is required to assess the oral health needs and access issues of BME communities who are not exempt from NHS charges as it is likely that they have different access and treatment issues from exempt patients.

Also, further research should look at patients' treatment history rather than just 'last appointment' as was the case in this study.

Such research will enable the local NHS to commission evidence-based services as required by the World Class Commissioning programme.

³² *Dental Commissioning in Context*, <http://www.pcc.nhs.uk/353#WCC>; *Commissioning NHS primary care dental services: meeting the NHS operating framework objectives*, http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/PublicationsPolicyAndGuidance/DH_082104

What the local dentists can do:

- Offer and book interpreters when needed
- Complete ethnic monitoring
- Ensure provision of information in the appropriate languages and formats

What the BME Health Forum can do:**Complaining & feedback**

Further work is required to examine the complaints system and enable successful complaining by people who are not fluent in English.

Information

The BME Health Forum needs to support and facilitate the dissemination of information with regard to preventive advice, finding a dentist and entitlements as described above.

Working with dental practices

The BME Health Forum is committed to working with two dental practices in the following year. Within this work the Forum should encourage the use of interpreters and gather evidence whether the use of official interpreters can lead to increased health outcomes for people who are not fluent in English.

Glossary

Amalgam

An alloy that consists chiefly of silver mixed with mercury and variable amounts of other metals and is used as a dental filling

BME

Black and Minority Ethnic

Bridge

An artificial replacement, fixed or removable, of a missing tooth or teeth, supported by natural teeth or roots adjacent to the space

Crown

An artificial substitute, as of gold or porcelain, for the crown of a tooth

Dentate

Having teeth

Equality impact assessment

An equality impact assessment is a tool for identifying the potential impact of a organisation's policies, services and functions on the population it serves and its staff. It can help an organisation provide and deliver excellent services to residents by making sure that these reflect the needs of the community. By carrying out an equality impact assessment a council may also ensure that the services that it provides fulfil the requirements of anti-discrimination and equalities legislation

Extraction

A dental procedure whereby a tooth is pulled out

Fluoride

Any of a number of naturally occurring compounds of the element fluorine. Fluorides have been found to be effective in preventing tooth decay and are routinely added to drinking water

KCW

The boroughs of Kensington & Chelsea and Westminster

PCT

Primary Care Trust

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Residents' Panel Survey: Health Care Report – Extract relating to Dentistry, 2009, Royal Borough of Kensington and Chelsea

Appendix 1

Results

Patients' questionnaires

About the patients:

Interviews were conducted with a total of 51 interviews (31 from Westminster, 20 from Kensington & Chelsea). Eight residents are or were refugees.

Length of stay in the UK

Less than 1 year = 3

1-2 years = 5

2-5 years =3

5-10 years =10

11years or more =30

Ethnic origin

Afghanistan=1, Brazil=2, Bangladesh=5, Caribbean=1, China=1, Colombia=1, Egypt=4, Eritrea=4, Ethiopia=1, Hong Kong=1, Iraq=1, Malaysia=1, Morocco=5, Pakistan=2, Peru=2, Portugal=3, Sierra Leone=1, Somalia=5, Sudan=9, Yemen =1

Gender

Males=9

Female=42

Age

20-29=7

30-39=14

40-49=12

50-59=11

60-69=5

70+=1

No answer=1

Do you have a disability?

Yes=8

No= 43

Do you have children?

Yes=40

No=11

Are you or your partner on any of these benefits or tax credits?

Yes=42

a) Income Support =23

b) Job Seekers Allowance=1

c) Pension Credit Guarantee Credit=3

d) Working Tax Credit=7

e) Child Tax Credit=12

f) Disability Allowance=3

No=8

No Answer=1

In total 30 people identified themselves as having difficulty communicating in English.

18 people spoke a language other than English to their dentist or said they had difficulty speaking English or that friends and family helped them.

15 people identified being unable to speak English as a factor that stopped them going to the dentist or made them postpone their visit.

15 people said that they have had to use friends of family to communicate with the dentist.

More analytically

In what language did you communicate with the dentist? (44 people gave information about their last visit to the dentist in the UK, although in two instances, the patients had been to a dentist abroad since and in 1 case, we have no dates about whether the UK was the last visit or not.)

Arabic=7
Bengali=1
Chinese=2
English=26
English & Arabic=1
English with help of friend or family=4
Poor English, no interpreting=2
Portuguese, Castilian=1

Are there any particular problems that have stopped you from going to the dentist or made you postpone your visit?

Yes = 32

No = 16

No answer = 3

Huge variety of reasons given:

6 said they were too busy (3 specified with childcare and 2 specified work or study).
4 said they had a previous bad experience (1 noted poor quality and 1 specified hygiene issues saying that on two occasions, the dentist did not use gloves).
4 said they were scared of going to the dentist
3 wouldn't go if they were ill (1 of these suffered migraines and asthma).
6 wouldn't go because of the cost.

Other issues mentioned were being told they were not entitled to free treatment, transport, being lazy, lack of info, language problems, lack of trust, difficult to get an appointment on the NHS and one person was referred to hospital and had to wait too long.

The people who had not been to the dentist for over two years (including those who have never been to the dentist) n=10

Yes=9

No=1

Two mentioned fear of pain/treatment, 1 mentioned cost, 1 mentioned a bad previous experience, 1 mentioned transport, 1 mentioned being busy with her baby, 1 mentioned being lazy, 1 mentioned language difficulty, 1 mentioned work, 1 mentioned being scared of catching an infection.

The most important factor stopping people go to the dentist or postponing their visit

Fear of Pain=12

Anxiety about treatment=9

Fear of Cost=8

Inconvenience of travel=4

Being unable to communicate in English=2

Difficulty in finding a good dentist=2

Difficulty in getting a suitable appointment=1

Put off by of the environment of the dental practice=1

Thinking that going to the dentist would be a waste of time =1

Thinking that treatment would do more harm than good =1

In addition 3 people said none of the factors would put them off and 7 gave no answer.

Number of people who put the following as the top 3 factors for stopping them from going to the dentist or postponing their visit.

Fear of pain=20

Anxiety about treatment =15

Difficulty in getting a suitable appointment=14

Being unable to communicate in English=13

Fear of cost =12

Inconvenience of travel =9

Difficulty in finding a good dentist=6

Put off by of the staff at the dental practice =6

Thinking that treatment would do more harm than good=2

Put off by of the environment of the dental practice=1

Thinking that going to the dentist would be a waste of time =1

Factors that matter at all:

Fear of pain=20

Anxiety about treatment =17

Difficulty in getting a suitable appointment=16

Being unable to communicate in English=15

Fear of cost =12

Inconvenience of travel =11

Difficulty in finding a good dentist=10

Put off by of the staff at the dental practice =8

Put off by of the environment of the dental practice=5

Thinking that treatment would do more harm than good=3

Thinking that going to the dentist would be a waste of time =1

Have you ever had someone help you communicate in English with the dentist? Who helped you?

Yes=15

No =28 (4 of these had dentists who spoke to them in their native language. 2 also mentioned that the lack of help made it a struggle or was difficult).

