Full Equality Impact Assessment of Dental Failure to Attend
Advisory note

Patient Engagement Project Write Up

1. Background

1.1. A full Equality Impact Assessment (EqIA) was undertaken on the failure to attend (FTA) advisory note introduced by the Dental Support Team. The FTA advisory note offers guidance to dental practices on the effective management of patients who FTA appointments at general dental practices and orthodontic practices within NHS Bradford and Airedale.

1.2. Patients missing appointments without giving notice has become a considerable problem across Bradford and Airedale. This results in wasted practitioner and dental staff time; further stretches NHS dental resources; loses practices potential UDA/UOAs1; and deprives other patients of an opportunity for treatment. Practices were advised to periodically monitor the extent of missed appointments to help understand trends and target problem areas and consider appropriate interventions to reduce FTAs.

1.3. FTA data for the first ¼ January 2010 – March 2010 showed that 50 of the 74 NHSBA practices had taken part and had experienced 6,864 FTAs in total.

1.4. It was intended that once the FTA data had been collated by the Dental Support Team, 2 focus groups would be undertaken at practices experiencing the highest number of FTAs to target patients in order to develop a clearer understanding of patient experience for failing to attend an appointment and consider practical ways to reduce FTAs. This work is still to be undertaken.

1.5. In addition to this the Equality and Diversity Team conducted a broader patient consultation exercise to assess the impact the advisory note may have on vulnerable patient groups. Vulnerable groups were highlighted in the FTA guidance notes as patients with learning disabilities, physical disabilities, sensory impairments, mental health problems, older people, and patients for whom English is not a first language.

1.6. This report provides an outline of the key issues identified during focus group discussions with vulnerable patients from various community and voluntary sector groups undertaken by the Equality and Diversity team.

1.7. The aims of this project were to:
   1. Understand how patients had been affected by the introduction of the FTA advisory note
   2. Appreciate the reasons why vulnerable patients may FTA and
   3. What interventions could be introduced to support patients and reduce FTAs

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1 Units of Dental Activity/Units of Orthodontic Activity: the mechanism by which dental contracts are monitored and managed
2. **Methodology**

2.1. A focus group methodology was used to gather qualitative data on the experiences of patients. 20 voluntary and community sector groups and organisations were approached to participate in the project. These were identified to ensure representation from vulnerable patient groups considered to experience adverse impact. 13 groups participated representing all of the vulnerable groups as stipulated in the FTA guidance notes. A total of 117 people participated. Of the 117 people 91 were patients and 26 were comprised of advocates, group facilitators or support workers. These were individuals who had responsibilities either through a formal or informal capacity to act for or on behalf of the patient. These individuals were present at each focus group and helped facilitate discussions. The project manager was present and responsible for producing the report. One focus group was attended by a Dental Support Assistant.

2.2. A breakdown of each focus group is as follows.

<table>
<thead>
<tr>
<th>Focus Group</th>
<th>Focus Group Reference</th>
<th>Number of Patients</th>
<th>Number of Support Workers</th>
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<tbody>
<tr>
<td>African and Caribbean Women’s Support Group</td>
<td>FG1</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>Attock Community Association South Asian Women’s Group</td>
<td>FG2</td>
<td>12</td>
<td>1</td>
</tr>
<tr>
<td>Mayfield Centre Milan Group South Asian Women’s Support Group</td>
<td>FG3</td>
<td>13</td>
<td>1</td>
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<tr>
<td>Grange Interlink Asian Elders Group for Women</td>
<td>FG4</td>
<td>14</td>
<td>1</td>
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<tr>
<td>SURF Service Users Representatives Forum (NHSBA)</td>
<td>FG5</td>
<td>4</td>
<td>1</td>
</tr>
<tr>
<td>JOIN Learning Disabilities Support Group</td>
<td>FG6</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Supporting Peoples Service Users Involvement Group</td>
<td>FG7</td>
<td>0</td>
<td>1</td>
</tr>
<tr>
<td>European Workers Association</td>
<td>FG8</td>
<td>0</td>
<td>9</td>
</tr>
<tr>
<td>Community café for Black African Caribbean elderly</td>
<td>FG9</td>
<td>5</td>
<td>1</td>
</tr>
<tr>
<td>Disabled People's Forum</td>
<td>FG10</td>
<td>2</td>
<td>1</td>
</tr>
<tr>
<td>Peoples First Keighley &amp; Craven &amp; Bradford Peoples First</td>
<td>FG11</td>
<td>8</td>
<td>4</td>
</tr>
<tr>
<td>Physical Disability and Sensory Needs Partnership</td>
<td>FG12</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Bradnet over 55s D/deaf and Hearing Impaired People Support Group</td>
<td>FG13</td>
<td>18</td>
<td>2</td>
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<tr>
<td><strong>Total</strong></td>
<td><strong>91</strong></td>
<td><strong>26</strong></td>
<td></td>
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<td><strong>Total</strong></td>
<td><strong>117</strong></td>
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2.3. Open-ended questions were asked during focus groups meetings to shape the discussion. These were devised and agreed between the Dental Support Team and the Equality and Diversity Team. A flexible and adaptive approach was used to allow patients to emphasise their own perspectives and experiences.
2.4. This report summarises core themes and recommendations for improvement which emerged during the focus group discussions. Included are accounts of patients and support workers who provide an advocacy or support function to patients. A more detailed discussion of focus group findings is provided in Appendix 1 and a further detailed write up of each focus group meeting can be made available upon request.

2.5. The aim of the project was to understand how patients had been affected by the introduction of the FTA advisory note, the reasons vulnerable patients may FTA and what interventions can be introduced to support patients and reduce FTAs.

2.6. The NHS dental services review (Steele 2009) affirms that “there is relatively little information available about what is happening in NHS dentistry, who wants and gets NHS care, what happens when they receive it and, crucially, whether the services they receive are making a contribution to oral health”. Focus group findings extend beyond the initial scope of the project, which was to explore patient experience of the FTA advisory note. They go further to shed light on some of the issues noted in the quote above for Bradford district, and explore what works well for patients and what does not. Patients have shared much broader views, thoughts and experiences of dental services in general, consequently, recommendations are also broader and further reaching than the initial aims of the project.

3. Recommendations

Patient understanding and experiences of the ‘Failure to Attend’ advisory note

3.1. Steele (2009) emphasises the importance of maintaining good communication with patients as a measure of high quality provision. Project findings demonstrate that patients felt this was lacking in relation to the introduction of the FTA advisory note, hence support this recommendation.

3.2. Many patients from the focus groups, including elderly patients, patients who did not use English as a first language, patients with mental health problems, patients who had sensory, physical or learning disabilities and patients with drugs and alcohol issues, were unaware of the failure to attended advisory note. They were unaware of whether their practice had implemented the advisory note because they had not seen any information or received any communication informing them of its implementation and in particular any consequences for them.

3.3. Some patients had been removed from practices but were unclear about the reasons why, while others had experienced being removed and had later been informed that this was for failing to attend, and only then became aware of its implementation. The majority of patients had not received information about the introduction of the guidance note in advance. Patients recommended that practices inform them about the introduction of processes like this in writing, through leaflets and posters in accessible formats, and verbally via proactive and engaged receptionists.

3.4. Patients recommended that individual patient circumstances be considered when implementing the advisory note and particular consideration be given to vulnerable groups including the elderly, patients with learning, physical or sensory disabilities, patients with mental health problems and patients with alcohol or drug dependencies. Patients recommended that vulnerable groups be shown leeway, support and flexibility as they experienced more severe inequalities in negotiating healthcare provision and accessing services in an effective and timely manner, being removed from a practice exacerbated difficulties.
3.5. Patients recommended that practices operate fairly and only remove patients who had failed to attend an appointment and not other family members who had not missed any appointments.

How to reduce FTAs

3.6. Patients recommended a number ways to reduce FTAs. These included informing patients about the advisory note in the first instance, informing patients of the financial implications for the practice, sending out reminders to patients about appointments, like a letter, a telephone call, an email, a text message or fax.

3.7. Patients recommended that they be directly informed about any changing practices or the introduction of new policies such as the advisory note, in writing. This information could be reinforced by the receptionist and could be followed up with a letter or putting leaflets and posters in surgeries or sending out patient newsletters.

