Welsh Dental Symposium

Helping to shape the future of dentistry and improved oral health in Wales: A summary of the day

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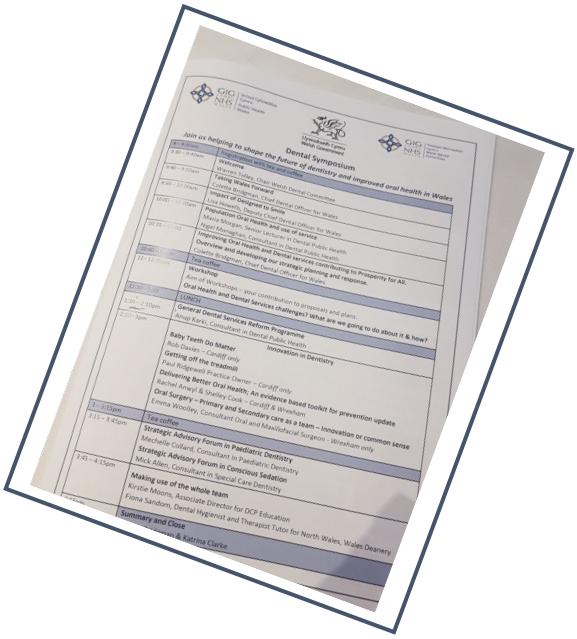
Introduction

The first Welsh Dental Symposium was held at the request of the Chief Dental Officer for Wales Dr Colette Bridgman, the symposium was arranged by the Public Health Wales Dental team but hosted jointly by Welsh Government, The Welsh Dental Committee and The Dental Public Health Team.

The aim of the event was to give those working in dentistry in Wales an opportunity to understand the context, existing national programmes, local initiatives and new policy direction of the Welsh Government. The event also provided an opportunity for the profession to comment on Welsh Government plans and influence any upcoming change.

Venue

The symposium was held in the Principality Stadium in the centre of Cardiff just a few minutes' walk from the bus and train station and close to several large carparks. The central location was ideal for those traveling in from west and mid wales as well as those living in the surrounding area.


Dental Symposium

Join us helping to shape the future of dentistry and improved oral health in Wales

The agenda

Morning Session

Warren Tolley, Chair of the Welsh Dental Committee (WDC), opened the day welcoming all delegates and outlining the plan for the day and the role of the WDC. Dr Colette Bridgman, Chief Dental Officer (CDO) for Wales followed with an overview of the policy direction of the Welsh Government (WG) to date. Discussing the three, key priorities refocus of Designed to Smile (D2S), E Referral management system and The General Dental Service (GDS) Reform programme published in March 2017.

Lisa Howells, Deputy Chief Dental Officer WG talked about D2S: Moving from good to great, thanked those working in D2S teams for all their amazing work done thus far.

Nigel Monaghan, Consultant in Dental Public Health and lead for Oral Health Intelligence and Maria Morgan Senior lecturer in Dental Public Health provided picture of Oral Health in Wales and dental service use.

The CDO took to the stage again to talk to the room about future plans in the light of The Parliamentary Review and Prosperity for All: the oral health and dental service response. Highlighting the plan, sharing the policy context, and guiding principles behind it. Dr Bridgman took the room through the draft plan and discussed the importance of having feedback and discussion around the plan, and the aims of the workshops to be held.

After a quick refreshment break of tea, coffee and fresh fruit where the room was buzzing with discussion from the mornings talks and networking, each member of the audience were asked to split into their respective workshops, each badge had a coloured dot indicating which group and room they were allocated.

Each workshop had a specific theme aligned to the Prosperity for All: the oral health and dental service response (draft framework) which are outlined below. An experienced facilitator led each session and each room had a note taker.