No answer =8

When was the last time you went to the dentist in the UK?

Less than 6 months =21 (18 NHS, 3 private, 5/21 had an extraction at their last visit, 4 of whom were NHS, 1 was private)

6 months-1 year =9 (All NHS, 2/9 had an extraction at their last visit)

1-2 years =5 (1 private, 4 NHS, 1/5 had an extraction at their last visit, NHS)

2-5 years =6 (1 K&C resident had visited a dentist in Morocco six months ago. From the other 5, 3 live in Westminster, and 2 in K&C. Four had an extraction last time they visited the dentist)

5+ years =2 (one had visited a dentist in Portugal two years ago), the other had an extraction when she last visited the dentist. Both live in Westminster).

Never visited a dentist in the UK =6 All Westminster residents. 1 had visited a dentist abroad within the last year, 2 within the last 2 years, 3 had never been to the dentist (All 3 were young women, 2 from Bangladesh, 1 from Morocco).

No answer=2 (But 1 later gives details of having attended a dentist in the UK without any dates).

Summary

35 people went to a dentist in the UK within the last two years. Of these, 31 people had NHS treatment.

44 (19 K&C, 25 Westminster) people have been to a dentist in the UK, 39 (17K&C, 22 Westminster) people had NHS treatment at their last UK appointment.

1 person has given no information about whether or not he has attended a UK dentist.

When did you last visit a dentist abroad? In which country?

Within the last year=6

Within the last 5 years=10
Longer than 5 years ago=11
Never=21
No answer=3
In total, 11 people visited a dentist in another country while living in the UK (5 K&C; 6 Westminster).
Within the last year =4
1-2 years =1
2- 5 years =3
5+years =3

Next time you want to go to the dentist, do you know which dentist you will go to?

Yes=35
No=14
No Answer=2

Your last visit to the dentist:

How did you choose this dentist?

Advertised at GP practice=1
I have known him for a long time=1
I walked past it in the street=6
Local=9
Randomly from a list given by the GP=1
Received a leaflet=1
Recommendation=23
Referral from another dentist=1
The dentist is Arabic=1
No Answer=7

Why did you go to the dentist? (n=48)

Check up =5
Cleaning =3
Crack in tooth =2
Decayed tooth=2
Dentures =2
Filling =5
Gum disease =2
Infection =1
Loose tooth =1
Pain =17
Problems =5
No Answer=11

Summary

Check up/cleaning only =6 (Westminster=5, K&C=1)
Specific Problem=31
No Answer =11

Were you given a convenient appointment? (n=44)

Yes=32
No=11
No answer=1

Did you think the practice was clean? (n=44)

Yes=35
No=8
No answer=1

What treatment did you receive? (n=44)

Antibiotics (including tablets)=4

Bridge (including 'adding teeth')=5 (aged: 35, 35, 39, 42, 45) Three of these patients had the treatment on the NHS.

Check up only=1

Check up and cleaning only=6 (5 had been to the dentist within the last 6 months and 1 had been to the dentist over a year ago).

Cleaning=9

Crown=1 (Private treatment)

Dentures=2 (aged: 65, 51) (The first patient had her old denture fixed on the NHS while the second patient got new dentures on the NHS.)

Extraction=13 (aged: 65, 39, 38, 39, 51, 70, 65, 55, 38, 42, 66, 60, 47) (Had last visited the dentist: Less than 6 months=5; 6 months-1 year=2; 1-2 year=1; 2-5 years=4; 5+ years=1) (11 of these patients were exempt from charges, 1 was a non-exempt NHS patient and 1 was a private patient).

Fillings=18

Was referred to hospital 6 months ago but no reply yet=1

No answer=1

Were you given a treatment plan? (n=44)

Yes=18

No=18 (includes 9 cases where the patient had fillings, 5 of extractions, 2 cases of cleaning only, 2 cases of adding artificial teeth. The fillings and extractions are all NHS cases.)

No Answer=8 (includes 1 extraction and 1 filling)

How much did you pay for the treatment? (n=44)

Free =33 (2 patients also had private whitening treatment, 1 of whom said the cost of that was £400 and 1 had treatment by the hygienist which cost £80. All these patients are on income support)

£500 (private treatment for broken teeth extracted & replaced, on disability allowance, probably exempt)

£16.20 (for fillings but also paid £200 private treatment. No benefits.)

£300 for each gap (private treatment, on income support, probably exempt.)

£24 (says it was NHS service for cleaning. Receives child tax credit.)

£20 (private treatment to fix broken piece, no benefits.)

Couldn't have treatment, very expensive. (Implant teeth, is probably exempt as is on income support)

£70 (private treatment, antibiotics, on working tax credit)

£10 deposit in case of missed appointment (Says it was NHS, ongoing treatment for gums, is on income support, probably exempt)

£200 - dentures, £25-extraction (Says NHS, is on Pension Credit)

Can't remember (private treatment for a crown that came off, no benefits)

No answer=1

Did you have any private treatment?

Yes=9

No=34

No answer=1

For 5 patients the treatment was exclusively private and for two their treatment was combined with NHS treatment. Exclusively private treatment consisted of replacing a crown, antibiotics, fixing a chipped tooth, implanting teeth, extracting teeth and replacing them.

Combined treatment included two cases of whitening, 1 of treatment by the hygienist, fillings.

When were you first told what the cost of treatment would be? (n=12)

Before=5

Afterwards=3

No answer=4

Were you happy with the care you received? If no, why not? If yes why?

Those who had some NHS treatment (n=39)

Yes =22 (8 had extractions)

No =15 (3 had extractions,
No answer=2 (1 had an extractions)

From those who had exclusively private treatment (n=5)
Yes=4 (1 had extractions)
No=1

From the people who had not been to the dentist for over two years n=7
Yes=4
No=3

Amongst the positive answers, reasons given were good communication, good service, and being thorough

Amongst the negative answers, reasons given were: "when filling fell out, asked to go private", rushed, "Seen different dentists, can't build relationship", "Not happy with black filling, destroyed smile", bad communication, unhelpful, "removed bridge by accident", pain, rude, unclean, expensive, long wait, no respect, filling fell soon after being placed.

From the people who identified language as a barrier and who has NHS treatment at their last appointment. (n=11)

Yes=5
No=6

Do you think you have a healthy mouth and teeth? (n=44)

Yes=23
No=21

Reasons given for not having a healthy mouth were: gum problems=6, chewing on one side only=1.

Would you go back to this dentist? If not why not? If yes why? (n=44)

Yes =27
No=17

Those who had NHS treatment at their last appointment: (n=39)

Yes=26
No=13

Additional comments:

Amongst the positive answers, comment were: good experience, good service, being treated well, convenient appointments, that the dentist spoke Arabic and that the patient has no choice but to continue attending because s/he are unsure about the quality of other dentists

Amongst the negative answers, reasons given were expense, bad service, poor treatment, bad experience, bad attitude, feeling rushed, poor attitude to children, lack of respect, ongoing pain and the location being too far.

