NHS
Health Education England

Socially Inclusive Dentistry

Executive summary of the 1st National Conference

Developing people
for health and
healthcare

Socially Inclusive Dentistry

Executive summary of the 1st National Conference

Introduction	3
Executive summary	5
Background to Social Inclusion	6
Workshop synopsis	10
Workshop 1	11
Workshop 2	16
Workshop 3	19
Workshop 4	22
Workshop 5	26
Acknowledgements	32
Reference material	33

Introduction: Developing dental care for socially excluded and marginalized populations

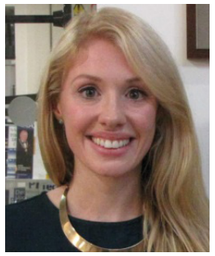
by Andrew Dickenson & Janine Doughty

The term social exclusion encompasses those who are "suffering multiple and enduring disadvantage" and are "cut off from the opportunities that most of us take for granted" (Department of Health, 2010). The World Health Organisation (2008) describes social exclusion as

> *"dynamic, multi-dimensional processes driven by unequal power relationships interacting across four main dimensions - economic, political, social and cultural" (...) "*
>
> *It results in a continuum of inclusion/exclusion characterised by unequal access to resources, capabilities and rights which leads to health inequalities".*

The Department of Health-funded Inclusion Health (2010) review has identified four key groups of people experiencing social exclusion; the homeless, Gypsy, Irish or Roma Travellers, sex-workers and vulnerable migrants. The National Conference on Socially Inclusive Dentistry was organised in an attempt to develop the conversation about inclusive dental services for these groups, to explore barriers that may be faced when developing such services, how we may overcome these and to consider where we go from here.

This executive summary reflects the breadth of discussion during the 1st national conference and attempts to summarise the key learning and action points. It is anticipated that this executive summary will support future education, research and commissioning of dental services for the socially excluded and marginalized populations.



Andrew Dickenson **Janine Doughty**

November 2016

Executive summary

- Social exclusion still remains hidden in our society
- The socially excluded, by definition, are the homeless, Traveller communities, sex-workers and vulnerable migrants but must also include the child in care.
- More research is required regarding the health and dental needs of the excluded populations
- Education of dental teams is essential
- Effective commissioning is required to allow access to dental care
- The planning and delivery of dental services must be reviewed

Background

What is social inclusion in dentistry?

Social inclusion in dentistry is the embracing of some of the most vulnerable members of society, a process of outreach-inreach; building trust and seeking socially excluded groups through specialized services and the subsequent integration of these seldom-heard groups into general dental practice where they can be provided with ongoing care. These groups experience inequitable burdens of oral and medical disease. Socially inclusive dental services are those which draw upon our collective responsibilities as health care professionals to target and attempt to reach the dispossessed in society.

Who are the socially excluded?

In the United Kingdom (UK), an estimated 3,569 people are sleeping rough on any one night and 71,540 households are living in temporary accommodation (Homeless Link, 2016). People experiencing homelessness are a diverse group because their homeless status may be described as: rooflessness (rough sleeping), temporary accommodation or hidden homeless (sofa surfing). The conference also focused on looked-after children as it is recognised that nearly half of males aged under 21 currently in the criminal justice system and approximately 25% of homeless people have been in care (National Audit Office, 2015). There are increasing numbers of Travellers in the UK, at present there are 58,000 people who identify as Gypsy or Irish Travellers and the total number of Traveller caravans in England has risen by 1,183 between January 2015 and January 2016 to 21,306 (ONS, 2011; Department for Communities and Local Government, 2016). The number of sex workers in the UK is currently unknown, but is estimated to range from 50-80,000 (Cusick et al, 2009; Kinnell, 1999). The majority of existing dental literature focusses on the oral health of the single, and primarily male, homeless population (Smile4Life, 2009; Collins and Freeman, 2007; Simons, Pearson and Movasaghi, 2012).