1. ***Patient & the public at the heart of everything we do***

Facilitator: Kirstie Moons, Associate Director for DCP Education

2. ***A Step Up in Prevention***

Facilitator: Mick Allen, Consultant in Special Care Dentistry

3. ***Dental Services Fit for Future Generations***

Facilitator: Paul Brocklehurst, Professor of Health Services Research at Bangor University

4. ***Developing Dental Teams and Networks*** -

Facilitator: David Thomas, Director of Postgraduate Dental Education at Wales Deanery & Fiona Sandom, Postgraduate Tutor for Dental Hygienists and Dental Therapists

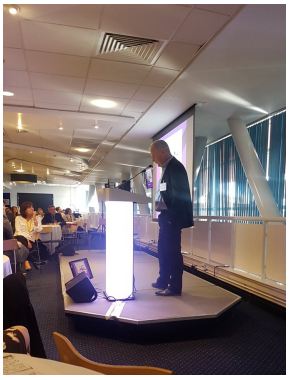
The workshops were lively and full of debate and open discussion, each group was a mixture of clinical staff; General Dental Practitioners (GDPs), Specialists and Consultants, Dental Nurses, Dental Therapists and Hygienists as well as practice managers, practice owners, Health Board dental leads.

All the comments from these sessions were noted. Please see Appendix A for a summary of each workshop.

Following the workshops delegates had a chance to recharge their batteries with lunch and refreshments, over lunch delegates also had a chance to visit the stands in the marketplace. The stands were made up of all different teams showcasing work, service on offer and -projects such as ;Designed to smile, Help Me Quit, Baby Teeth Do Matter, Cardiff Deanery, Aneurin Bevan University Health Board Care Home, NHS Dental Services, Cardiff Dental School, Primary Care One, PCC demonstrating The Making Prevention Work in Practice resources and Aneurin Bevan University Health Board team delivering the Welsh Government all Wales programme on improving mouthcare for older people living in care homes.

Afternoon session

Anup Karki, Consultant in Dental Public Health and lead for Dental Service innovation and Quality followed lunch, taking the room through the GDS Reform Programme, where we started, where we are going and what the future may hold!



Then came the Innovation in Dentistry section, this part of the day was made up with GDPs and therapists working in practices and communities talking about the work they are doing.

Rob Davies started the session off discussing Baby Teeth Do Matter how it was introduced and the impact it has had so far both in his practice and across the pilot sites.

Paul Ridgewell discussed how being part of the GDS Reform programme since 2010 has impacted positively in his practice, how he has had to work hard to change his mind set, the make up of the team and how it all work for patients and staff. It was clear this topic was of great interest to the GDPs in the room and the questions came in.

Rachel Anwyl and Shelly Cook both dental therapists working in Powys Community Dental Service finished of the session giving a fun and informative talk on Delivering Better Oral Health, despite technical hitches both were complete professionals are were not phased one bit by the hitch!

Another tea and coffee break allowed for a stretch of the legs and chat with colleagues, and allowed those who preferred not to ask questions to note down their comments or questions and pop them on the display boards dotted around the room. The comments were collected at the end of the day, see Appendix B.

Mechelle Collard, Consultant in Paediatric dentistry and Mick Allen, Consultant in Special Care Dentistry followed the coffee break, each giving an update of the work being carried out in their respective Strategic Advisory Forums discussing the aims and priorities of the forums.

The final talk of the day was by Kirstie Moons, Associate Director for DCP Education and Fiona Sandom, Dental Hygienist and Therapist Tutor for North Wales, Wales Deanery; Making use of the whole team. The talk covered the needs of the patient, latest research in skill mix as well as prudent Health care and the benefits for a team using skill mix.

Katrina Clarke, Deputy Chair of the Welsh Dental Committee and Colette Bridgman, CDO closed and summarised the day by thanking all the speakers and facilitators as well as the delegates for attending and contributing.

All the presentations from the day are available via the link below:

https://drive.google.com/open?id=19HxHAKiKoGcr8v8QVcLicd6ZK4waNIfh

Key Themes from the workshop

A number of key themes emerged throughout the day.

Many comments were received about the need to have a greater emphasis on targeting advice, especially to the groups who we would class as more vulnerable.

Using social media to target the younger generation and those who are harder to engage with in society (homeless was one example) was also a commonly raised point across workshops as well as on the comments board.

Improving communication was a big talking point across all workshops, communication with patients, between teams – GDS/CDS, D2S and GDPs, Specialist services and GDPs and communication between HB and Practices.