Six month reviews

3.8. Some patients talked about being removed from practices for not attending six month routine review appointments. They made the differentiation that technically they had not missed an appointment, that they had just not made the appointment in the first place. Support workers thought that the six month review was advised or was an option but not a requirement. In some cases where patients did not attend a review, other family members were also removed from the practice.

3.9. Patients questioned whether the six month review was the most appropriate recall method in place to produce good oral health outcomes.

3.10. Steele (2009) recommends that there be a continuity of the relationship between patients and dentists, built around the most appropriate recall interval for the patient. It also recommends that oral health be for life. Patients felt that in relation to the FTA advisory note and the six month review they did not experience either of these principles. They considered it a right to expect these principles be adhered to from NHS dentistry and felt that they had a right to return to their practice for care.

Increasing access to dental care

3.11. The NHS dental services review (Steele 2009) states that people have a right to access an NHS dentist and that the NHS needs to work to make this a reality and to extend this to a meaningful oral health service. It is noted that in 2007 45% of dentists would not accept new NHS patients and an estimated 2.4 million people go without dental care (Piachaud et al 2009). This was the experience of many patients from all of the focus groups participating in the project, in that many patients and their family members were without a dentist and were experiencing difficulties accessing an NHS dentist and recommended that the PCT address this issue.

3.12. Steele (2009) highlights that not everyone is the same and providing for the varying needs and aspirations of all of patients is important. Black and minority ethnic patients, patients with sensory impairments, learning and or physical disabilities talked about experiencing difficulties in finding a Dentist if they were not supported by a family member or Support Worker.

3.13. Patients wanted much more autonomy when accessing dental facilities and recommended that language and communication support for people who were hearing impaired or did not use English as their first language be more readily available.
3.14. Steele (2009) states that people are uncertain about how to find a dentist, that the information required is often not available in the right places, is not co-ordinated or is not kept up to date. This was the experience of patients and Support Workers. They experienced access to NHS dentists as unsystematic and irregular and talked about difficulties in the methods used to find a dentist, such as the internet or PALS, often describing processes as difficult, inappropriate or leading to limited success. It is recommended that processes to find a dentist be clearer and better communicated in various multilingual and accessible formats to patients.

3.15. It is recommended that patients be informed about what to expect from their dentist (Steele 2009). This was supported by patients participating in the project. They were unclear about what treatment to expect, what their entitlements were, the costs of and charges of NHS treatment. Patients entitled to free NHS treatment should be provided this. Pay plans should be clear and patients should be advised in writing of any changes.

3.16. Patients talked about individuals from the same family experiencing a dissimilar quality of service from the different practices they were registered with and recommended that the same high quality of service be universally available across all practices to all patients.

3.17. Steele (2009) states that even where services are available, they are not always accessible and that people’s access to services is constrained by the way services are designed and delivered. Focus group discussions highlighted that in some cases difficulties in access is resulting in an inappropriate use of emergency dental care.

**Providing information in accessible formats**

3.18. The NHS dental services review (2009) states that clarifying what it is that NHS dentistry offers, what dentists provide and what patients should get is an essential step in the provision of good dental care. All patients recommended that there be greater clarification about patient entitlements and patient rights in dental care.

3.19. In addition, patients recommended that they would benefit from more widely available information about how private and NHS services are structured, what patients can expect to pay and advice on how and where to complain about bad experiences. It was recommended that this kind of information be disseminated widely through community and voluntary groups and be made available in “easy read” formats for people with learning disabilities and in different community languages for patients who do not use English as their first language.

3.20. Not everyone is the same and providing for the varying needs and aspirations of all of the consumers of dental care is important (Steele 2009). It was the experience of BME patients, patients with sensory, physical and learning disabilities that practices did not know how best to support them or that they did not have sufficient systems in place to enable them to communicate with them and make effective use of services. It is recommended that practices undertake further patient engagement work with patient groups to ensure that they receive the necessary information, advice and support to give them the best opportunity to achieve and maintain optimal oral health.

3.21. Patients with physical disabilities corroborated this and further recommended that practices provide detailed information about physical access at the practice. Patients recommended that practices undertake assessments on their accessibility and have the information readily available for patients.

3.22. It was recommended that boards and visual aids in waiting areas be less clogged, clearer and easy to read. Patients said they were not very informative and stimulating and contained lots of text which hindered patients who are hearing impaired or did not speak English as a first language.
3.23. Many patients from all the focus groups commented on the important role a good receptionist can play in eliminating barriers to accessing services. They recommended that receptionists play a more proactive role in helping to inform, notify and support patients to receive good quality timely care in the most effective manner.

3.24. Good oral health and the quality of the service should be the benchmarks against which success is measured (Steele 2009). Patients thought that a measure of a good quality service was the consultation process and recommended more time and opportunity be allowed to ask questions to alleviate fears and improve understanding of oral health issues.

3.25. Patients wanted more information about oral health issues focusing on prevention and promotion in accessible formats. Patients recommended that for adults and children with hearing impairments, mental health problems or learning disabilities DVDs with pictures and moving images would be a better way of communicating. Multilingual information should also be provided in different community languages for BME patients who do not use English as a first language.

**Flexible care and out of hours provision**

3.26. Patients recommended that dental services be accessible out of hours, 24 hours a day, seven days a week and suggested learning from health drop in centres and replicating the same model for dental care. This would be particularly beneficial for patients with chaotic lifestyles due to their health issues, patients with mental health problems and patients with drug or alcohol dependencies.

3.27. Patients recommended that there be increased opportunities and more informal routes to information and care provision, such as ‘drop in’s’. This was particularly emphasised for patients with drugs or alcohol issues, who found it difficult to access care in a structured manner. Patients asked for flexible approach to dental care as a way of increasing access and uptake of the service, dismantling fears and creating greater awareness around oral health.

**BME patient experiences**

3.28. Steele (2009) notes that not all patients are the same and that it is important to provide for the varying needs and aspirations of all patients. Patients corroborated this and recommended that dentists be more responsive, adoptive and sensitive to individual patient requirements. Patients recommended that dentists be particularly mindful of the needs of the elderly, disabled patients, patients with learning disabilities or sensory impairments, patients who did not speak English as a first language, BME patients and people who led chaotic lifestyles as a result of health issues.

3.29. Nazroo et al (2009) points out stark ethnic inequalities in access to and use of dental care. BME patients participating in the focus groups supported this and expressed concerns about receiving differential treatment due to their race, ethnicity or other associated characteristics such as language.

3.30. Patients linguistic and cultural needs need to be met. Patients recommended provision of face-to-face language and communication support be available to improve their experience of accessing and using dental services effectively.

3.31. BME patients wanted to be involved in their treatment plan and be talked through the treatment process. Patients wanted to be clear and know exactly what to expect from their dentist and understand the treatment being offered. They recommended that clarification in understanding and consent be sought before undertaking any kind of treatment.
Disabled patient experiences

3.32. Disabled patients said that some of the minor physical adjustments that had been made to some dental practice were not always appropriate or completely accessible, such as wheelchair ramps. They said that wheelchair access does not mean that the practice has all the facilities a wheelchair user with limited mobility requires to be treated at the practice or that the premises is accessible to patients with other mobility or access issues. Patients recommended that practices improve access to their premises for all patients and engage with patients in order to understand what their requirements are.

3.33. Patients felt that some buildings had not been suitably modified for people with physical disabilities and recommended that accessibility audits be undertaken with practices to assess specific access issues and this information be readily available to patients.

3.34. Patients felt that practices did not want disabled patients to register with them because they could not meet their physical requirements. In some cases patients were being referred to hospital waiting lists where they had to wait to be treated for some time. These delays need to stop and patients need to be seen in a timely manner.

3.35. It is recommended that practices listen and take on board patient feedback to change their systems and make services more accessible to all patients including patients who experience communication or physical barriers.

3.36. It was recommend that practices effectively use IT to record patient needs to help improve the experiences of patients who have physical access needs or specific communication requirements, in order to provide a more seamless and accessible service.

Staff training

3.37. Many patients including people with metal health problems, drug and alcohol issues, limited English and disabilities felt that their needs were not being addressed by their practice because they were in a minority and did not present in significant enough numbers for it to change its practice.