When will you see a dentist again? (n=51)

Soon (including 'very soon' and 'asap') =10

Within a month =12

Within 2 months =2

Within 6 months =3

Only when needed =18

No answer=6

From these results it can be surmised that:

People who are in the middle of a course of treatment or have had treatment recently and feel they need more soon =13 (Three were probably in the middle of a course of treatment. Six were happy with the treatment they received, 7 were not)

People who recently (within the last 6 months) had treatment and do not intend to get more soon=9 (they were all happy with treatment they received).

People who haven't had treatment recently (more than 6 months) and would like to get treatment soon=12 (6 were happy with the treatment they received, 3 were not and 3 did not answer).

People who completed a course of treatment sometime ago (more than 6 months) and don't feel they need anymore in the immediate future=14 (5 were happy with the treatment they received, 6 were not, 3 didn't answer)

Have never had any treatment, and will have it when needed=3

Do you think it's easy to find an NHS dentist?

Yes = 23

No =22

No answer = 6

Reasons for saying 'Yes' included that there were many dentists around (n=5); that many surgeries advertising NHS treatment (n=1), that there was adverts, leaflets or lots of info sources (n=1), that friends' recommendations made it easier to find a dentist (n=1).

Reasons for saying No included:

1 said s/he didn't know where to find one

2 said it was hard to find a good one (one added especially for children).

6 said there were lots around but were not sure of the quality.

6 said that few dentists seem to accept NHS patients (3 of these specified that a few local dentists do not accept NHS).

1 said they were told they did not have enough points

3 said there were long queues or had to wait a long time.

1 said it was difficult because she had to wait for children to accompany her because of language difficulties.

The people who had not been to the dentist for over two years (including those who have never been to the dentist) n=10, Westminster=8, K&C=2

Yes=3

No=5 (few dentists accept patients on the NHS, have to wait until my children are available to interpret for me, there are lots of dentists around but I'm not sure of the quality).

No answer=2

Have you taken steps to find an NHS dentist? If so, what?

Yes = 21

8 said they asked friends (one of these also asked GP and one mentioned it was difficult because leaflets were in English)

5 said they asked in the community

2 found them off the street

3 searched the internet

1 said they researched and networked.

1 visited 2 local ones.

No =15

1 added that she was not confident about the quality so wouldn't look.

No answer = 15

The people who had not been to the dentist for over two years (including those who have never been to the dentist) n=10, Westminster=8, K&C=2

Yes =6 (internet, asked in the community, asked friends, saw in the street)

No=3

No answer =1

Is it important to you if the dentist is a man or a woman? Why?

No =39

Yes, Prefer female =6 (all these patients were female)

Yes, Prefer male =4 (two of the patients were female)

Reasons for preferring female dentist: religion, softer touch, easier to talk to, don't feel shy.

Reasons for preferring male dentist (offered by female patients): Bad experience with female dentist, Male dentists are better.

What are good reasons to go to the dentist?

16 stated oral health, however an additional 8 mentioned oral health issues such as infection control (1), taking care of mouth (1), hygiene (1), good breath (1) and decay prevention (3) and avoiding dentures (1).

8 mentioned regular check-ups.

5 mentioned cleaning.

1 mentioned aesthetic.

5 mentioned general problems.

13 specified pain.

8 mentioned a variety of problems such as gum problems (3), unhealthy mouth (1), bleeding (2), damage to teeth (1) and removal of damaged teeth (1).

In total oral health/hygiene prevention and check ups were mentioned by=31

Particular problems including pain, gum problems or damage teeth were mentioned by=22

Both were mentioned by=7

No answer= 5

Have you ever missed a dental appointment? (Didn't turn up and didn't cancel) If yes - What would make it easier for you to keep appointments?

Yes=14

No=24

No answer=13

From those who answered yes

3 said a text reminder would help them keep the appointment.

1 said a more convenient appointment would help them not to miss it.

1 said a £15 surcharge would help them keep it.

1 just said they forgot sometimes.

The number of people who have put the following as the top 3 things that would make it easier for them to make it to an appointment.

Reminder text=18

Reminder phonecall=28

Going to a dentist near home=28

Going to a dentist near work=3

More pleasant environment at the dentist=11

Being less anxious about the treatment you will receive=4

Being able to communicate in your own language with the dentist=12

Being able to communicate in your own language with the receptionist=5

1 said they don't need reminding.

Knowledge questions:

Is there anything you can do to prevent tooth decay and gum disease?

35 mentioned brushing teeth often as one the things to do. 4 of these specified doing it after meals, 2 specified doing it twice a day and 1 specified doing it before bed.

11 mentioned having regular check-ups, 1 of which specified having a 6 monthly check-up.

1 just said it was important to visit the dentist without specifying how often.

9 mentioned using mouthwash. (1 of these specified hot water and salt mouthwash).

7 mentioned flossing.

6 said to avoid sweets or chocolate.

2 said to avoid cold drinks.

1 said to reduce tea, coffee and alcohol.

1 said to eat a lot of vegetables.

1 said to use good toothpaste.

1 said to take good care of teeth.
1 said to follow dentist's orders.
1 said to have fillings.
1 said 'bleeding gums'. (?)
5 didn't answer (1 of which said it was too late cause they had already lost most of their teeth).

The number of people who put the following in their top 5, most important precautions for maintaining good oral health.

Brushing your teeth twice a day =46
Avoid sugary foods and drinks =35
Using toothpaste that contains fluoride =28
Have your teeth checked by a dentist or hygienist once a year =27
Use mouthwash =26
Avoid coffee and tea = 21
Quit smoking (including chewing tobacco) =15
Flossing regularly=15
Avoid fatty foods =8
Avoid alcohol =4
Avoid tough food=4
Avoid cold drinks=3
Do more exercise =0
Avoiding cold weather=0
Avoid vomiting =0
No answer=1

From the 4 patients that did not include brushing your teeth every day the answers were:

1) Avoid coffee and tea, quit smoking (including chewing tobacco), avoid fatty foods, avoid sugary foods and drinks. avoid alcohol.
2) Use mouthwash.
3) Avoid sugary foods and drinks, flossing regularly, using toothpaste that contains fluoride, have your teeth checked by a dentist or hygienist once a year, avoid alcohol.
4) Avoid fatty foods, avoid sugary foods and drinks, use mouthwash, avoid coffee and tea have your teeth checked by a dentist or hygienist once a year.
The population who have not been to the dentist for at least two years seem to be no different from the rest of population in terms of health messages. From the 5 most important health messages: 2 picked 4, 4 picked 4, 3 picked 2 and 1 picked 1.

Does the water in London contain any added fluoride?

Yes =15
No =4
No answer (don't know?) = 32

Can you catch a disease from going to the dentist?

Yes = 15 (9 of these specified that if it was not sterile or the equipment was not clean).
No = 21
Maybe/ possible = 5
No answer =10

Are amalgam (black) fillings bad for you?

Yes =19 Further comments on this were that amalgam fillings was painful, cheap, kept coming off and that they were banned in Brazil.
No =14 However some said that amalgam fillings were poorer quality and can be easily removed.
No Answer=18

Where would you go if you needed emergency treatment?