The use of skill mix was a topic discussed both in the workshops and on the communication boards as well as throughout the day by the speakers.

Some comments were noted and posted on the boards about feeling that UDAs and Health Boards stifled innovative work.

Some fresh ideas were discussed in the workshops around harnessing technology and future proofing – virtual consultants, real time commissioning, funding skill building.

It is encouraging to see that many points raised throughout the day are issues Welsh Government are tacking as a priority for dentistry in Wales through the Dental E-referral management programme, GDS Contract Reform programme and refocus of Designed to Smile.

For detail please see Appendix C

Key feedback on the event

Feedback from the event was overwhelmingly positive, some of the comments received are below, further comments can be found in the appendices.

“Just wanted to say a huge ‘well done ‘ for today. I think it went really well & I hope you get a lot of food for thought.”

“Excellent symposium. Should have one every year. Maybe after the end of the financial year when dentists are not stressing about UDA’s.”

“Felt it was very well organised and a good venue.”

“I enjoyed the positivity of the discussions and presentations”

“Really enjoyed the symposium, good opportunity to hear about new developments and up to date information. The group discussions were useful to share ideas and comments.”

For detail please see Appendix A

Conclusion

The symposium seemed to be a welcome opportunity for people involved in dentistry s to come together to understand the national policy direction, national programmes and collective challenge to improve oral health and dental services in Wales. The event also provided an opportunity for all attendees to network, share good practice, and discuss the changes happening in dentistry in Wales.

The participants seemed positive about the event and they actively participated in the discussions in the workshops.

It was clear that while this was the first event of its kind in Wales, the meeting of GDPS, Specialists, DCPs, Consultants, Practice managers and Health Board staff it should not be the last. Many delegates appreciated that dentistry was given such a platform for engagement, learning, sharing innovation and networking. They commented that they were hopeful that there will be similar event every year!

Appendices

Appendix A

Detailed Feedback

Feedback from the event has been overwhelmingly positive; the Twitter feed throughout the day using **#dentalsymposium** was full of great photos and gave a real feel for the day. Below is a snapshot of some of the comments received through Twitter, emailed comments from the CDP evaluation forms, and comments emailed directly to the Project Manager.

"I would just like to say how much I enjoyed the day, it was a great way to network and really interesting speakers."

"Congratulations on yesterday - it was a great day full of enthusiasm."

"Just wanted to say a huge 'well done ' for today. I think it went really well & I hope you get a lot of food for thought."

"Excellent symposium. Should have one every year. Maybe after the end of the financial year when dentists are not stressing about UDA's."

"Felt it was very well organised and a good venue."

"Very enjoyable day, with great speakers, all of which we very clear in the subject they were there to discuss. Arrival to the symposium could have been made easier by advising of gate number for entrance. Also having more/bigger signs at the entrance of the symposium to make it easier for guests to see. "

"Was a large group so worried some voices may get lost, but I guess that's the compromise when hearing so many voices"

"Very well organised, especially interesting hearing from original pilot practice. Shame about the timing (March) as feel this prevented many practices form attending."

"Very well organised and ran smoothly, all speakers well received."

“It was an excellent conference. Just by attending and networking, for me helped me understand the bigger picture of our PC Division and what needs to be done and what could be achieved.”

“Must say really enjoyed the day was great to hear off so many ppl.”

“I enjoyed the positivity of the discussions and presentations.”

Feedback from Stands

As part of looking at how we can improve future events, we requested feedback from the teams who had a stand at the symposium. Below are a just a couple of the comments received.

“Thank you yes we really enjoyed the event.

We did have visitors to our stand but maybe not as many as you would have thought from the number of delegates. I think people used the time to network with each other which is also very good .

The venue was good but perhaps if the market place was on the same level as the function room or even set up along the corridors to the main function room people could see what the displays were offering as they were walking past.

The people that came to our stand were very interested in what we were doing and I am always pleased to showcase all the good work that is being carried out in Wales especially the WHC/2015/01 Mouth care Improvement programme for care homes and improving mouthcare for adults in hospital .I am passionate about mouthcare Improvement and was pleased to see Designed to Smile represented as well I also used to work for Designed to Smile so know what a great programme it is.