3.38. Patients who did not speak English as a first language, patients with sensory impairments, learning and or physical disabilities, experienced various challenges in accessing and making effective use of dental services. They felt they were viewed as being different, hard work and requiring additional support. Patients recommended training be made available to address staff attitudes and behaviour towards them.

3.39. It was considered training would help develop a better understanding of patient needs and lead to improvements in how services are delivered, accessed and experienced. It was also thought that staff would be better equipped with the knowledge, understanding and skills to be able to work with and support patients in a more sensitive manner and give them the best opportunity to achieve and maintain optimal oral health.

4. Conclusions

4.1. The above recommendations are made by 117 participants from 13 focus groups representing various vulnerable patients groups across Bradford. Many of these are small achievable changes and require very little investment but can lead to significant improvements in patient experience. Implementation will enable practices to demonstrate in the Care Quality Commissions declaration how patient’s equality, diversity and human rights are actively promoted in the planning and delivery of services.
Appendix 1

Equality Impact Assessment - Dental Failure to Attend Advisory Note

Patient Engagement Project Write Up

Focus Group Findings

13 voluntary and community groups took part in the project. These were identified from the categories of vulnerable patients stipulated in the advisory note and included the elderly, people with learning, physical and sensory disabilities, people who did not speak English as their first language, as well as people mental health problems and people with drugs and alcohol. The findings are divided into various core themes and in the main patient narratives are provided to illustrate patient experiences and highlight how the indiscriminate nature of dental care needs to be tailored to patient need. In the main, patients told their own stories and shared their experiences, in some cases they relied on Support Workers to assist in the process, particularly in the focus groups where English was not a first language or where patients had learning or physical disabilities.

What patients like about their dentist

Patients talked about receiving high quality care from well organised well resourced practices, where the dentist took time to understand their concerns and talked to them about treatment; where Hygienists talked to them about prevention and health promotion; and where receptionists played a proactive role in informing them and keeping them up to date about any changes at the practice. Patients were telephoned to arrange six monthly reviews or were sent text messages to remind them about appointments, in some cases when patients missed appointments dentists gave them another opportunity and rearranged this for them. These, patients talked about were signs of good access and high quality provision.

“My Practice is good as they call me to remind me that I have a dental appointment (FG1).

“My Practice is very good at giving emergency appointments and they fit in with the school run. I’ve never had a problem with my Practice (FG1).

“My Dentist is very good and he offers me the right services all the time. He is local and I have been with him for very many years. My Dentist has very good manners, he’s very polite and very friendly and don’t feel intimidated but always completely at ease when I go see him (FG2).

“I’ve always received good treatment from my Dentist and on time whenever I have needed an appointment. He always deals with any questions I have or any concerns I might have (FG2).

A hearing impaired patient talked about a good relationship with his dentist “I do a lot of lip reading and can understand a lot of what they are saying. They have to take it at a slower pace and communicate with me” (FG13). He said he asked his dentist to look at him so that he can lip read. He said his dentist took time to stop and explain what he was doing before he put his mask on.

Patient understanding of the ‘Failure to Attend’ advisory note

Many patients from the different focus groups were unaware of the failure to attended advisory note. They were unaware of whether their practice had implemented the advisory note or not because they had not seen any information or received any communication informing them of its implementation and in particular the consequences for them.
“To be honest I don’t think they wrote to me to say if I missed an appointment they would take me off their register (FG4).

“Nobody told me. I better not miss one (FG11).

“No one has told me about this. I did not know that they can stop treating you if you miss an appointment. If I miss an appointment I would prefer to pay, like they used to a few years ago, rather than not be seen. It’s too harsh. My dentist hasn’t told me. I better not miss my appointment now that I know. To be honest I don’t miss my appointments, I try to remember, but when you are my age it’s hard to remember everything and there is always such a lot going on (FG3).

“While you wait they don’t speak to you, they don’t tell you about any new policies they have or new procedures. They didn’t tell me, look we’ve changed our policy now, so if you miss an appointment you will not be treated here anymore. It’s simple. There are all these posters up, but nothing that tells you about this (FG2).

There were inconsistencies in the implementation of the FTA advisory note from practice to practice which led to patients experiencing different outcomes.

“I’ve missed lots of appointments and I am not aware of this advisory note. Nobody has taken me off the register. I can make an appointment to see my Dentist whenever I like and have been with them for 9 nine years. My whole family is with them and we don’t have to attend regular appointments and even if we do miss appointments they don’t take us off the register. So I haven’t come across this problem (FG4).

Patient experiences of the advisory note

Some patients had been removed from practices but were unclear about the reasons why, while others had experienced being removed and had been informed that this was for failing to attend for an appointment.

Patients described circumstances and their experiences of being removed from dental practices after failing to attend for an appointment.

“I was at a practice for 15 years and I missed an appointment. I just completely forgot about the appointment and the practice took my name off their register. I just forgot and admitted that I had forgotten but the practice was just really harsh and were very angry with me. They were very annoyed and came across to be very rude and did not speak politely (FG3).

“My mum had an appointment to see her Dentist. She was waiting for two months before she saw her Dentist. She relies on me to take her because she can’t speak English. She attends all her appointments with Doctors and Dentists. However, on this occasion we missed the appointment because I was late in picking her up. Even though she has been with the Dentist for a number of years and it was probably the first appointment she missed, she was taken off the register (FG3).

“Like me. If you are with a Dentist for 10-15 years and you have attended all of your appointments and then you just missed one, surely the Dentist should consider how loyal you have been at attending your appointments? I think it is wrong when Dentist just take you off their register even though you have been their patient for 10-15 years. Striking you off the register, it is unfair (FG2).

“If you have been good at attending your appointments in advance and have gone for all the six month check up, but then you miss an appointment why do they take you off the register and why do they not negotiate and listen to your explanations to what has happened? (FG2)

“I was with my last dentist for 30 years. One day because my husband missed an appointment due to his night shift and waking up late, we were taken off his register. The Dentist I am with now is very
good and we see him regularly for treatment and he is good to me and my family. I had my previous Dentist for 30 years and could not believe that he treated me this way (FG4).

“The elderly who are in their late 60’s, 70’s and 80’s and often have dementia, forget about Dental appointments. This system goes against what they need. They need oral health at the right time, but people are being struck off without any consideration to their life circumstances (FG8).

A patient received mixed messages from her practice when she missed an appointment during Ramadan.

“I had an appointment with my Dentist in Ramadan. I completely forgot and missed the appointment. I never miss my appointments with my Dentist and when I realised I had missed the appointment I phoned my Dentist to explain to them. They said they wouldn’t take me off the register but they did. I later received a letter stating that they had to remove me from their list (FG2).

A patient talked about being removed from her practice even when she had spoken to them to explain her circumstances and cancel the appointment in advance. She also felt it was unfair that the same rules did not apply to dentists in the same way.

“I had a death in the family and I didn’t attend an appointment. I told them that I would miss the appointment but when I went back, the Dentist wouldn’t see me. I asked for further clarification and he sent me to another Dentist. The same Dentist had cancelled three appointments with me before because he was ill and when I called them to say that I was going to miss this one appointment there was no leeway even though I told them that I was going to miss this appointment in advance because I had a death in the family and had to go to a funeral. There was no leeway, no support, no flexibility. They just removed me (FG1).

A patient with visual impairment talked about her experiences of nearly being removed from a practice. The patient talked about being with the same dental practice for nearly 40 years because it was close to her home and accessible. She said that she had been attending appointments from the age of six and had recently missed a couple for health reasons. They threatened to remove her from the practice. She gave her reasons but they were unprepared to listen. She was afraid of having to register as a new patient with an unfamiliar practice so threatened that she would speak to the Telegraph and Argus. They then reinstated her. She was not pleased about using this tactic but felt that it was the only way to stay at the practice. She thought that practice staff failed to understand her circumstances and the difficulties a visually impaired person would experience in a situation like this.

In cases where patients missed an appointment and had been removed from a practice as a consequence, they tended to rely on emergency provision.

“I was registered with a Dentist for 15 years, I missed an appointment and I was taken off. Now I go to see an emergency dental team whenever I need and hence I’m not registered with a Dentist (FG2).

Other reasons for being removed from a Dental Practice

A patient talked about her 11 year old daughters experience of being removed from a practice list as an NHS patient and then being offered treatment as a private patient at the same practice.