Dental implications of exclusion

Existing literature identifies that the oral health of those who experience homelessness is poorer than that of the general population (Smile4Life, 2009). Although studies describing the oral health of vulnerable migrants, sex workers and Travellers are limited in number, their findings indicate a similarly disproportionate amount of dental disease and poor oral health. Zimmerman et al (2006) reported that in a sample of 207 trafficked women, 58% reported dental problems described as “tooth pain”. Many trafficked sex-workers in this study had experienced physical violence, 8% of whom reported direct trauma to the face; the assaults included punches, slamming in to a wall or being hit with hard objects including bats. A pilot outreach study involving Irish Travellers in East London found that approximately 60% of children in this community brushed once daily or less and obvious visual caries were evident in 66% of the 35 children examined (Doughty et al, 2016).

What services are currently available for the socially excluded?

Across the United Kingdom, there are multiple agencies working in silo to provide dental care for socially excluded people. For example, Crisis at Christmas Dental Service in London, Dentaid’s Real Junk Tooth Project in Dewsbury, Revive Dental Care in Greater Manchester and Community Dental Services including Whittington Health NHS Trust, Kings College Hospital NHS Foundation Trust and, Central London Community Healthcare NHS Trust; this list is by no means exhaustive (Doughty, 2015; Caton, Greenhalgh & Goodacre, 2016). The Socially Inclusive Dentistry conference was a targeted approach to drawing together these key groups in order to share their successes, challenges and more importantly to build a cohesive network through which ideas can be shared and voices of both professionals and those with lived-experiences can be heard.

Raising awareness through education

In response to the growing population of ‘seldom-heard’, socially excluded people and the inequity of availability of targeted dental services, Health Education East Midlands delivered a series of workshops led by speakers from the medical, social and dental spheres, and invited experts-by-experience to share their lived-insight on barriers to accessing dental services and to share the benefits that good dental care has made to both quality of life and overall wellbeing. Fifteen workshops involving sixteen speakers, some of whom had experienced homelessness, were delivered at three points across the day. Each of the workshops was served by a facilitator who recorded and transcribed the ideas and opinions that were generated. These transcriptions will be summarised to give an overview of the professional perspective of socially inclusive dentistry and will serve to highlight reasons why dentists may not engage with socially excluded groups and for those who are keen to engage and advocate for services, how they might go about doing so.

Background

Key learning points

The one day Socially Inclusive Dentistry conference saw 135 delegates including dental students, foundation and core trainees, key stakeholders, Local Professional Networks, NHS England Commissioners, academics, medical and social care professionals attend for a series of workshops across five themes pertaining to the current status of and potential to improve social inclusion in dentistry. The workshops spanned the themes of: volunteering, medical services, dental services, vulnerable children's services and research with socially excluded populations.

Feedback from the conference suggested that 98.2% of people felt that the conference had to a greater or lesser extent given them a better understanding of social inclusion and the problems faced by socially excluded groups. The online feedback highlighted that successes of the conference included: networking, meeting others who were passionate about inclusion healthcare and sharing of ideas.

One of the dental core trainee delegates shared the following statement:

> *"A sentiment that really struck a chord with me and a common theme throughout the talks was the idea that we should think of "services being hard-to-reach rather than hard-to-reach individuals". This has encouraged me to get involved in projects with a local Oral Health Promoter and speaker at the conference. I am excited about the prospect of being actively involved in the promotion of oral health.*
>
> *This was truly a great conference. It was well organised and inspired not just me but many of my colleagues and others within the audience. This was the first national conference on Socially Inclusive Dentistry and due to its huge success I am sure there will be many more to follow."*

Action planning

Following on from the success of the conference, the pertinent question is: where do we go from here?

The conference is just the beginning of a much bigger conversation on socially inclusive dentistry and our challenge now is to translate these conversations and ideas into on-the-ground action and change.