Please invite us to any other event !”

“We had an amazing interest in the PC One website with 14 sign ups to the secure area about 70+ people visited the stand and were very interested in the website – questions about clusters and what they were. Some people knew some didn’t
Venue was very light and airy – would have been nice to have coffee breaks down with the stands but understand a lot of people there and moving them all up and downstairs a task

Both Debbie and I enjoyed it immensely and got a lots of CPD out of the event some of which went into the newsletter on Thursday.”

Appendix B

Comments received from display boards

- Invite parents into the classroom when delivering OHE
- CDS/GDS communication
- D2S more engagement with GDPs
- Social media to educate 11 – 18 year olds
- Non-patronising education
- Target advice
- National advice – same message
- Private services are popping up in the NHS
- What about new patient access – number of practices taking new patients has halved in 5 years from 30% to 15% * - they are not even in the prevention equation *BDA data
- Patient need to take responsibility for their oral care – they need to be aware of the loss of 'chair time' when there is a failed to attend appointment. I believe a charge should be made for those patients.
- CPD needed teachers to implement D2S – brushing in schools is not always happening event if they say it is!)
- When 'new 'new' contract was introduced we were promised funding for GDP attending schools and nurseries, this never happened.
- DCPS lack a professional voice – there is silence in the profession from DCPs. Most dentists get involved with BDA/LDC etc. but there is no such environment for DCPs to do the same. Therefor opinion is lost or not collected from this group.
- Groups to focus on
- Young children, older adults, nursing home residents, Physical disabilities, Learning disabilities, pregnant women
- Then everybody else healthy and ill

Appendix C

Dental Services fit for future generations

How do we assess quality and the outcomes of care in our dental services at practice, Health Board, or national level?

How can we harness technology to reduce inequities in dental service provision?

How do we futureproof our dental estates (particularly in the GDS) so they allow us to deliver preventive-led care utilising the skill-mix of the dental team?

How do we assess quality and the outcomes of care in our dental services at practice, Health Board, or national level?

- Not enough audit/quality check at moment. Need golden thread from above to guide and ensure consistency across all areas/services. Quality standards and supporting meaningful change.
- Time spent needs to support meaningful change and needs to support change, not forms for forms sake – easier to report right info over time.
- Communication – tools for dentists to communicate with parents and teachers and across organisations. Time to talk to colleges , owned , empowered learning culture developing models reflecting area needs
- Needs to be auditable, measurable, baseline improvement with structured feedback from patients to capture patient experience
- Enormous amount of info being captured. Reports not being presented in a helpful way – comms need to be co-productive and not require lots of time away from patients due to paper targets. Opportunity to improve relationship between clinics and HBs
- No matter who you are you can identify needs in your area and overtime demonstrate benefit or risk reduction – 12mths ->3years
- Possible peer review to share/learn/monitor quality/improve relationships (consider RDO) need appropriate timeframes to measure change

How can we harness technology to reduce inequities in dental service provision?

- Communicate location of practice and specialist services to patient, practitioner and HBs to support referrals. Need easy to find who is taking on patients, who is open, out of hours, emergency (clinked to recruitment challenge in some areas)
- Virtual consultants with ‘dentally fit’ patient questionnaire available electronically for patients to complete in advance. Tech to support info sheet to patients/peer/between services – to hospital, GP both medical records/referals to support having conversations.

- Real time commissioning – flagging surge in demand. Allow to be more public facing. Need to acknowledge competition/conflict in some areas between some geographic proximity practices.
- Use alternative tools/different tools to access people not accessing services. Most homeless ppl have a mobile – engage with non-medical services. Use information tools like what's app and be approachable.
- Organise meet and greets in clusters where everyone can just come together to meet each other and start the conversation.
- Use technology for patient education, professional education, informal problem solving/sharing best practice
- Central resources in multiple languages and easy read / videos.

How do we futureproof our dental estates (particularly in the GDS) so they allow us to deliver preventive-led care utilising the skill-mix of the dental team?