“My husband and I and our three daughters were registered at X clinic and were all NHS treatment receiving patients. My husband and I and my two daughters were kept at the practice but the practice said they didn’t have room for our youngest daughter. When we asked why, they said that they were at full capacity and she would have to register elsewhere. I said to them please take me or my husband off the register but not our daughter because it is more important for her to be seen on time. We knew that it would be difficult to find a Dentist for her and we were prepared to go without dental treatment ourselves rather than our daughter. They said no. So we approached them a couple
of weeks later with the same request and the practice said to us if she was prepared to pay for her
treatment then they would take her on. This is unfair because she was registered at the same practice
as a free NHS treatment receiving patient, she is only 11. Why is it that they were able to do this?
First they said that they were at full capacity and later said that they would treat our daughter if she
paid. She is 11 (FG2).

A patient talked about how she and her family were left without a dentist and nothing alternative
was offered.

“I was at a practice on X Road and my Dentist committed a fraud. This is not my fault. I did not
know what was going on. Nobody from the PCT wrote to me. My whole family was with the Dentist
and none of us got a letter or a phone call to tell us that the practice was closing, for how long and
where we would need to go. For a long time my Dental practice was closed while I was phoning
them for an appointment and knocking on their doors to find out what was happening. Lots of people
from my street and from my area were registered at the same practice but we did not know what was
going on. Neither the PCT nor the Dental practice told us what was happening at this practice. Later
on we found out through the Telegraph & Argus that this Dentist had committed a fraud and had
been arrested and charged and the Dental practice was closing down. I hadn’t ever missed an
appointment to see my Dentist but I was taken off the register. All the patients at this practice don’t
have a Dentist anymore including my children. We didn’t miss any appointments and attended all
our appointments at this Dentist. Due to this Dentist committing a fraud we have been taken off the
register but not been given another Dentist to go and see (FG2).

Reasons for failing to attend

Patients talked about making real efforts to attend appointments often travelling long distances and
making arrangements to be supported by a family member or friend. Patients talked about feeling
apprehensive about the possibility of missing an appointment and how they tried to make every
effort to ensure that they communicated to the practice if unable to do so.

Some patients with drugs or alcohol issues also had mental health problems, many said that they
lead “chaotic lifestyles” and found it difficult to keep fixed appointments. They said that missing
appointments was not wilful and that it was a symptom of their condition and chaotic lifestyle. One
patient from the focus group remembered being very anxious about missing appointments which
led to him pulling his own teeth out.

A Support Worker summarised the various reasons patients may miss appointments.

“There are a lot of reasons why patients miss appointments. It is not because they don’t want to go
or they can’t be bothered. They have to travel long distances to see their dentist. Sometimes they
can’t speak English and do not have the language skills. They can’t communicate with the dentist.
People live alone or have mental health problems. There can be lots of reasons, but dentists don’t
make it easy for us either (FG3).

Six month review

Some patients talked about being removed from their practice for not attending a six month routine
review appointment. They made the differentiation that technically they had not missed an
appointment, that they had just not made the appointment in the first place. They felt this was
“unfair” as practices had not communicated that failure to make an appointment on a routine basis
for a review would also result in patients being removed from a practice.

“Dentists don’t just take you off their register when you don’t attend an appointment, they’ll also
take you off their register if you don’t attend for the six months review (FG3).

“Dentist’s don’t give you a choice to remove you from a list. Say for example, if you don’t attend
every six to twelve months for a check up they can take you off the list and they don’t even tell you
about it. It’s only when you phone up and they tell you you’re not registered anymore because you didn’t attend a six month review (FG1).

“My Dental Practice also has a six month review policy but nobody has ever told me this, even though I am English speaking. I have never received any notification of this policy and there is no notice, poster, information in reception to say that they will remove you from their list if you don’t attend a six month check up (FG2).

“I wasn’t aware of this. I did not know but my Dental practice has a six month review policy. If you don’t go to see your Dentist in those six months they will take you off their register. Nobody told me about this and I haven’t received a letter stating this. Although I don’t read English all my children read my letters to me. Nobody told me that there was a policy in place where a Dentist can remove a patient from their list if they miss a six month review (FG2).

In some cases where a patient did not attend for a six month review, other family members were also removed from the practice.

“My daughter was removed from the Dentist register. She didn’t go for two years because she was okay, she didn’t know she had to go to the Dentist every six months. She has been taken off their register and they didn’t even tell her. My daughter and I were living at the same address, my other daughter was struck off as well. Because I was having treatment with the same Dentist at the time they carried on seeing me but they stopped seeing both my daughters because they didn’t routinely attend to see their Dentist. They didn’t tell them, they could have told them. They could have told me while I was seeing them. I was seeing my Dentist when they struck off my daughters (FG1).

Many Support Workers for whom key responsibilities included providing patients with limited English skills, learning disabilities or mental health problems support to access health services were unaware that patients were required to make a six month review appointment. They too were unaware that a patient would only be seen at a dental practice for the duration of their treatment and would not remain a patient at the practice indefinitely, without receiving treatment (FG8). Some thought that the six month review was advised or was an option but not a requirement.

“Elder people in the communities wouldn’t know that they can be removed form the list. They assume that they are a patient for life just like it is at a GP practice. The six month reviews are forgotten by most people, a letter has gone to a different address, people can be struck off for all kinds of reasons. There needs to be some consistency on what kind of communication people would prefer (FG8).

“As Support Workers we were not aware that patients are on a dental practice register for a limited time, unless they book future appointments. Even we didn’t know they had to be seen every six months (FG8).

Patients and Support Workers talked about the problems of making a 6 month review appointment. After having been seen by their dentist, patients were unable to make the 6 month follow on appointment as they left the practice. They were requested by the receptionist to “make the appointment closer to the time” by telephoning the practice. This was impractical for some patients and led them to forget to make the appointment and consequently led to being removed from the practice. While some patients received reminders from their practice to make a 6 month review appointment, others said that they received no reminder and with the passing of time often forgot when they were due for their review appointment. Some patients talked about calling their practice to make a 6 month review, but were then requested to call back at a particular time in the week to make a routine appointment, they could not understand why the process was not straightforward.

Patient’s provided reasons why they may not make an appointment to see their dentist for a six month routine review.
“When you are paying for treatment, especially when you are on a low income you only go when you have to go. You don’t just pay for treatment you don’t need. When you don’t go they can take you off their register (FG1).

“We are under pressure to go and it costs us a lot of money. Fifteen pounds is a lot of money for me and I can’t afford it. That is why our teeth are bad. If you don’t go they take you off the register and if you do go it costs a lot of money (FG1).

Patients seemed unaware of why they had to attend a six month review appointment.

“With our Dentist it’s like we are a business for him. He only sees us when he wants to see us and he insists that we come to see him every six months for a review and we don’t understand why because my teeth are fine (FG3).

“I don’t know why it is that you have to attend for a six months review when your teeth are fine. Shouldn’t you have a choice of when you want to attend? (FG3).

Accessing NHS dental services

Many patients were experiencing difficulties accessing an NHS dentist. Some patients thought that there was a shortage of NHS dentists. Some thought that the availability of private Dentists had increased and NHS Dentists had decreased and commented on the PCT needing to “address this issue and balance the numbers” to meet patient demand because “everybody wants to access good quality NHS treatment” (FG8).

“I keep calling different registers. Different Dentists to register. I have been calling through May but haven’t been able to register with a Dentist and it’s been nearly three years since I have seen the Dentist (FG2).

“I have terrible bleeding gums and don’t have a Dentist. I’m trying to register with a Dentist but I haven’t been able to (FG2).

Some patients who thought they should be entitled to free NHS dental treatment felt compelled to find a private dentist.

“There are no (NHS) Dentist’s available so you have to register with a private Dentist to have dental treatment on time. This is too expensive even if you are on benefits, you still have to register with a private Dentist (FG2).

Patients experienced access to NHS dentists as unsystematic and irregular. This was impractical to manage with the family in how they accessed and used dental services.

“The trouble is in a family you don’t have one single Dentist anymore. The mother finds a Dentist, the daughter can’t. Or the daughter can find a Dentist but the father can’t. Or the father finds a Dentist and the son or daughter can’t, that’s the trouble. Everybody has a different Dentist in our family and two of my children don’t even have a Dentist (FG3).