Dentist=14
Hospital (one of which added whatever was nearest)=16

GP=4
Walk in centre=1
Private=1
Depends on what time of day=1
The A&E is far=1
Would never go to A & E=1
No answer=11

What would you consider an emergency?

Accident (including 3 who mentioned tooth fracture)=6
Pain to severe pain=28
Infection=2
Loose teeth=2
Bleeding heavily=12
Gum problems (swollen/ disease)=4
Abscess=1
Fever=1
No answer=14

Where would you go if you needed urgent treatment?

Dentist=12
Hospital=22
GP=2
Night time pharmacy=1
No answer=14

What symptoms require urgent treatment?

Pain=30 (1 mentioned pain resulting in lack of sleep, 4 mentioned severe or unbearable pain)
Infection=4
Bleeding=10
Swelling=3
Gum disease=4
Fever=2
Losing a filling=1
Minor teeth issues=1
Accident=1
Trauma=1
Anything irregular=1
Same as emergency (which in this case was bleeding, strong pain, broken tooth)=1
No answer=11

How often should you have your teeth cleaned by a dentist or hygienist?

Every month =3
Every 2 months =1
Every 3-5 months=14
Every 6 months=20
Every 9 monthly=1
Once a year =4
When needed/ advised =2
No answer =6

If the patient has visited a dentist in the UK within the past 5 years. (n=43)

Did you have to pay the dentist at your last visit?

Yes =10
No =33

Was your treatment covered by the NHS? (Prompt: Are you sure? The question seeks to find out not only if the patient used NHS services but also if they genuinely know the difference.) n=43

Yes =34
No =9

Do you believe it is equally easy or difficult to get an appointment at an NHS practice as at a private practice?

Yes =10

4 of these ticked the box that said that **personal experience of trying to book an appointment** influenced their perspective.

3 of these ticked the box that said that **friends' experiences** was a factor.

No =21

6 of these ticked the box that said **media (television, newspapers, internet)** has an impact on their perspective.

7 of these said that **friends' experiences** was a factor.

6 of these said that **personal experience of trying to book an appointment** influenced their perspective.

No answer=13

Do you believe that you can get the same quality of care in the NHS and in a private practice?

Yes=8

No=29

No answer=6

What if any differences do you believe there are between the two services?

Private practice is too expensive (or mentioned money as a factor)=6 -

Private practice is better quality=14 -

In private practice you get quicker appointments=10 -

Private practice is cleaner=6 -

In private practice there was more care, attention or friendliness=7 -

In private practice there was better communication=1

In private practice the dentists were more professional or qualified=6

In private practice they had better resources, materials or range of treatments=4

Private practice was a better service=3

In private practice patients get more time =2

Easier access in private practice=1

No answer=17

**Has your dentist discussed the differences between private and NHS care with you?
What did he/she advise you to do?**

Yes =12

Additional comments:

- for fixing a problem
- when asked for particular treatment
- for daughter's brace
- for better quality
- keeps saying that treatments are not available on NHS
- covers can't be done on NHS
- hygienist
- for better and quicker service
- regarding payment
- because of teeth condition

No =25

No answer = 6

How often would you like to get your teeth cleaned? (n=43)

Every 1-2 months=2

Every 3-4 months =12

Every 6 months =22

Once a year =1

Whenever needed=1

No answer=5

Is it important to you that a hygienist rather than a dentist cleans your teeth?

Hygienist=12

Dentist=2

Either=13

Don't the difference=4

No answer=12

How often would you like to get your teeth checked? (n=43)

Every 3-4 months =8

Every 6 months =22

Once a year =7

Every two years=1

Whenever needed=1

No answer=3

If the patient has not visited a dentist in the UK within the past 5 years.

Why have you not visited a dentist in the UK? (n=8 all Westminster)

Not needed, can't find, expensive

Bad experience

No problems

Don't want to

No problems

Check up before leaving

Lived in South America

No need

Pick the top reasons for not having seen a dentist

No answer=3

I didn't need to go, I don't like going to the dentist=2

I couldn't spare the money, I find it difficult to communicate with the dentist in English, I didn't have time=1

I couldn't spare the money, I'm worried that if I go to the dentist I will have to start a lengthy and expensive course of treatment, I find it difficult to communicate with the dentist in English, I couldn't find a suitable dentist=1

I didn't need to go=1

If the patient has visited a dentist abroad within the past 5 years. Why did you visit a dentist abroad? (n=11)

Holiday =3

Pain while on holiday= 4

Living abroad =4

Better service=1

Required urgent treatment while being abroad=8

Treatment abroad is better=1

I know my dentist and I don't want to change him/her=1

Treatment abroad is cheaper, Treatment abroad is better=1

Results from the Shadowing Exercise

Twenty-two people who were either dissatisfied with their dentist or did not have a dentist were shadowed in an attempt to see if they would be successful in finding a dentist. The volunteers tried to shadow another 3 people but were unable to do so.

1) A.D., 30, Speaks English, Has lived in the UK for 6 months, and has already been to the dentist once. She had private treatment to fix a tooth that broke during the flight.

Barrier: cost.

Volunteer helped fill in HC1 form. Because A.D. volunteers but is not in paid employment, the certificate arrived early without need for any clarification. The volunteer accompanied A.D. to the dentist. This dentist was chosen because he is located near her home and is highly recommended. A.D. had a check up, preventive treatment and advice about her loose teeth. Very happy with treatment will return in 3 weeks time (on going treatment to prevent bruxism.)

2) J.C., 29, Speaks some English. Has lived in the UK for 1 yr 4 months. Has never been to the dentist in the UK.

Barrier: cost, Worried about the Home Office.

The volunteer helped J.C. fill in the HC1 form. However, J.C. did not want to include pay slips because she was worried about the home office finding out that she occasionally worked longer hours than the 20 hours entitled in her student visa. She also moved house and was staying with friends so she didn't want to put her temporary address on the form. She did not receive a certificate within the time frame of the project.

3) R.E., 26, speaks some English. Has lived in the UK 1 yr and 10m. Has not been to the dentist in the UK.

Barrier: worried about the Home Office, unstable housing.

Volunteer helped complete the HC1 form. However R.E. changed address and decided to wait until she settled before sending back the form. She was worried about sending her payslips but sent them eventually.

4) P.S., 25, speaks some English. Has been in the UK for 9 months. Has not yet been to the dentist in the UK.

Barrier: cost; worried about home office.

Volunteer helped her fill HC1 form. P.S. was worried about sending her payslips. Eventually she did but had not yet heard back.

5) M.F., 54, her daughter has interpreted for her in previous visits to the dentist. Has lived in the UK 19 months. Has been to the dentist in the UK before but found it too expensive.

Barrier: language, worried about Home Office.

Volunteer guided her through the application of the HC1 certificate. However, M.F. did not initially want to send the payslips because she was worried about working too many hours even though she had a residency visa rather than a student visa. Eventually, she sent the second form with the payslips and she received the exemption certificate.

6) T.B., 20, needs interpreter. Has lived in the UK for 17 months. Has never been to the dentist either in UK or Bangladesh.