- Dental services included in HB estates plans and add dental services to multi service hubs with planned bus routes.
- Improvement funds with fund matching to improve access or utilise underused rooms in existing premises to offer extra services.
- Develop joint strategies with HB to develop services for at risk groups, improve skill mix and increase capacity. Send skilled team out to care homes, shelters, food banks outside of UDA as need identified.
- UDA prevents flexibility, prevents skilled individuals (such as hygienists) delivering services and puts burden on dentists.
- Build in time to allow practices to develop strategy and engage on service improvement.
- Fund skill building where a need has been identified. DCP grades, training quality, establishing carer pathway.
- Modules added to apprenticeships to allow specialism and allow individuals to drive their learning based on need for collective whole.
- In house training – quality assessment and online written work but learn in practice. Training is long term investment for person, practice and HB. Needs belief things won't change again in 12 months!
- Need service to be separate from business profit. Need to be realistic about the cost of running 'a chair' and investment in existing practices.
- Need patient to be aware of emphasis on prevention and consistent messages at all levels.
- Need discussion about change management and physical limitations around existing practices. Maths needs to add up. Need flexible funding models.

Developing Dental Teams and Networks

What does the dental team of the future look like and how will this impact on how dental services are run?

Dental care providers in an area should get together and form dental networks – what would be the benefits of this? What are the challenges?

How can dentistry better engage with primary care clusters?

1. What does the dental team of the future look like and how will this impact on how dental services are run?

- The CDS is already using skill mix to enhance the team approach.
- Dentists should delegate more – there is an element of tribalism.
- Better use of DCPs within their scope of practice.
- Hygienists would like to use more of their extended duties.
- Dentists sometimes like to take their own impressions.
- There is reluctance amongst some dentists to allow DCPs to use their oral qualifications.
- Infrastructure is a barrier to developing skill mix, some practices are too small. Larger practices tend to manage better.
- There are restrictions on DCPs being released to attend training courses
- There are not enough training opportunities for DCPs.
- There is a disconnect between GDPs and therapists.
- The UDA is a divisive driver. It motivates team members in different ways. The perception is dentists work quicker therefore meeting their contract requirements more efficiently.
- Get rid of patient charges.
- DCPs should be paid an hourly rate.
- There should be more in-practice training.
- Additional funding is required if practices are to expand.
- Should other members of the team have a performer number?
- HMRC are looking at the independent contractor status of dentists and whether under the current contract they are actually self-employed.
- Clusters in different locations.
- Centrally employed.
- Structured career pathways.
- Changes in attitude and culture are required.
- Staff evolution in pilot practices.
- Multiple surgeries located near medical centres – multi-disciplinary approach.

2. **Dental care providers in an area should get together and form dental networks – what would be the benefits of this? What are the challenges?**

- Practices are isolated. There should be a pool of trained staff.
- Primary care services should work together. Sharing resources will reduce referrals to the secondary sector. Better to share limited resources.

- Information and best practice should be shared through better use of web sites and social media which could be restricted for service users.
- Sharing equipment?? Privately funded kit may be a barrier to this?
- Consider changing how we deliver CPD while improving and maintaining governance, quality, audit and peer review. Study clubs?
- Communication is poor.
- Better engage with Practice Managers.
- We don't share our innovations.
- We are risk averse.
- Don't forget the patient and the third sector. What are their expectations? What services are available? Opening hours? Are patient needs being met? There is an ever increasing population.
- Educating patients - they don't always have to see a dentist. Children should go more regularly.
- What about the welfare of the dentist? Better access to Occupational Health Services. They should network better to help alleviate stress. More opportunities for flexible working.

3. How can dentistry better engage with primary care clusters?

- Dental practices have to take ownership but private business must stay private.
- Clusters should be geographically based and multi-disciplinary.
- Dental engagement is limited – GPs are paid to attend!!!
- There should be multi-disciplinary educational events to encourage greater participation.
- There is a primary care imbalance with the focus on GPs.
- GP locals are different.
- There is a different level of responsibility between Practice Managers in GP and dental practices.
- Need additional funding
- Improve dental nurse training and the pay structure.
- Due to a poor career pathway for DCPs, retention of staff is a challenge. Morale is poor.