Patients talked about individuals from the same family experiencing a dissimilar quality of service from the different practices they were registered with and felt that the same high quality of service should be universally available across all practices. A Support Worker2 talked about her personal experience.

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2 Support Workers work with different patient groups including, the elderly, patients with learning and physical disabilities to promote independence and assist patients access and make use of services such as social and recreational services as well as all aspects of health services, including dentists. Support Workers have trust and good rapport with patients and so were relied on to communicate the patient’s story. In some cases they assisted patients tell their story and communicate their experience. Mainly patients with learning disabilities relied on their support.
“Receiving a service is not a privilege but a right. Outcomes and experiences are different, there is a postcode lottery and the quality of one’s experience is different to the other. My Dentist has a hygienist who is very helpful. My husband is registered at another practice where they don’t have one. He asked the Dentist why they don’t have a hygienist and the Dentist said it was too expensive to hire one. We are both getting a different level of service from the Dentists (FG8).

Patients and Support Workers were uncertain about how to find a dentist. They talked about difficulties in the methods used to find a dentist, such as the internet, often describing the process as difficult or inappropriate and leading to limited success. They felt that the information they required to find a dentist was out of date, uncoordinated and not kept in the same place.

“My son has used a website and whenever you call the dentist on the website they always say they’re fully booked, so how do patients go and find a dentist? Our oral health is suffering, it is getting worse and worse, not ours but that of our children’s as well, and we are in real trouble because we cannot find a dentist and no one is listening to us (FG3).

“They told my daughter to go on the internet to register. Now if she wasn’t there, I wouldn’t have anyone to do this for me. I don’t know English, I can’t use a computer and don’t know what the internet is (FG4).

“It is not a straightforward process trying and finding a dentist. It’s a 3 or 4 step process. For example, I have called NHS direct, the 0845 number and then they will give me a telephone number for the dental service. When I call the dental service they’ll ask me to call back at a certain time and then tell me they have no space for new patients. To register, it takes forever. Sometimes all they do is just refer you to the PALS register and all that means is that you’re on another register before you actually go on the dentist’s register. See I work with all the Asian women here and I can tell you it’s not easy. Whenever, I have had to phone up to find someone a dentist it’s not straightforward (FG3).

“When we call the PALS service to find a dentist, they just give us a list of telephone numbers to call or they put your name on their register but you don’t hear from them in months. I must have registered about 12 months ago and I still don’t have a dentist (FG3).

“I work with Asian women and a lot of people come to me when they have problems in seeing their doctor or finding a dentist or seeing the optometrist or they need language support or even travel support as they do not have the means of transport to get to where they want to. And I know for a fact that there are at least twenty families that I know that live in my area that don’t have a dentist and each time they call the PCT service and each time they call up a dentist they are not really getting anywhere. They’ve called local care direct, they’ve called some of the dentists, but no one is prepared to take them on their register and all they are doing at the moment is sitting on a PALS register, but they still don’t have a dentist (FG3).

In the main patients accepted that in order to see an NHS dentist they had to travel long distances and made efforts to do this. However, for some, it was a particular problem. For example, parents with children, the elderly, patients with a physical or learning disability, all found travelling long distances difficult to manage.

“Why is it that when I live in a particular postcode or area I have to travel 10 miles to go and see my Dentist? That’s not right and it’s not fair because I’m a pensioner and why can’t I go to see a local Dentist. It’s silly and they don’t think about how difficult it is for me to travel all the way round Bradford (FG3).

Making a telephone call to make an appointment to see the dentist or cancel an appointment proved a challenge for some patients, particularly patients who had a mental health problem, a speech impediment, a hearing difficulty, the language skills or the confidence to do this. The alternative to face-to-face contact was a telephone call and this was not always practical.
Deaf or hearing impaired patients unable to use a telephone, felt practices did not have sufficient systems in place to enable them to communicate with them effectively and often felt that they had to make a face-to-face visit to get the desired outcome. Patients with a hearing impairment felt dental practices did not know how to support them.

**Dental charges**

Many patients expressed confusion about payment of care and seemed unclear about cost of NHS dental treatment and the charges structure. In some cases patients receiving state benefits such as income support thought that they had paid for treatment when this should have been provided free of charge, while others felt not enough was done to clarify whether indeed they should have paid or not.

"People tend not to be aware of free treatment and what the criteria is. Dentists and receptionist should be responsible in asking this question. Often they deliberately don’t ask the question and take advantage of the situation. People are not prepared to challenge this because people want to hold onto the Dentist as it is hard to find one. They will pay a higher price even when they cannot afford it (FG8)."

In cases where patients were unable to find an NHS dentist and were unable to pay for treatment privately they talked about an inappropriate use of emergency dental care.

"The problem is you can’t find a Dentist in Bradford. That’s the problem. The only way I can see a Dentist is if I make an appointment to see an emergency (FG3)."

**Changing services**

Patients across the different focus groups talked about experiencing changes at their practice without being consulted or informed. Some NHS practices offering private treatment started charging their existing NHS patients private rates for treatment. Patients in receipt of state benefits expressed confusion about entitlements as they were being required to pay for treatments they ought to have received free of charge. In some cases patients mentioned that even though they had made clear that they were not required to pay for treatment they had been required to do so but had not queried this any further. Support Workers supporting vulnerable patients also told of stories where patients were paying for treatment because they did not know what their entitlements were or because they lacked the confidence or English language skills to be able to query the charges. Support Workers also considered treatment and pay plans unclear to patients generally and said that patients did not fully understand how much they should be paying for good quality work. Despite this patients often stayed with the same dentist.

"I have stayed with my Dentist from when he was NHS. He knows my history, when I joined. I have stayed with the same Dentist and I pay for my treatment even though I’m on benefits and I should be entitled to free treatment. I am faithful. I might not get the same service from another Dentist so I have stuck to the same Dentist (FG1)."

"My NHS Dentist turned private and gave us no information about his change. He went private and I was forced to stay with him because I have known him for ages and I don’t want to change as I don’t know if I will get another Dentist elsewhere even though this means I have to pay for my care (FG1)."

"I’m scared of moving from my Dentist. At least I know what I’m getting and he knows my condition. I pay for my treatment although I shouldn’t do (FG1)."

"Now that we are in a recession, oral health really needs to be dealt with otherwise there will be a major crisis as some people cannot get an NHS Dentist. People are losing their jobs and with less money in their pockets the access to good Dentists needs to be made available. The elderly who have
Experiences of disabled patients

Patients with sensory impairments, learning and or physical disabilities talked about experiencing difficulties in finding a Dentist if they were not supported by a family member or Support Worker. It was the experience of Support Workers that Dental practices were reluctant to take on patients with learning or physical disabilities because they were seen as being “hard work”. Support Workers played a vital role with patients in helping them live independent lives and often made appointments, cancelled them or accompanied and advocated for them during them.

Patients with sensory impairments, learning and or physical disabilities experienced various challenges in accessing and making effective use of dental services. Support Workers often corroborated this. In the main their experiences were to do with staff attitudes and behaviour or lack of facilities to support their personal physical requirements. A patient said practices “sometimes have a loop system and you ask them what it is and they don’t know. Often the mechanics of the machine are stored away and yet they advertise the loop as an access in a practice (FG10).

Patients with sensory impairments, learning or physical disabilities often felt that they were viewed as being “different” less capable or “hard work”. A Support Worker’s view was that dentists were less likely to take on patients with learning difficulties because they required more time and resources and dentists were unaware of how best to support them. Some patients described how practice staff were “uncomfortable” around them, they would spend less time with them or were inhibited when communicating with them verbally or non-verbally. A visually impaired patient said “It seems as though they don’t want to touch me and are frightened of me or people with disabilities (FG10). The same patient said “If a Dentist has a patient who is visually impaired or completely blind they have no idea what do to”.

A patient talked about being “invisible” because she was deaf. She shared an experience at her dental practice. She arrived at the practice and gave her name at reception and wrote a note to the receptionist to say “I am deaf and you need to come over and walk in front of me to tell me when it is my time to see the Dentist, so I can lip read, otherwise I won’t know I’ve been called”. She said she sat at in the waiting area looking for someone to come up to her, as instructed. In retrospect, she said she remembered one person coming into the waiting area with a mask on and thinks she may have called her name. But at the time she carried on waiting for 45 minutes or more. She said she began to feel very anxious and finally went to reception to say she had been waiting for 45 minutes and that she still had not been seen. The same receptionist she had left a note with instructions earlier, at this point pointed out that someone had called her name out 45 minutes ago. She said that even though she had gone to some length to inform the receptionist, she felt unheard and “invisible”. Another hearing impaired patient talked about being at a practice for a number of years and how the practice was still unaware of what his needs were and forgot him every time he went to see them.