Barrier: Has never been to the dentist, language.

The volunteer was unable to contact T.B. directly because of the language barrier and therefore contacted T.B.'s husband to ask him to take her to the dentist. She later attended T.B.'s language class to ask her how her appointment went. T.B. had her teeth cleaned and 1 filling. She also received advice about brushing her teeth and flossing. She was happy with her treatment.

7) M.A., 20, needs interpreter. Has lived in the UK for 1yr and 1m. Has never been to the dentist either in UK or Bangladesh. Had an idea about which dentist she would go to when she needs to go.

Barrier: has never been to the dentist, lack of support, language.

Volunteer was unable to contact M.A. directly because of the language barrier but contacted M.A.'s family to ask if they would take her to the dentist. M.A.'s husband and mother in law

said that they would take her and that they didn't need any help. When the volunteer saw M.A. again she said her family did not consider taking her to the dentist as important.

8) A.S. 27, needs an interpreter. Has lived in the UK for 4 months, has never been to a dentist either in the UK or in Morocco. She's pregnant.

Barrier: lack of information, language.

Volunteer took her to a dentist. Was told she was not entitled to NHS treatment. Was not able to get an interpreter. Volunteer took her to a different dentist. She was able to get an appointment for NHS treatment (the volunteer thinks this was because she was pregnant) and will get her family to interpret for her.

9) I.S., 39, her son has interpreted for her in previous visits to the dentist. Has lived in the UK for 15 years. Last went to the dentist 1 week ago but was not happy with her dentist.

Barrier: dissatisfaction, language.

Volunteer encouraged I.S. to contact a new dentist and make an appointment. The dentist cleaned her teeth and gave her advice and she felt much happier compared to the previous dentist.

10) N.G., 40, would like to have an interpreter. Has lived in the UK for 20 years, last went to the dentist nearly a year ago but was not happy with the service

Barrier: dissatisfaction, language.

Volunteer found an alternative dentist through NHS Choices. N.G. had an appointment and is happy with the new dentist. However she would like to have an interpreter.

11) A.H, 33, relatives interpreted for her in previous visits to the dentist. Has lived in UK for 14 years. Last went to the dentist over a year ago but was unhappy –said he removed a bridge by accident. Tried to get an appointment with local dentist but was told they were no longer accepting NHS patients.

Barrier: access, dissatisfaction, language.

Volunteer and A.H. visited a dentist and arranged an appointment. Is happy with the new service.

12) R.D., 33, speaks English, Interprets for others. Has lived in the UK for 25 years. Last went to the dentist in 2008. She was not pleased with her current dentist because her filling fell out soon after treatment and she was in a lot of pain. Said she wanted to go to a new dentist very soon.

Barrier: dissatisfaction, did not appear interested in getting treatment.

The volunteer tried to encourage her to go to the dentist but eventually lost touch.

13) M.J., 45, A friend has interpreted for him in previous visits to the dentist. Has lived in the UK for 16 years. Last went to the dentist in 2006. He had had private treatment which he found very expensive.

Barrier: cost, mistrust, language, not interested in getting treatment.

The volunteer talked with M.J. about making an appointment with a new dentist but M.J. did not want to because his last dentist had been very expensive and he thought had made the situation worse. He also thought there was no point because he had very few teeth left.

14) Z.K., 38, her husband has interpreted for her in previous visits to the dentist. Has lived in the UK 2 years, last went to the dentist Dec 08. She was not happy with her dentist because she suffered pain. After suffering severe toothache all night because she was unable to get an emergency appointment during the night, she has decided that she prefers not to go to the dentist.

Barrier: mistrust, language.

The volunteer was unable to help.

15) J.A., 67, speaks English. Has lived in UK for 26 years, last visit to the dentist 1 year ago, in UK for private treatment and in Malaysia.

Barrier: cost.

Volunteer told her how to get hold of an HC1 form to get a certificate reducing the cost of treatment.

16) L.M., 51, her daughter has interpreted for her in previous visits to the dentist. Has lived in UK 9 years, visited dentist in Portugal 3 months ago, and dentist in UK 1 month ago. She needed to have her denture fixed. She was not happy with the dentist, whom she found unhelpful and said there was poor communication between them.

Barrier: dissatisfaction, language

Volunteer and the patient searched on the internet for a new dentist and asked friends. Chose a dentist in Fulham. (Patient lives in Kilburn). Had a new lower denture made (free). Given instructions on how to keep her dentures clean. Was not happy with the denture and feels it will have to be replaced very soon. Will go back to this dentist in two weeks to have a denture for her upper teeth made.

17) A.M., 29, speaks English. Has lived in UK 9 years. Last went to UK dentist 5 years ago, and to dentist in Portugal 2 yr ago. She had a black filling and she wasn't happy with it cosmetically.

Barrier: dissatisfaction

Chose a dentist in Fulham. (Patient lives in Kilburn). Free NHS treatment. She had a temporary filling put in which fell out within a few hours. Filling had to be replaced two more times and is now uncomfortable. Very unhappy, would never go back. Is planning to go to a different dentist.

18) J.S., 70, her son usually interprets for her in previous visits to the dentist. Has lived in the UK for 4 years. Has not been to the dentist since she first came to the UK.

Barrier: language, disability (needs a walking aid).

The volunteer talked to J.S.'s son to get the name of the practice J.S. had visited before. At the practice, she asked for an interpreter but the receptionist (or practice manager) said she didn't know how to book it. The volunteer went back with information about how to book an interpreter. However, when she tried to book an appointment the receptionist with the information was on holiday and the other staff said that they were concerned that the practice would have to pay for the interpreting and refused to book it. The volunteer used a friend to interpret from Farsi and through this friend was able to find a dental surgery where the dentist spoke Farsi. J.S. says she's happy to ask for an appointment in this practice.

19) A.N., 43, speaks English. Has lived in the UK 25 years, last attended the dentist 2 weeks ago, but her dentist was away so she considered changing dentist because she was unhappy with him.

Barrier: dissatisfaction, lack of information.

Volunteer sent her a list of practices in the area. In the end A.N. decided to finish her current course of treatment with this dentist and look for a new dentist afterwards.

20) H.I., 53, speaks English. Has lived in the UK for 15 years last went to the dentist 1 year ago. She thought it was rushed and she was not happy with the treatment her children received. H.I. had not been aware that she could change dentist, she thought it was like GP registration.

Barrier: lack of information.

Volunteer gave her an option of 4 different practices she could attend.

21) I.H., 42, friends have interpreted for him in previous visits the dentist. Has lived in the UK 12 years, last went to the dentist two years ago, but was not happy with his dentist. He doesn't want to go to the dentist because of previous bad experience. Said he hoped he never needed a dentist again.

Barrier: mistrust

The volunteer was unable to help.

22) M.L., 41, speaks English. Has lived in the UK 8 years, last went to the dentist in Jan 09. In the past, she has been unhappy with the dentist near her home, and went to another dentist which was fine but a long way away. She feels they treat patients who ask for free treatment on the NHS less well.