NICE (2014) guidance on improving community oral health suggested a targeted approach to providing dental care for "those whose economic, social and environmental circumstances or lifestyle place them at high risk of poor oral health or make it difficult for them to access dental services". Recommendations include: creating tailored interventions, developing outreach services, demonstrating tooth-brushing, providing free oral hygiene materials and encouraging the use of dental services through local care pathways.

Ideas generated from the Socially Inclusive Dentistry conference included: student ambassadors, developing the role of the oral health educator, CPD benefits for those who volunteer, social enterprise schemes, targeted core trainee or clinical fellow roles. Conference speakers particularly emphasised the importance of longevity, familiarity and continuity in all projects involving socially excluded people and the avoidance of one-off initiatives. Furthermore, one of the core themes running throughout the day was the concept of "out-reach-in-reach"; a process of reaching out to socially excluded populations, building trusting relationships, and subsequently integrating them into a healthcare system that is both accessible by and supportive of all members of society.

The future development of socially inclusive dental services may best be facilitated by the formal assembly of a group of interested people including from the medical, dental and social care sectors and dental professionals as well as advocates from socially excluded groups. Using the national Health Inclusion Network as a platform, the aim of the group will be to draw together those people within and outside of the NHS who are providing dental care for, or undertaking oral health research with, socially excluded populations.

Future challenges

The approach to developing socially inclusive dentistry requires a multifaceted, multimodal, framework. The Ottawa Charter Health Promotion model provides a guiding structure to develop socially inclusive dental services. It illustrates the need for action at all levels from the individual through to grass roots initiatives, service provision and socially inclusive public policy (World Health Organisation,1986).

The aim of the Socially Inclusive Dentistry conference was to provide a dental forum to project the voices of the seldom-heard and to connect like-minded dental, medical and social service professionals through shared ideas and common goals. There are challenges ahead in the quest for the equitable distribution of healthcare resources and socially inclusive dental care, but as a profession we have skills and assets available to us that can be used to improve the oral health of some of the most vulnerable members of our society and is it not our ethical imperative to do so?

Workshop synopsis

The conference balanced key note lectures with focused workshops. There were five main workshops run by subject-matter experts, supported by trained facilitators who captured the discussions:

Workshop 1:
Dental services for socially excluded people

Workshop 2:
Volunteering with socially excluded people

Workshop 3:
Medical and social services for socially excluded people

Workshop 4:
Developing services for socially excluded children and young adults

Workshop 5:
Research with socially excluded people

Workshop 1:
Dental services for socially excluded people

Purpose of workshop:

a. To ensure socially excluded (S/E) people are supported through their health journey

b. Consider how to identify and remove barriers to accessing dental care

c. Gain an appreciation of the underlying social and environmental factors affecting socially excluded people and how these influence dental seeking behaviour.

d. Understand how dentistry sits within social care in general – to be aware of issues, barriers and how to effectively communicate with agencies in order to access additional support

Key questions:

What factors might stop socially excluded people from accessing dental services?

How can services be organised to make access easier and more appropriate for socially excluded people?

What personal fears/ anxieties might dentists have about working with socially excluded people?

Services that already exist that could align with dentistry in establishing effective collaborative care for S/E people:

- Mental health services
- Alcohol and drug specialist services
- Other medical services: TB screening, GUM clinics, specialist GP services
- Social services including supported housing and outreach services
- Pharmacy services; these already have established local champions and contribute to the MECC initiative
- A&E: direct pathway to signpost access to treatment. This requires local protocols and commissioning. There are concerns that patients who need immediate care may be disadvantaged by this arrangement (due to lack of transport, local knowledge, apprehension) and possibly requires administrative support to ensure patients have been able to access the appropriate care
- Podiatry services

How can dental services make connections or contribute to other medical / social services?