A visually impaired patient with no sight who wore dark glasses to block out indoor and outdoor light told about staff awareness and attitudes towards her disability. She said her dentist challenged her and asked her to remove her glasses and to wear transparent safety goggles, even when she explained that she had to wear light blocking out glasses to protect her eyes. She feels much of the interaction was about lack of knowledge about the disability and an unwillingness from her dentist to ascertain how best to support her. She said she understood the health and safety requirements and is willing to wear dark light blocking safety goggles that met her requirements, if provided (FG10).

A patient with a hearing impairment talked about her receptionist having a “very poor attitude and often smirking or laughing at you as though they have never met a deaf person before. They need to be a little more deaf aware” (FG13). Another hearing impaired patient said a” Dentist needs to
be skilled in how to support a patient and needs to speak to them face-to-face, provide visual aids. They can’t talk to them behind a mask. They can’t talk to them behind glasses or when a patient has their mouth wide open. Deaf people can lip read, so if a dentist took time and talked to you face-to-face it would cut out any misunderstanding” (FG13).

A Support Worker talked about the experience of a family member with learning disabilities.

“My four year old nephew has real anxiety issues about going and seeing the dentist. Dentists are not trained to think about children with special needs and why it is that they behave the way they do. He has real anxiety issues and is very afraid and the only time he ever really has to go to a dentist is when it is an emergency situation. He gets very anxious, he can’t sit still, he constantly moves all the time and the dentist does not help. He (the Dentist) starts shouting and he keeps saying “Why is he moving? Can’t you tell him to keep still? I’m only going to be few minutes”. But why can’t the dentist see that obviously he is not a normal child and there is something not quite right here. The dentist is so insensitive, he gets very very angry. He should really know better. Why is it that they behave like that? He actually once shouted at my nephew and I just did not know what to do. I just accepted it, that’s the way things are (FG3).

In addition to staff knowledge, perceptions and attitude, physical access was a particular problem where practices were based in old houses in built up residential areas or pedestrian zones. Parking close to the practice was for local residents rather than patients attending the practice. Blue badge holders thought they were parking a long distance away from the practice. Patients using wheelchairs often relied on family members to take them to see the Dentist because it was difficult to park close enough to the practice as a disabled badge holder or because there were limited identified spaces. A patient said that practices are accessible for patients who are physically able (FG12).Patients felt that some buildings had not been suitably modified for people with physical disabilities in general even for those that do not use a wheelchair.

A wheelchair user described an experience at a dental practice where he used a ramp to access the building. He said the practice was in an old Victorian house on a busy main road and he found car parking difficult as it was not directly outside the building. He had use of an automated wheelchair without a foot rest, designed specifically around his physical needs. His wheelchair is narrower, more compact and more manoeuvrable than standard wheelchairs and he confidently uses this. The practice he attended had a narrow and steep ramp. He was a confident user of his wheelchair and even though he experienced challenges negotiating the ramp he was able to do this, however, he warned that the ramp would cause problems for someone using a manual wheelchair which is more difficult to push up and down a narrow and steep ramp. When he gets to the entrance of the building the doors open into the building into a small vestibule and a further door leads into the main building and the reception area. From here he is able to manoeuvre his way to his Dentists clinic on the same level. He is able to lift himself out of the wheelchair into the dental chair and back. However, when he leaves the building the doors open inwards and the only way for him to leave the building is to make the journey out of the building backwards. Since there is very little space for him to manoeuvre the wheelchair outside the building he has to proceed down the ramp backwards. He went on to say that for the most part of his journey he is able to use his specially adapted wheelchair to negotiate himself up the ramp, into the building, out of the building and down the ramp, however, stresses that many wheelchair users would experience problems. He went on to say that just because practices have ramps this does not necessarily mean that they are accessible and safe for all disabled people or users of wheelchairs.

Many patients felt that practices did not want disabled patients to register with them because they could not meet their physical access requirements in some cases they thought they were receiving a poorer service. A wheelchair user pointed out that practices required a hoist to help patients move into the dental chair, since most practices did not have one to do this, he found that patients were referred to hospital waiting lists where they had to wait to be treated for some time.
Experiences of BME patients

Some patients felt that they had been receiving differential treatment due to race, ethnicity or other associated characteristics. Patients at focus groups with South Asian elders highlighted their views and experiences.

“Lets be clear, where white people live they tend to have good services, they tend to have a good GP and a good hospital, but where we live we have really poor services. Let’s be straight, people who have been treated well talk about services and nobody ever says anything good because where Asians live the services are not very good at all (FG3).

“Dentists treat us in a very bad manner. They think that we can’t speak English and think that we can’t communicate with them. They must think that we’re really uneducated and we don’t know what we are doing. Every time I go in to see my dentist he doesn’t really speak to me properly. He must think that I can’t speak English. I can speak English but he may not understand what I am saying because of my accent so I don’t say anything and I try not to ask many questions in case he becomes really irritated with me as well (FG3).

Patients recommended provision of face-to-face language and communication support be available to improve their experience of accessing and using dental services effectively. South Asian patients recommended that they be involved in their treatment plan and be talked through the treatment process and clarification in understanding and consent be sought before undertaking any kind of treatment. Patients also wanted to be clear and know exactly what to expect from their dentist and understand the treatment being offered.

Eastern European Support Workers working with first generation migrants talked about how dentists and health professionals in general are viewed.

“There is also the belief that the health professional is English and from here, whereas ‘I am from abroad and don’t belong here’. ‘He is correct as he is part of the culture and I am not because I am not English’. Due to this they won’t challenge the Doctor or Dentist when they experience a particular problem. They dare not ask any questions that are pertinent to their health...Some of them are too frightened to ask (FG8).

Patients shared difficult experiences of family members, including children, people with mental health problems and elderly patients and talked about the importance of dentists being responsive, adoptive and sensitive to individual patient requirements.

“My son has terrible reflux he used to go to the children’s specialist service system in Horton Park and they used to treat him really well. They knew how to treat children with anxiety, or special needs or disability. As soon as you put something into my son’s mouth he starts to be sick he has this really bad reflux problem. Now he has grown up but still has a problem and he goes to see a normal dentist. The normal dentist does not really take into account that people have different needs. There’s nothing wrong with him, he’s fine physically and mentally but he just gags, he has this reflux problem and starts being sick or feels sick. Sometimes as soon as the dentist puts something into his mouth he feels sick. The dentist gets angry with him now even though he is a lot older. They say to him “Hurry up, we need to get on with things” and he gets really frustrated, it helps him in no way (FG3).

It was felt that some patients, particularly the elderly required more time, understanding and an opportunity to ask questions and relax, in order to help them overcome previous bad experiences, or fears and phobias of visiting a dentist.

“My mother went to the dentist, her tooth was really rotten, she was afraid of going to the dentist. Eventually when she went they couldn’t take out the tooth properly. It took about 3 appointments to get the tooth out from the root, it was a very very bad experience for her. She has abscess issues and she just goes to her doctor for antibiotics. They don’t give it to her but she won’t go to the dentist
again. Dentists really need to think about how they treat their patients, so after an experience like that, they should think this must have been a very traumatic experience for this patient, how can we make it easier for her next time. They don’t do anything like that. They don’t think about how people are absolutely terrified about going to the dentists (FG3).

“They need to think about the individual patient. My husband had his tooth taken out from the wrong side of the mouth. How can you make a mistake like that? Surely he would have been able to see that the tooth he took out was healthy and the tooth he didn’t take out was still in his mouth and that did needed taking out. Now when my husband has tooth pain he doesn’t go to see his Dentist. He takes painkillers and copes with the pain. He just won’t attend the Dentist again (FG4).

An elderly visually impaired patient had not been to see a dentist for over 20 years. She had dentures which she no longer wore because they did not fit properly. She had “poor experiences” with the dentist in the past which remained with her and affected her confidence and so she did not wish to visit a Dentist to have new dentures fitted. She talked about not being able to eat, drink and talk properly, and was prepared to continue to live like this (FG12). Similarly, other patients talked about other significant incidents in their lives which led to similar negative associations with dentists.