Patients and the public at the heart of everything we do

How do we ensure that those with the greatest need are willing and able to access dental care?

How do we respond to changing patterns of need and demand?

How do we shift resources (specialist services) to the most appropriate settings?

How do we ensure that those with the greatest need are willing and able to access dental care?

- Access NHS – reduce UDA Contract by 20%
- Contract is wrong
- Targets over health care pro
- Integration with primary care/CDS
- Collect data on FP17
- Better education for Patients/public – national advertisements, social media – screen rather than leaflets! Social media/Apps
    - Drill down on what's available and target areas

    - Multi disciplinary approach
- Target 11-18 years - lost population!
- Standardised message – not patronising!
- Health visitors lack confidence delivering messages in oral health
- Prevention time added to contract
- Salary GDPs ?? use resources better
    - Identify skill gaps – OH, clusters, utilise team
- Quick UDA fix
- Need risk analysis – geographic
- Patient responsibility
- Part of wider care – how do we integrate primary care / communicate better between teams, schools, midwives, HV, other practices!
- GDS/CDS to integrate better
- Clusters – don't work for dentistry – held by GMS
- Registration
- Links between D2S and GDS
- D2S – ACORN? Collect needs Ax – data via FP17
- D2S – links to GDS practices
- D2S going into practices
- Sharing resources – flexibility
- Carrot and stick
- Communication
- Focus on younger generation – social media!
- Follow patient journeys – GA -

How do we respond to changing patterns of need and demand?

1. Skill mix! DCPs –
2. Mobile services-taking the service to the patient
3. All wales approach
4. Skill mix difficult in small practices
5. Sharing resources – PC
6. IT sharing – consistency
7. LHB should not be a restriction to patient treatment or referral!

How do we shift resources (specialist services) to the most appropriate settings?

1. Referral audit – who, where, waiting lists?
2. Patient satisfaction survey – what are they getting, what do they want??
3. Bring specialist services into GDP practices
4. Working hours – twilight service
5. Patients can't afford to take time off work – OOH busy
6. Cultural change – providing info for patients
7. Target deprived settings
8. Education – message to patients
9. More up to date data
10. Tailored information
11. LHB commissioning

Post it comments –

- Tax fizzy drinks!
- Fluoride in the water
- Educate pregnant mums on OH
- Engage with advertisers
- More dental awareness leaflets in synagogues, mosques, temples in different languages!
- More visual aids in dental practices
- Workplace wellbeing – 18 – 25 year olds
- There needs to be equity of service provision to those who really need it
- The success for D2S is limited if all HC professionals are not on board

A Step up in Prevention

What are the current barriers to the delivery of preventative dental care or advice on behaviour modification?

How can practice and HB teams meet the WG 'expectations' regarding the delivery of preventative care in practices and services?

What groups in the population do we particularly need to focus preventive efforts on?

Q1: What are the current barriers to the delivery of preventative dental care or advice on behaviour modification?

- Lack education for DCPs – need more dental health
- Learning more of basic modifications (DCPs)
- No Masters degrees available in Wales
- DCPs are able - need more training (if available, people would do it)
- Require more workforce training funding
- Need to utilise the services already out there, i.e. Help Me Quit. Dentists are not aware
- Communications from support services
- Getting patients 'through the door' – learning how to direct patients
- Business model – if not appealing to business owner
- Patient perception of need – don't want to pay for it. Patients want to be free of pain and just move on, only accessing emergency services
- Swansea practice have waiting lists – Cwm Taf practices available. Baby Teeth Do Matter has helped in Cwm Taf (pilot)
- Gridlocked in practice with targets
- Risk assess patient based on needs
- Lot of deprived patients who won't come back
- Evidence based – patients will forget brushing after 2 weeks – waste of clinical time.
- Issue 12 month prescription – performer numbers are a barrier
- DPAs in nursing on site - direct access with dentist back at base, i.e. 12 month prescription
- Patient swapped as she had seen someone who wasn't a dentist – acceptance.
- Replicate model as in health - patients don't expect a consultant to take bloods – nurses will do it and that is acceptable. Patients expect to see dentists and are willing to wait. They will also travel for continuity. Loyalty is not with practice but with the dentist. Mind sets need to change.
- Don't focus on targets – look at patients in a more holistic way
- Crux is that care is target driven – don't get paid for prevention
- Share responsibility of oral health with patient otherwise as a dentist your wasting your time.
- Main issue is UDA and part patients – change their mind set engaging patients in their own care.
- Barriers – patients can't afford it or don't have time.
- UDAs don't score all the activity.