- Dental practices and other agencies often send appointment letters but with no follow-up for non-attendance
- Develop referral pathways between medical, social and dental services especially those dental practices that identify themselves as socially inclusive and willing to take on socially excluded people
- Children: social care processes are in place but this is less organised or effective for adults. There is less contact when dealing with adults, mainly due to the transient nature of their life-style
- Need to identify a key link person within each social care organisation responsible for co-ordinating services. Many suggestions proposed, including monthly email updates (possibly using a dashboard), direct contact / reception team dedicated to a group of patients, 'flagging' vulnerable patients to their respective teams when appointments have been arranged.
- Organisations such as Pathway and Groundwell provide peer support services where people who have previously experienced homelessness facilitate attendance at dental or medical appointments. These peer support programmes have been shown to be very successful in encouraging attendance at appointments.

What are the perceived barriers that may prevent dentistry and other medical / social services from collaborating and how could that be overcome?

- Lack of understanding of the remit of each organisation
- Lack of trust between organisations
- Absence of financial incentives to develop referral pathways.
- Time constraints
- Key contacts within each organisation need to be easily identified
- Lack of individual confidence or understanding of the issues. This was the experience of many early years professionals. This is an educational issue as there were many interlinked concerns, such as when to refer, now to make a referral, the ethical or legal aspects of referring plus no understanding of how to prioritise the problem.
- Communication barriers. Are dentists confident in initiating conversations regarding other medical, health or social problems? This is a concern particularly around mental health conditions.
- Difficulties created by individual care plans
- Lack of understanding around social exclusion

- Difficulties of identifying some patients who could have social exclusion needs. Patients don't always divulge their whole health care needs eg; would a patient who has podiatry needs feel capable of discussing this with a dentist? Would the dentist appreciate that maybe the foot condition may take priority over the dental problem?
- Would either party feel confident that sharing the information would lead to an effective referral or signposting to allied agencies? Patients are more concerned about being placed on waiting lists, as their life-style frequently leads to broken appointments.
- Individual dentists apprehension about performing treatment on vulnerable patient groups, especially outside the dental environment eg; voluntary work, access centre sessions. It was suggested that greater clarity should be provided by the Indemnity Providers

Should training on social inclusion be implemented in Foundation and Core programmes (focus on dealing with more specific vulnerable groups)?

- Hospital placements expose trainees to vulnerable patients, but there is limited educational input
- Trainees don't always have the background awareness for specifically addressing all the health needs of vulnerable patients, especially around supporting sex workers who are the victims of facial trauma.
- Trainees expressed an interest in visiting homeless shelters and volunteering for outreach programmes. However many felt that this would be an opportunity to understand need rather than receiving specific training.
- It was suggested that dentists should receive specific training in mental health. Organisations such as Pathway National Homeless Charity are developing educational programmes to inform healthcare professionals about the management of people with mental health issues and people who are misusing substances.
- There was interest in learning more about drug services, homelessness care providers (hostels, shelters), and community liaison workers (for certain minority groups).
- Education and support for linking to voluntary agencies. This would focus on developing dental care plans that were realistic, achievable and appropriately funded.
- Greater links with Pharmacies. Dentists are aware of the role pharmacies play in supporting substance abuse. Increased educational input into pharmacy training, possibly through the LPN (both dental and pharmacy) could assist in both appropriately supporting oral hygiene messages and signposting to dental care. It was agreed that for many substance misuse patients this might be only contact to signpost local dental

Perspectives from charitable organization (Stan Burridge - Pathway)

There is a need to develop a local faculty for homeless and inclusion health. There is already evidence of good practice, especially with the development of one stop shop arrangements, where a patient is supported by their case worker / charity volunteer. This requires pre-planning, comprehensive understanding by the dentist (to avoid cancellations on the day due to lack of information), realistic treatment planning and an understanding that the treatment, where possible, is completed in one visit. This model is effective when a patient can link with many different services through the same point of access – service location is therefore essential. This arrangement demands flexibility and planning. The actual site is less important and with appropriate support the patient is normally prepared to travel. Access to care can be innovative, such as mobile dental units which visit hostels, day centres, GP Surgeries. This model is adopted by the charity Crisis, which provides year round access to a dental van that moves throughout London. It also offers afterwards. Crisis reports that outreach is effective in gaining repeat patients, which allows preventive as well as remedial dental care.