Suggestions for improvement

Reducing FTAs

To help reduce the number of failure to attend patients made a number of suggestions that would go some way to ensure patients kept their appointments. These suggestions included sending out reminders to patients about their appointments, including a letter, a telephone call, email, text message or fax.

“Dental Practices should send out text messages and remind patients about appointments because Dentist are not computerised they cannot do that (FG1).

“I understand that Dentists lose time and they lose money if you don’t attend an appointment. I don’t try to miss my appointments on purpose but it would be helpful if they called people, just telephone people to remind them. It would be helpful if my husband received a text message to say that I had an appointment (FG2).

“Dentist’s appointments are always two three months and sometimes you can forget these. You should receive a card from your Dentist in the post like an electricity or gas bill to remind you about your appointment. We all remember when to pay our gas and electric bill in the same way if we received notification from our Dentist we would know when our next dental appointment was (FG2).

Patients asked to be informed about existing, new and changing policies that could impact on them. In case of the failure to attend advisory note, many patients did not think they had been informed about the introduction of the advisory note, but had been affected. Patients felt that directly informing patients face-to-face was the best form of communication, for example, when a patient attended an appointment a receptionist could inform them about any changes. This could be followed up with a letter or putting leaflets and posters in surgeries or sending out patient newsletters. All of these suggestions patients felt would assist in keeping them informed.

“We would like some warning about policies at the Dental practice. For example, if you don’t attend a six month review you will be removed form the list or this policy may take you off the list without warning when you miss an appointment(FG2).

“Dentists need to make their reception areas more attractive and clearer. There are lots of posters covering posters and you cannot see what is underneath. They need to tell us about their policies and regulations at their practice. What they can do is put up posters on their walls or gives us information to read. There is hardly anything there that I can understand (FG2).
“If they are ready to throw you off a list then why can’t they send you a letter or tell you verbally that they have a policy in place that if you don’t attend the appointments they will take you off. They should make patients read this and sign this (FG1).

**Provision of information and communication support**

Patients from all the focus groups talked about difficulties in accessing good quality care and treatment and made suggestions about what would improve their experience. Patients suggested providing oral health information in an “easy read” format for people with learning disabilities or for patients who did not use English as their first language.

In addition to oral health promotion information, it was suggested that patients would benefit from information about practice policies and services, to include detail about how private and NHS services are structured, what patients rights are, what patients can expect to pay; and advice on how and where to complain about bad experiences (FG12). It was suggested that this kind of information be disseminated widely through community and voluntary groups to raise awareness.

Patients with physical disabilities also felt that practices should provide detailed information about whether a practice is truly accessible. For example, whether it has a loop facility in use, whether a fax can be used to communicate with the practice, whether there are any steps, whether doors are automatic, whether chairs in waiting areas have arm rests, whether there are grab rails, accessible toilets, disabled parking places, etc. Patients recommended that practices undertake assessments on their accessibility and have the information clearly displayed in their practice so it is shared with patients and readily available.

Patients requested that information and resources are available in various community languages.

“For Asian people who don’t speak English, Dentists need to have translation facilities. It is a very common problem. All leaflets are in English, all receptionists speak English and there isn’t enough information in different community languages. For example information about gums, information about teeth (FG2).

In addition to translated information and resources, patients felt provision of face-to-face language and communication support would significantly improve their experience of accessing and using dental services effectively. Patients who did not speak English as their first language experienced difficulties in communicating with their dentist as did patients with hearing impairments. In many cases such patients were advised to bring a family member with them to assist in the communication process. This caused delays as appointments had to be arranged around the availability of the family member.

Patients with visual impairments and learning disabilities often found letters and posters inaccessible and relied on a family member or Support Worker to read the content to them. Patients with hearing impairments advised that for many hearing impaired people English was a second language and therefore posters with lots of text were an ineffective method of communicating messages to them. However, succinct text with pictorial images can be useful. For adults and children with hearing impairments it was thought that DVDs with pictures and moving images would be a better way of communicating.

A further recommendation was about boards and visual aids in waiting areas being less clogged, clearer and easy to read. Patients said they were “often not very informative and stimulating and sometimes have a lot of text which hinders people who are deaf and who don’t speak English as a first language” (FG13).

Support Workers pointed out that in some community languages interpreters and translated information and leaflets used anglicised words or transliterated words which lost or had no
meaning and can be hard for patients to understand. They suggested involving patients in interpreting and translation projects to get the balance right.

Patients talked about having the time and opportunity to ask questions during the consultation and have a dialogue to alleviate any fears or clear up misunderstandings.

“\text{I’ve missed an appointment because I have a real fear of going to the Dentist... It would be helpful if the Dentist spoke to me and talked about the treatment. Maybe then I would feel less afraid but they don’t tell you as they just pick up the drill and go right into your mouth (FG4).}"

“You don’t have enough time to ask questions, to talk about your health. Dental appointments are all very quick and they don’t help you come to a good decision and then you have to see them in six months. In the meantime, you forget any questions you had and what you want to ask them next time. You see your Doctor frequently but you don’t see your Dentist. I come away from my Dentist not saying what I should have said (FG1)."

Allowing patients space to talk

A patient thought it was imperative that the Dentist talk through and clarify the treatment process and seek consent from the patient before undertaking any kind of treatment.

“I went to see my Dentist and he took my tooth out. I didn’t want my tooth to be taken out, I just wanted a filling. He didn’t do an x-ray or ask me but just took my tooth out. The thing is when I go to a hospital or anywhere else, I am asked to sign a form before they proceed. I told my Dentist not to take my tooth out but just give me a filling. If he didn’t think a filling was required then he should have simply just told me. He was talking more to the Nurse then he was to me. I felt too intimidated to say anything by the time I knew what was happening (FG4)."

A patient suggested that Dentist’s involve patients in the care plan, use ordinary English words and cut out jargon when explaining what they are doing.

“I think they use their own terms which are not understandable. They shout out all these numbers, you don’t know what they mean. I was educated here (in the UK) and although my English is good, I cannot understand everything they say. They should discuss the treatment with you as after all it’s your health and your teeth. You just trust their judgement and later on regret it (FG4)."

Patients also wanted to be clear and know exactly what to expect from their dentist and understand the treatment being offered.

“As patients I don’t believe we are aware of what our rights are so we don’t know what to expect. You don’t know what kind of treatment to expect from your Dentist. You just go open your mouth, have your treatment and go home (FG2)."

Flexible access

Patients commented on the need for increased opportunities and more informal routes to information and care provision. This was particularly emphasised for patients with drugs or alcohol issues, who found it difficult to access care in a structured manner. Patients asked for flexible approach to dental care as a way of increasing access and uptake of the service, dismantling fears and creating greater awareness around oral health.

“They should have day surgeries where they are looking at particular issues. For example, sensitive teeth, tooth decay, brushing your teeth, flossing, bleeding gums and these are all the areas they can look at. To have an informal session where you can go and ask the Dentist any questions like an open morning or flexible day. It’s just something to empower patients so that they feel confident and ask what they need to know. So they can ask questions and can speak to someone informally (FG1)."
“We would like more advice and information about our oral health and the health of our teeth and what we need to be doing to looking after them, apart from just brushing our teeth (FG2).

Patients commented on the need to have an accessible dental service out of hours, 24 hours a day, seven days a week and suggested learning from health drop in centres and replicating the model for dental care.

“They should be available on the weekend, out of hours and flexible. People are human and suffer pain and it would be helpful if Dentists are available out of hours to help (FG9)

“Dentists can have more informal sessions. They can have open mornings where you don’t have to have an appointment, but can go in and see a Dentist for whatever you need. Or an open Dental Practice like the health centres that are open all day and you don’t need an appointment and you don’t have to be registered there (F1).

This kind of model would enhance access to dental services for patients who often are not considered in service planning and design. For example, people with drugs and alcohol issues felt that they led chaotic lifestyles and found it difficult to keep appointments and benefit from a rigid system (FG5).