- Lacking in 360 degree feedback – practices don't share best practice as they are separate businesses
- Direct access (within NHS)
- Performer numbers for DCPs
- Prescription for whole year
- FV for SOE not working – update software platforms
- Patient charges and perception of needs (individual and population)
- Training requirements for DCPs and costs
- How do you monitor change
- From HBs perspective, look at prototypes and compare changes – pick up intelligence

Q2: How can practice and HB teams meet the WG 'expectations' regarding the delivery of preventative care in practices and services?

- Discussion about identifying requirements for both patient risk groups and non risk groups;
- Contract Reform – focus on DCPs for relaxation of UDA;
- HBs will need to ensure systems in place for monitoring delivery of services by practitioners – quality of services and VFM;
- Risk Assessment (ACORN) – some concerns practices may become dis-incentivised by the process. Need to ensure enough time for preventive advice;
- Discussion about funding for practices to employ DCPs. In prototype practices associates get a higher rate per UDA (to cover 10% reduction for prevention);
- Discussion about up-skilling the workforce – HB competency levels and contracts – difference not always clear between Tier 1 (undergraduate BDS) and Tier 2 (enhanced skills);
- Clusters – to include availability of DCPs for practices. Prototype practices need to identify what services they need. Discussion about ethical approach and potential for different levels of commitment in practices. Work/Life balance for staff should be better under contract reform. Clusters viewed as a good thing but currently GP focussed – need for better engagement;
- Potential for problems with claw-back of UDA if access levels have increased;
- Discussion about whether excellence should be rewarded with higher rate UDA – some UDAs are being earned too easily e.g. too many check-ups;
- Discussion about how too achieve position where more DCPs are working in practices. Agreement about the need to make direct access a reality (currently all work must be supervised by the dentist);
- Some concerns expressed about logistical problems (accommodation) at practices if they are to accommodate DCPs e.g. if a practice wants to replace a dentist with a DCP for providing oral health advice – still need a room but no chair required. Practices will need to rationalise space/rooms for whole team. Views expressed that if developing skill mix necessitates significant change to the fabric of a practice then more funding will be required;
- Discussion about independent provision of oral health advice (DCP clusters/local travel). However, this approach does not necessarily bring services closer to home for patients;
- Some concerns about e-referrals which will facilitate more detailed monitoring of practices. Certain patterns of care may emerge which are more relevant to some areas than others;
- Views expressed that a drop in Patient Charge Revenue will be a barrier for HBs;

- View expressed that D2S should be rolled out unilaterally to all areas (including private schools) to ensure an inclusive approach e.g. links with GPs/Health Visitors etc. and to ensure vulnerable people living in more affluent areas are not excluded;

Q3: What groups in the population do we particularly need to focus preventive efforts on?

- GPs – prescription drugs/treatment – side effects of - dry mouth
- Pharmacists (as above) – meds review/fluoride toothpaste
- Picture Exchange Communication System
- Special care/learning disabilities – structure/prevention/routine
- Roll out treatments
- Dental phobic – groups that can't attend/addicts
- Working with schools/SP care to build structure/habits/confidence/process
- Teenage parents – more education/off instruction
- Teenagers in general – schools input
- Use resources in schools so it becomes routine
- More education – pre-natal care/can we incorporate OH
- Midwives
- Fluoride toothpaste – raise awareness
- D2S – doesn't go into private schools – need to be realistic on funding available
- Prevention in perio
- Engaging with GPs and clusters – would be helpful
- Money for GP clusters tied up
- Got to give GPs something to tie into – won't engage as haven't found their own feet
- Extremes of age – very young/older people