Dentistry needs to be aware of the Social Inclusion Healthcare Enterprise (http://inclusion-healthcare.co.uk). This organizations mission statement is to improve the health and wellbeing of the homeless and other marginalised groups through the delivery of responsive and high quality healthcare services. It is a social enterprise that invests in the continued development of a unique and innovative service that works in close partnership with partners, staff, service users and stakeholders. In April 2015 SIHE became the approved provider of Leicester City Assist Practice for asylum seekers and refugees. This organization was awarded a CQC rating of 'outstanding'. Their policy is to reduce failure of attendance through every client being allocated a named healthcare worker that acts as an advocate, who reminds them of their appointment and actually attends with them. As a multi-agency organization they have access to drug & alcohol workers, social services, nurse specialist as well as having arrangements with voluntary services, probation and parole boards. However there is currently no dental support.

There is a strong argument that social exclusion groups are a target for Making Every Contact Count (MECC) intervention. It is necessary to raise awareness within the dental profession around implementing MECC – this requires education and planning around appropriate interventions to support patients. It is always easier to identify barriers to MECC (eg; funding), but it don't necessarily have to be funded through a health organization as there are other opportunities with voluntary and charity groups.

Funding opportunities need to be explored, especially to assist social enterprises. Lottery Funding needs to be considered.

Workshop 1 Conclusions:

- Effective models already exist to support the socially excluded
- Dentistry needs to develop multi-agency links
- Combine education and working with pharmacies would be an effective care network
- Funding constraints will always impact on healthcare, but local networks should consider how to competitively apply for available funding
- Education should be incorporated into dental training programmes regarding working with the vulnerable and marginalised patient groups.

Workshop 2:
Volunteering with socially excluded people

Purpose of workshop:

a. Discuss the advantages of delivering dental care through charitable models

b. Identify how voluntary services could be funding to deliver efficient and safe services

c. How volunteering links to continuing professional development

d. Identify the risks, how these are mitigated and how this is indemnified

e. Discuss the additional advantages of volunteering with recognised charities

Key questions:

What are the advantages and challenges of delivering dental care through a charitable model?

What may be the perceived barriers to dentists volunteering with charities?

What may encourage dentists to give their time/resources to charity?

Advantages

- Improves client health, in terms of physical, mental, emotional and spiritual health.
- Education of the public and healthcare professions
- Delivery of care that may otherwise not be readily available to certain members of society.
- Provides a service within their own, familiar, environment rather than them trying to overcome the barriers that exist in conventional healthcare.
- It gives access to care without financial implications
- Improved access as charitable initiatives may remove the need to significant travel arrangements
- For the volunteers it provides a sense of social inclusiveness by supporting local community initiatives
- For the stakeholders, the people that provide the financial backing, it provides feedback on their contribution to society through annual reports
- It raises public awareness of charities, which increases charitable donation.
- For dental practices it engages with its staff, gives a practice focus and signposts them as a destination practice.
- Produces a sustainable and reproducible model.
- Allows for flexibility of services. For example, they can accommodate walk-in and scheduled appointments as dictated by patient preference.
- Offers an opportunity to link patients to peer support who can then help to facilitate attendance at dental appointments.
- Can provide an opportunity for relief from dental pain, oral health promotion, and one-off dental services such as oral cancer screening, fillings or scale and polish.

What are the challenges to providing dental care using a charity model?

- Funding
- Sourcing and maintaining equipment. Dentaid have identified that one of the most important team members is an engineer willing to volunteer to maintain equipment.
- Location. A suitable venue must be available
- Advertising. Signposting of the services available is essential otherwise clients and other aid agencies won't know how to appropriately access.
- Developing partnership working with other agencies
- Sustainability
- Ensuring that the services are developed in a way that matches the needs of the socially excluded population through their involvement in service design.

What may encourage professional to volunteer their time and resources to a charity?