Barrier: mistrust

The volunteer was unable to help.

Results from the Focus Groups

Two focus groups were held with BME residents from Kensington & Chelsea and Westminster. Almost all the attendees were unable to communicate in English and spoke through interpreters.

The focus groups were centred around the following three topics:

Finding a dentist –how you go about looking for a dentist, what criteria matter to you and have you had difficulties getting NHS appointments in the last 2-3 years.

Treatment – Are you happy with the treatment you received, how did you communicate with the dentist, did you receive advice about oral health issues.

Pricing –Are the presentation of the treatment plans and the pricing are clear, are you aware of the possibility of getting help with dental costs.

The first group was a group of 11 Somali women invited by the community organisation Midaye.

Finding a dentist

They chose their dentist according to the recommendation of friends and family and were willing to travel to a different borough for the dentist of their choice. Other considerations for choosing a dentist were locality, language and religion of the dentist. The women who did not find their dentists through a recommendation, found them through looking around in their local area.

When asked when they saw a dentist, most women said ‘every time I’m in pain’. However in practice this meant attending the dentist every 6-8 months or a year, or occasionally every 2 years.

None of the women said they needed a female dentist. One said she preferred a male dentist.

None of the women had difficulty getting suitable appointments.

Treatment

All women had been to the dentist in the UK, 6 were overall happy with their current dentist, 5 were not.

Seven women said they were unhappy with the treatment they had received and had suffered from ongoing pain after the treatment. One said that she thought the dentist lacked the sufficient skills, 6 said that the dentist was unwilling to investigate underlying problems (e.g. by taking x-ray) and opted for antibiotics and premature teeth removal. Many women felt their teeth had been extracted too soon, and that dentists didn’t try and save them.

Only 1 woman said that she’d been given any preventive advice. The women who felt that they had been given poor quality medical treatment thought that this may be partly attributable to poor communication (that the dentist didn’t listen to them)

The women also felt that because they are from a BME or refugee background, they were received with a less welcoming attitude, and the dentists were not caring, did not listen to them, did not treat them equally or fairly, and were not respectful. Some women also expressed the view that their dentist was not professional and made BME patients wait longer than other patients.

Although nearly all the women needed someone to interpret for them at the dentist, they all felt that the communication problems they had with the dentist were not attributable to the language barrier but to the dentist’s reluctance to listen to them. Most use children or others to interpret; they have not been offered interpreting and did not know that they can ask. They would like to ask but are hesitant about doing so. All the women said that they would prefer an official interpreter to a friend interpreting.

Three women would like to complain about the treatment they received. None know how to complain but they would prefer to do so in their own language and on the phone.

The women who were happy with their dentist felt that their dentist gave them a lot of information and advice and took time and responsibility over their treatment.

Payment

Only one woman ever paid for treatment –that was probably private.

None of the women knew if their dentist was NHS or private but they all knew they were entitled to free treatment

The second focus group was a mixed group of 12 people involving both men and women mainly Ethiopian and Somali. The majority spoke through interpreters.

Finding a dentist

Five people were happy with their dentist, 1 was unhappy and 6 had not been to the dentist within the last 5 years. Two had found their dentist through recommendation from friends, 1 from a recommendation from the GP, one had found their dentist by seeing their practice by walking around and one had found the practice through the internet. One patient had been turned down at the first practice.

None had difficulty getting appointments although they would like to have quicker appointments.

The gender of the dentist was not important.

One person attended an Arabic doctor in order to be able to communicate properly.

From the people that had not been to the dentist in the last five years, none had tried to get an appointment. Reasons included: a previous bad experience, feeling there was no need, having no information, having been told most dentists are private and being unable to go by oneself because of the language barrier. One also expressed the concern that if he made an appointment and then did not go he would still have to pay for the appointment.

Treatment

One person felt they had been given inappropriate treatment (a wrong injection). This patient was unable to speak English and while her daughter had initially interpreted for her, she had then left and the patient was unable to communicate with the dentist. Nevertheless she did not feel that this difficulty in communication was responsible for the problems with the treatment. Another patient complained that he had to wait 6 months for a hospital referral and another felt that the dentist had been rude.

Those who had friends interpret for them at the dentists and those who spoke to the dentist in English but felt unable to communicate well enough all said they would rather have official interpreting.

Four people said they had never received any oral health advice from the dentist, 1 said she had received such advice and 1 said that she received the advice once she asked for it.

Five people were worried about the sanitary conditions at the dentistry, how often equipment was changed and how the hygiene of the practices is supervised.

One patient was concerned that she was treated differently because she is foreign.

Payment

Payment was not an issue apart from as a barrier for finding a dentist and making an appointment. (Concern that treatment would be expensive and would be charged for a missed appointment). There were also some complaints that the dentists did not give them any advice on how to fill the form to claim reduction in costs.

Results from the Dentists' questionnaires

Seven dentists were interviewed. Four were located in Westminster (Bayswater, Paddington, Pimlico) and 3 in Kensington & Chelsea (Earls Court, High Street Kensington, Westbourne Grove)

Contract sizes of the practices varied between 8400 and 18000 (check two). Westminster practices had larger contracts than those at Kensington & Chelsea.

Abatement values were all 90-95% NHS except for one Westminster practice where the abatement value was 50%.

All the practices had a high proportion of BME patients estimated at around 60-80%. On two occasions, the dentist interviewed suggested that the proportion was around 30% but the receptionist/practice manager said it was 70%.

Increasing the number of patients

Only one practice in Westminster said unequivocally that they would like to increase the number of patients they have. They said that they had done leaflet drops, placed a sign outside and tried to advertise in local papers but apparently there were no local papers in which to advertise.

The other 3 Westminster practices linked the issue of increasing patients to the contract. One said that they would increase the number of their patients if the contract increased but this was not something they pursued, one said that they wanted to increase the number of patients and had tried to achieve that by asking the PCT for more units and the third said that they would like to increase the number of NHS patients so long as the contract increased and had tried to do so by advertising in magazines, putting an NHS sign outside and creating a website.

All three practices in Kensington & Chelsea said that they would like to increase the number of NHS patients they have. The steps they have taken to do so include advertising in yellow pages, at Tesco and at Chelsea & Westminster hospital, producing promotional material such as key rings, distributing leaflets to the surrounding areas, providing details of the practice to the local embassies, increasing capacity by hiring an associate, providing a new treatment room and opening on Saturdays. One practice said they get most of their patients through emergency services at Charing Cross hospital and that they have their details passed on by NHS direct and that they have a high ranking on google. None of the practices in Kensington & Chelsea were concerned about exceeding their contract –one practice described the contract as 'unlimited'.

Two practices said they were not interested in increasing their number of private patients. One of these suggested that NHS patients were more stable. From the 5 practices who said they were interested in increasing their private patients 4 said that the steps for increasing private patients would be the same as for increasing NHS patients. The Westminster practice with the 50% abatement value explained that 90% of their private work comes from NHS patients and that therefore by increasing the number of NHS patients would also increase their private work. One Kensington & Chelsea practice said that they increased their private work by giving options for private treatment to all patients, providing opportunities for further training to dentists so they could perform, specialised, cosmetic procedures and by advertising new instrumentation and rejuvenation procedures through posters in the waiting room. Although this practice has a 95% abatement value, the dentist interviewed originally suggested that the abatement value was around 80% value. When she realised that her original estimate reflected her own work rather than of the practice she said 'I guess I'm just lucky' indicating that in this practice private patients were considered a better investment than NHS patients.