Patients with drug and alcohol issues felt that it would be better for them to have a more widely available mobile trailer dental service with flexible drop in facilities to allow them greater access and ease in accessing dental care. People with learning, physical and sensory disabilities also suggested this, as it would give them greater control of when they accessed care. They also thought that it would be easier to make this more technologically advanced in order to meet the diverse needs of disabled people.

A patient questioned the need for six monthly reviews and suggested a triage system to allow patients choice and more say in when they should be seen.

“It would be helpful if there was a triage system at a Dental practice so that they can build in a system for seeing people who need urgent treatment soon rather than expecting them to wait for two or three months. A triage system like a little bit of what they have at the Doctors or Accident and Emergency. They can have a Nurse to build a profile of the patient and assess whether the patient needs treatment now or six months down the line. This would mean that patients would not have to attend their six month review if they don’t need to be seen...I don’t think it is necessary to have a six month review if you’re teeth are healthy. When you need treatment of course you should see somebody even if you have treatment within the six month period (FG2).

Practices responding to patient feedback

Patient talked about practices showing patients more understanding and support and being flexible to patient suggestions about changing their systems to make their services more accessible. One patient talked about a system in effect at her practice and the barriers this presented for her.

“My sons surname is different, my two children myself and my husband have the same family name but my son has a different surname. The dentist only sees us in alphabetical order so four of us see the Dentist routinely at one time and my son has to see them at a different time. I have asked them to change the alphabetical system so that they can see us all as a family rather than seeing my son when it’s his time in this alphabetical list. Whatever they have in place is not fair and they can surely change this. It causes me an inconvenience when I have to take my son to an appointment at a separate time to the rest of the family (FG1).
Proactive receptionist staff

Many patients from all the focus groups, including patients with English as a second language, patients with sensory, physical or learning disabilities and the elderly, all commented on the important role a good receptionist can play in eliminating barriers to accessing services. They talked about receptionists helping to inform, notify and support patients to receive good quality timely care in the most effective manner.

“It’s also important to have welcoming receptionists and ideally sound proof waiting areas so that you can’t hear the drill noises coming from the surgery (FG5).

“Often if there is a change at a Dental practice somebody will put a sign on the wall but what if someone cannot read or the writing is too small and they can’t understand. The receptionists should feel responsible enough to tell you about these changes (FG8).

“A good receptionist role should be telling patients about policies, maybe getting patients to read a leaflet in their own time when they are waiting for a Dentist for half an hour. Sometimes you’re late and you are sitting in reception and the least they (receptionists) can do is give you some leaflets to read and tell you “that this is a new policy at our Practice; this is what you should know: this is why you can’t miss an appointment; this is the impact it might have on you and these are the implications for a missed appointment”. A good receptionist would speak to you about all of these things. Maybe she can ask you why there is a reason you keeping missing appointments. You should be able to speak to the receptionist and she should follow this up rather than the Dentist (FG1).

“A good receptionist would communicate a problem a patient has. She can tell you if you’ve missed an appointment, if you’re late or if there is a new policy in place. It’s her responsibility to communicate that so that you don’t get removed from a Dentist list (FG1).

Support Workers talked about receptionists being gatekeepers to care and how it is important for them to take their time with patients and treat them with respect and dignity to enable them to access services in a timely and effective manner. Support workers working with BME groups, patients with learning disabilities and the elderly described many cases where patients had been in a difficult interface with a receptionist which had left them in panic, frightened and put off accessing care in the future.

Support Workers working with elderly first generation Eastern European migrants described what can go wrong in an interface between a receptionist and a person who does not speak English as a first language.

“When they get into a difficult situation and receptionists take an impatient tone it leaves them anxious and they are not able to speak English fluently, even though they have a grasp of the English language. Receptionists get hostile and angry and the first generation get upset, panic and can’t think of the words to use...Receptionists should be made aware of this and be more patient with those that struggle with English (FG8).

“Receptionists are often aggressive and don’t listen...The first generation have a slightly thicker accent and tend to have that same tone of voice even in English, which may not be understood well...The pronunciation is heavier...Receptionists think that they are being aggressive but it is just the style of the language (FG8).

Training

Patients were not always quick to criticise dentists or make generalisations and think they were all the same. They were sympathetic and talked about time pressures they experienced. However, patients did want to point out that dentists need to develop skills and understanding to manage and offer treatment to specific patient groups with particular requirements.
“People who might have chronic health problems or mental health etcetera should be able to access the appropriate services suited to them. Often Dentists are very general in their approach, they do not have a specialist skill. There really should be Dentists who have specialist skills so they can devise a care plan for people with such problems (FG8).

Patients said that practice staff would benefit from training to understand the diverse patient groups they served, including elderly patients, practices with drug or alcohol issues, learning disabilities, sensory impairments, physical disabilities, limited English language proficiency and mental health difficulties. It was considered training would help develop a better understanding of patient needs and lead to improvements in how services are delivered, accessed and experienced. It was also thought that staff would be better equipped with the knowledge, understanding and skills to be able to work with and support patients in a more sensitive manner.

“I am blind and have been with my Dentist for 40 years and he has changing staff. When I went in to see them at one point the Nurse came to call my name in the waiting area and saw me get up and see me with my glasses on. She went into the Dentists room and said “It’s the blind lady” and I heard her in the waiting area because she was quite loud. So I would say that staff need awareness raising training” (FG12).

Many patients including people with mental health problems, drug and alcohol issues, limited English and disabilities felt that their needs were not being addressed by their practice because they were in a minority and did not present in significant enough numbers at their practice for it to change its practice. When a visually impaired patient advised her practice to take up training in order to better support patients, the excuse was not good enough in her view.

“I said to a receptionist once that she needs training to think about how you speak and support people with disabilities and her response was “we don’t have many people who are visually impaired that come into the practice and wouldn’t have enough money to go on any training” (FG10).

Training it was thought would allow staff to think about the differences between patients. For example, a wheelchair user talked about people with physical disabilities having different physical requirements, including people using wheelchairs. Wheelchairs are often different for example, and adjusted for each individuals and they have varying degrees of confidence in using them. He noted that practices often considered erecting a ramp sufficient action to assist disabled patients in using their service and wider issues including attitudes towards disabled patients went unaddressed. A visually impaired patient talked about staff attitudes to assisting her.

“If you think about my situation, I am blind. I can hear but cannot see anything. Often when I go to a practice I don’t know where the chairs are or the waiting area is or where the reception is. I have to feel my way round and people often see me approaching and I can hear them talking about me but they won’t talk to me and tell me which direction to head to (FG10).

It was recommended that dentists engage more with local communities to develop a clearer understanding of patient needs.

“Dentist, Clinicians etcetera should attend meetings themselves to understand the communities they work with and think about how they are affected and think about people’s experiences and how they can improve the service for patients. Dentists are quite removed from the reality of the service they offer and need to engage with the communities (FG8).

Improving physical access

Patients with physical access issues found it difficult to suggest improvements that could be made to practices based in old houses in order to make them more accessible. They felt that some of the minor physical adjustments that are made to some dental practice were not always appropriate or completely accessible, such as wheelchair ramps. A patient said that just because a practice had a
wheelchair accessible ramp did not mean that it also had all the facilities a wheelchair user with limited mobility required to be treated at the practice. Practices also need to provide labelled disabled parking close to the building.

A patient talked about making the layout of the waiting area more accessible to a visually impaired person.

“When you walk into a practice and they ask you to sit over there, where is over there for a blind person? I can sometimes get lost in my own house, so how am I to understand the layout in a practice….They often change the chairs around and would be more helpful if the receptionist could take my arm and tell me where the waiting area is. In the same way where they say to you walk down the corridor and it’s on the left-hand side. How do I know where the corridor starts and how far down I go and which left to take? Often people with visual impairment need very subtle guidance. One has to imagine the life of someone who has no vision at all compared with someone who has 20/20 vision (FG10).

Many deaf and hearing impaired patients commented on “sensing a tense atmosphere in a waiting room”. Although patients could not hear the noise, they “sensed the tension and nervousness, which is often difficult to manage”. They talked about waiting areas in dental practices needing to be more inviting as well as physically accessible for people with different disabilities. A patient talked about practices effectively using IT to help improve the experiences of patients who have physical requirements in order to provide a more seamless and accessible service.

“It would be helpful if your disability is logged somewhere and the receptionist knows what your needs are and therefore supports you (FG10).

References


Equality and Diversity Team

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