- Continuing Professional Development. Effective means of raising the standard of practical skills, especially in the earlier years of training.
- Opportunity to develop practical skills, in particular tier 1 minor oral surgery, which most early years practitioners don't get exposed to in conventional practice
- Experience of treating high need patients without the constraint of financial targets
- 'Feel good' factor ie; contribution to society
- Formal recognition eg; through a Faculty of Health & Social Care
- Financial incentives eg; discounted membership of professional organisations
- Altrusim ie; personal reward
- Business development ie; gaining specific contracts from NHS England for managing high needs patients
- Promoting business through newsletters, media etc
- Development of CV

"Any business that evaluates itself on the bottom line is looking at the wrong numbers"

Richard Branson

What are the perceived barriers to the dentist volunteering for a charity?

- Time. Dentistry is a time consuming profession and many practitioners are unable or unwilling to release time for charitable work
- Safety aspect of working with high-risk clients
- Ethical issues. Does volunteering change lives or health? Is it sustainable change or short-term measures
- Indemnity concerns
- Lack of appropriate skills eg; minor oral surgery
- Embarrassment
- Uncertainty as to what charities exist in the UK
- Lack of confidence to organise own oral health promotional initiatives
- Bureaucracy involved in setting up own clinical charitable initiative e.g. CQC registration, indemnity, process of setting up a charity etc.

Other aspects of volunteering

- Linking with other professional groups eg; Pharmacies
- Voluntary groups have an increasing profile in society, at a time when the National Health Service is experiencing significant financial and service pressures
- Avoids referral into secondary care or special care dentistry for routine dentistry
- Enhances learning through education. Learn about different drugs, medical conditions, communication with challenging clients.

Workshop 2 Conclusions:

- Voluntary sector offers a different perspective on health care
- Voluntary work is effective in Improving physical, mental, emotional and spiritual health
- Additional clinical skills can be acquired by treating high needs cases
- Volunteering can enhance the dental practice, both financially and as an organisation
- Volunteering will have a personal financial impact
- Volunteering is associated with personal challenges, risks and ethical dilemmas

Workshop 3:
Medical and social services for socially excluded people

Purpose of workshop:

a. Share experiences of working with socially excluded people

b. Discuss ways of aligning services with other agencies within health and social care

c. How to start building health networks

d. Identify barriers to working with other agencies and how these may be overcome

Key questions:

What services could dentistry align with to provide collaborative care for socially excluded people?

How could dental services make connections / contribute to other medical or social services?

What might be perceived barriers to collaboration and how might these be overcome?

Sharing experiences

- The perfect solution would be an on demand service for socially excluded people that allows for flexible attendance patterns with availability for both fixed-time and walk-in appointments.

How could this be arranged?

- Arrange clinics at specific times of the week ie; a walk-in centre model
- When are the most appropriate days for clinics? It can't just be on days or at times which suit the clinicians. Do we have any concept of the optimum times based on quality research? If we don't create the right service then patients will continue to access Emergency Departments.
- Why do socially excluded people access ED? Because there is an expectation that this will allow access to free and immediate care. However research data shows that there's nothing about most dental access that is immediately urgent and could be directed to a routine clinic.
- However health-seeking behaviour is known to be different in the Gypsies and Traveller communities, who normally access care when they have acute pain symptoms. They use the NHS 111 service which signpost to the nearest access centre (not open 24 hours) or ED rather than local NHS dental practices.
- The key research question is therefore 'are we offering appropriate emergency dental care?'. This is difficult to determine as the Travelling community is relatively invisible to conventional healthcare workers. It is a challenge to signpost to services when the Traveller communities normally have low levels of literacy, so written material can be an inappropriate method of communication.