Barriers

When asked an open question about any barriers faced by NHS patients, three of the dentists responded that there were none. One dentist said that many patients were not aware that

they were entitled to NHS treatment because in the past they have been refused NHS treatment by a dentist and that patients still think that they need to register with a practice. One dentist suggested the stairs were a problem, and one said that the number of units in the contract was the problem. Another said that fear was a barrier and that many BME patients did not regard oral health as a priority and therefore only visited the dentist when in pain. One dentist that very occasionally a dentist did not want to treat certain patients because he envisaged problems further down the line.

When given a list of options regarding barriers to accessing dental services, 4 dentists said that anxiety about treatment was the biggest barrier, 2 said that fear of pain was the biggest barrier while one said that being unable to communicate in English was the biggest barrier.

The ranking for the three most important barriers was as follows.

Barrier	Number of dentists
Anxiety about treatment	6
Fear of pain	5
Fear of cost	4
Inconvenience of travel	1
Difficulty in getting a suitable appointment	0
Put off by the staff at the dental practice, (receptionist, nurse, hygienist, dentist)	0
Being unable to communicate in English	1
Put off by of the environment of the dental practice	0
Perception that it is difficult to find a good dentist	2
Thinking that going to the dentist would be a waste of time	0
Thinking that treatment would do more harm than good	0

The results about which of these factors was considered a barrier at all was as follows.

Barrier	Number of dentists
Anxiety about treatment	6
Fear of pain	6
Fear of cost	6
Inconvenience of travel	3
Difficulty in getting a suitable appointment	2
Put off by the staff at the dental practice, (receptionist, nurse, hygienist, dentist)	2
Being unable to communicate in English	4
Put off by of the environment of the dental practice	1
Perception that it is difficult to find a good dentist	4
Thinking that going to the dentist would be a waste of time	2
Thinking that treatment would do more harm than good	3

Additional comments included that fear of cost was often not a problem because many patients don't pay, and that sometimes the staff at the practice are too stressed and don't talk to the patients enough. One dentist said that one important barrier which was not suggested by the questionnaire was laziness and not taking responsibility for one's self.

Gender

Four dentists said that some of their patients wanted to see a dentist of a particular gender. Three said some women (particularly Muslim women) wanted to see a female dentist and two dentists said that some patients asked to see a male dentist because they did not trust female dentists. One dentist said that these patients were mostly older Arab men. One dentist added that on two occasions, patients had requested a non-Asian dentist.

Communication

All dentists said that they have patients who don't speak English and who come to the appointments with friends and family who interpret for them. One dentist said that roughly 15% of his patients are unable to communicate in English. All the dentists said that interpreting by friends and family was usually satisfactory. Two dentists said that interpreting by friends and family occasionally caused difficulties. One said that problems were caused when the interpreter's English was not good enough to do the job and the second one said that sometimes the person interpreting interfered with the patient's decision making process.

Three dentists mentioned that there had been occasions when treatment had to be postponed because the patient was not able to understand what the treatment would involve.

Six out of seven dentists said that they had never used interpreting services because they had never needed to. The dentist who had used interpreting services said that interpreting services had been good in the past but the last 3-4 times he had tried to use them more recently no interpreter had been available and therefore he had given up trying to use them.

One dentist said that on occasion he has had to ring other patients to interpret for a patient who was receiving treatment, one dentist said that she had to ring her father so that he could speak to one of her patients in Italian and another dentist mentioned how a patient rang a friend from the practice so the friend could interpret over the phone.

Six dentists said that they were able to communicate with their patients in a number of different languages because they spoke a number of different languages personally but because they could use other staff members including nurses and practice managers as interpreters. One dentist mentioned that when she did consultations in Greek she occasionally ran into difficulties because she did not always know the technical vocabulary in Greek (she had been trained in English). Another dentist said that although he was fluent in Hindi and Bengali he did not conduct consultations in those languages for legal reasons – he thought it was better to let the patients bring their own interpreters because that way it was the patient who was responsible for the quality of the interpreting rather than the dentist himself.

Six out of seven dentists agreed that less than perfect communication inhibits the service patients receive. They said that communication was essential in order to reach a correct diagnosis and that it was important that patients understood the treatment plan so that they came back to complete the course of treatment. Another reason mentioned was that patients needed to realise how serious their problems were so that they did not either underestimate or overestimate the severity of their condition. Communication was also said to be important for informed consent. Two dentists said that miscommunication with patients was not very common/ quite rare.

Oral health issues particular to BME communities identified were oral hygiene, gum disease and periodontal problems. Chewing betel leading to higher staining and increasing risk of cancer was mentioned as were poor diets including sweets and fizzy drinks leading to large cavities. One dentist said that people from countries where they had very poor diets and no fluoride in the water had morphological problems with their teeth and that Somalians tended to use dental sticks rather than toothbrushes to clean their teeth which were not as effective. One dentist mentioned that Africans tended to have had poor quality dentistry in their own countries and therefore their teeth needed more maintenance.

In terms of support from the PCT to deal with these issues, one dentist suggested that the contract should do more to encourage preventive work. Another dentist said that leaflets on the issue of betel chewing in Bengali and other languages would be useful.

With regard to having to promoting oral health and the effectiveness of such a strategy with BME patients, one dentist said that it was not easy to convince people of the need to treat gum problems because the explanation was not as straight forward as showing them that they have a hole in their tooth. However, he showed patients a diagram of how gum problems lead to teeth becoming loose. He said that it is important to engage patients to contribute

toward their own oral hygiene as no 1 priority to achieve good oral health. Another dentist said that if patients stayed with the practice for years the advice would eventually sink in and their oral health would improve but that some patients are not interested –they say that everyone in their family has lost their teeth and it's not important. One dentist said that oral health advice was more effective with young people and that older people often didn't care but that over all BME groups are more worried about having clean and healthy teeth than the average native British person. By contrast another dentist said that oral health advice was less effective with BME groups because they didn't care and didn't listen.

One dentist said that the practice has computer programs and books to show people the consequences of poor oral health. They also have a hygienist but that seeing the hygienist is private treatment. If the patient does not want to pay for a hygienist then the dentists do the cleaning within the NHS framework. The dentist said that in his opinion the dentists do as good a job cleaning teeth as the hygienist, but that the hygienist is able to offer the patient more time.

Another dentist said that have a hygienist who sees patients on the NHS, oral health promotion days, and that they are training an oral health promoter. Effectiveness of these methods depended on the individual patient.

With regard to whether there way any specific issues that caused dissatisfaction to BME patients, these were the results:

Cause of Dissatisfaction among BME patients	Ranking according to importance by 7 dentists (1 is most important). Factors not considered relevant were not ranked.
Pain experienced	1,1,2,3
Cost of treatment	1,3,3,5
actice	1,2,2,4
Difficulties in communicating with the practice staff	2,5
	1,1,4

With regard to whether there was any help from the PCT that could help dentists increase the number of NHS patients they have or treat them better, 5 dentists mentioned leaflets in different languages. One dentist said that material should be produced in different languages encouraging parents to bring their children to the dentist as soon as they have all their teeth. This material should also explain to parents that they should not give their children sweets and should not use going to the dentist as a threat to the child. Another dentist said that leaflets in different languages should explain that there are NHS dentists and that if you are on benefits, treatment is free. Such leaflets should be available in GP practices, and job centres. One dentist (Westbourne Grove) mentioned that leaflets in Bengali would be particularly useful. One dentist suggested that the PCT should offer more units to dentists who can prove they see a bigger proportion of BME patients.

Two dentists (one Westminster, one Kensington & Chelsea) said that the NHS could help improve NHS dentistry services by increasing the number of units they are allocated. Other problems with the contract mentioned were that sometimes a patient needs very simple treatment which is nonetheless classified as band 3 and therefore very expensive for the patient. Another dentist said that for patients with multiple needs who required very expensive treatment, the banding system was too rigid and that multiple band 3 treatments should be permitted. Another dentist (Kensington & Chelsea) said that the PCT's priorities interfered with clinical practice such as when the PCT told a practice that they were having too many band 3 treatments or where not seeing enough children. He said that new contract was not supposed to require dentists to record every aspect of treatment, but increasingly, this was requested. Practices need security, and long-term contracts that do not change.

Other suggestions were that PCTs should do outreach work with regard to children, advertise the fact that NHS dentists are available, promote dental health in the population, so that patients have regular appointments and support staff training. Also specialist referrals are thought to be problematic because they take a very long time to come through and occasionally don't come through at all. Also patients are confused about the differences between NHS treatment and private treatment.

Additional comments

While a number of practices had posters up explaining that interpreting in different languages was available, it was clear that in 6 out of 7 practices, not only had the interpreting services never been used but the receptionist and/or practice manager had no idea how to book such an appointment. In one practice (Westminster) the practice manager said that sometime last year she had tried to arrange for an interpreter with language line but had been told that service would cost £75-100 and therefore she did not pursue it. In another practice (Kensington & Chelsea) the receptionist (who may also have been the practice manager) told me she did not know how to book an interpreter and asked me how to go about it.

The dentists, while being aware of the theoretical possibility of getting an interpreter, do not know that it's free or how to go about arranging it.

Private treatment

In one practice (Kensington & Chelsea) the practice manager told a patient, inquiring about the cost of having his teeth cleaned, that he would have to be seen by a dentist who would assess the situation and if the cleaning was something the dentist could do by himself it would only cost £16.40 but if it had to be done by the hygienist it would cost £45. The same patient inquired after having a root canal and the practice manager told him that the dentist would have to assess him and see whether the root canal could be done on the NHS or whether it had to be done privately because currently there was a very long waiting list for NHS treatment.

Results from the commissioners for Kensington & Chelsea and Westminster

There seems to be a discrepancy between the views of patients and the views of dentists with regard to the accessibility of NHS dentistry –patients feel NHS dental services are not very accessible while dentists say that they would like to have more NHS patients. What do you think causes this discrepancy?

One commissioner said that she did not know what caused this discrepancy. The other said that access to services had been a problem in the past and there is a time lag between patients' beliefs and patients' experiences. Many patients believe services are inaccessible because they hear that this is the case in the media. Also some services are not always available which can create the impression that they are never available. Generally, services are becoming more accessible. However, accessibility and availability are different, and there may still be problems with visibility, opening times and environment.

How do NHS dentists get paid for providing NHS treatment and how has this changed in the new contract? Has it affected services?

In the last 3 years, rather than get paid according to units of activity dentists have been getting paid according to bundles of treatment which take the patient from unhealthy to healthy. The three bands correspond to 1) Check up and clean, 2) Check up and basic treatment e.g. fillings; 3) Complex treatment e.g. root canals, extractions. Dentists get paid approximately £175,000-200,000 to see about 2000 patients, however there are different rates of payments for different dentists. The payments are received monthly and if at the end of the year the dental practices haven't fulfilled their contract the local NHS can claw money back. The Kensington & Chelsea Commissioner added that he has agreed that if the practices go over their contract they will be paid for the extra work but that this is no generally a problem since the practices generally under perform by 4%.

This method of payment removed incentives to over treat and challenged 'drill and fill' attitudes because dentists are no longer getting for each treatment activity (for example they get the same payment for 1 filling as they do for 3 fillings, same payment for a root canal as for an extraction).

Do you think that giving NHS contracts to practices that offer a lot of private treatment has been a successful strategy?

There are no new contracts offered to practices that do mainly private work. It is difficult to combine a large NHS practice with a large private practice, and each practice should be either private or predominantly NHS. (Some private cosmetic treatment has to be available to NHS patients). The difficulty lies with the history of commissioning practices -prior to the new contract any dentist who wanted to offer NHS treatment was able to do so. When the new contract came in, all dentists had the option to continue. But now we try to commission new practices so they are predominantly NHS.

Are there currently financial incentives for staff at dental practices to try and convince patients to become private patients?

One commissioner said she did not know. The other commissioner said that although dentists may believe that private patients are more profitable there was probably no difference. On the other hand, various companies sell products to dental practices which they have an incentive to sell on to their patients.

If dentists genuinely want more NHS patients, why do they not advertise this fact more widely (e.g. signs on the street)?

Because they're not very good at marketing, and because the business increases mainly by word of mouth. One commissioner added that there are also issues around the fact that dentists may want only certain types of patients and prefer keeping steady patients, rather than recruiting new patients. Also some dentists had difficulty with the council over putting up signs.

Do dentists have a similar duty of care as doctors to ensure that their patients can fully understand what treatment they are about to receive and any additional advice the dentist has to offer?

Yes.

Do you think it is acceptable for patients who are not fluent in English to have the consultation interpreted by their friends and family?

Interpreting by friends and family is not desirable but it has to be acceptable in certain circumstance, if for example, the patient prefers a family member and it is possible to establish the patient's informed consent in this matter. Interpreting by children is not acceptable.

Are there any plans to expand the capacity of NHS dentists? What criteria will be used to judge which practices/contracts should be expanded?

Yes. There are plans for two new practices in Westminster and three in Kensington & Chelsea. There will also be expansion of existing practices in both boroughs. Expansion will be based around a number of criteria, which are not published but include access, quality, capacity, tools, opening hours, and infection rates.

What do you think should be done by the NHS and by dentists to improve access to NHS dentistry in general and BME access in particular?

We need to learn more about the market of BME patients, which communities we have, their demographics, where they live, understand the attitudes and design marketing that meets their needs, for example make advice available that it's ok to visit the dentist during Ramadan. Also practices need to make use of interpreting services, have leaflets in many languages, be welcoming and friendly and provide quality service.

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