- Research is also affected by low literacy, as asking questions such as "why haven't you attended a dentist" is likely to get a distorted response as the ED had already fulfilled all their requirements for treatment and given resolution of pain.
- This produces two potential solutions; one is to have part of the day allocate for emergency visits and the other for walk-in attendances. This lends itself to a research proposal and a pilot study to compare this model of dental care. This could be piloted across two practices, or across two different geographic areas for comparison. However, while this seems a sensible approach to addressing inequity in reality it has a major inherent risk of increasing inequality. This happens by creating a service (based on professional opinions) and then finding that those needing the service (ie; the socially excluded) are unable to access appointments because they're taken by other people who find out about the service and know how to use the system. Therefore the people that genuinely need the system, but don't have the necessary literacy or social connections, will ultimately be discriminated.
- Improving equity is complex and requires service reconfiguration. It is important to avoid providing the same services for people of the same background otherwise it positively reinforces the belief that they always access care through that service. Redesigning services must be driven through quality research. Research is also essential in supporting a case for changing services with commissioners, as one of the key drivers of the NHS Forward View is to challenge inequity.
- NIHR are currently undertaking research to explore the integration, effectiveness and cost of homeless primary care services. (http://www.kcl.ac.uk/sspp/policy-institute/scwru/res/roles/homelesshealth.aspx)

Can we identify any solutions through research?

- The current service model has "piggy-backed" alternative working patterns onto existing Out-Of-Hours sessions. However this has failed to engage with minority groups as it only attracts people who use it as an alternative to conventional dental access. Using a community clinic or dental practice with extended opening hours does not meet the needs of Travellers. The proposed solution is a mobile clinic which travels to the clients and subsequently provides referral to mainstream services once trust has been developed and any initial dental pain has been addressed. Return to main stream services could be facilitated by peer support programmes. Currently this model doesn't fit with NHS commissioning and therefore relies on the services of charitable and voluntary organisations.
- However, research can assist service redesign through economic evaluation. Demonstrating both a case of need and an economic saving, by proving that a new service reduces ED attendance rates, could actually persuade commissioners of the utility of that investment. going to get the funding from to do this research

The number of Gypsy Travellers is vastly under-estimated in national censuses, mainly through the stigma and discrimination created by the term 'Gypsy / Traveller' or because many Gypsy Travellers now opt to live in houses. Data from 'caravan counts' can give a rough idea of numbers, but it will always been an underestimate. Lack of accurate data remains a challenge for researchers, with only 24 identified published papers that identify how Gypsy Travellers engage with dental health services.

Workshop 3 Conclusions:

- More focussed research on the dental and health needs of that allows for flexible attendance patterns with availability for both fixed-time and walk-in appointments is essential.
- Cost:benefit analysis of providing new models of dental access will guide commissioning

Workshop 4:
Developing services for socially excluded children and young adults

Purpose of workshop:

a. Define the key challenges for socially excluded children to accessing dental care

b. Identify solutions to these barriers

c. Understand how to signpost children in care towards dental services

See people not as 'hard to reach' but services as 'hard to access'

Key questions:

What may prevent socially excluded children and young adults from accessing dental care?

How might these barriers be overcome and are there any ways that oral health promotion could be integrated into day-to-day care?

Which services could signpost these children to dental services and what methods might be used?

Key data:

- 69,540 children and young people were looked after in a 12 month period
- 55% were boys and 45% were girls
- An increase of 1% compared to 2014 statistics
- 5,330 children were adopted in 2014/2015
- 10% will have 3 or more placements a year
- 16% of children starting to be looked after are 16 and over

(Department of Education 2015)

Understanding children in care:

- Accommodated under a voluntary agreement with their parents' consent. {Section 20, Children's Act (1989)}
- Subject to Full Care Order {Section 31}
- Subject to an Interim Care Order {Section 38}
- Subject to Emergency Protection Order {Section 44}
- Compulsory Accommodation, including those remanded to the local authority or subject to a criminal justice supervision order with a residential requirement.

What are the key challenges for children accessing dental care?

- Organisational
- Time
- Financial
- Cultural
- Legal. Identifying guardianship.
- Frequent changes in placement
- Parents' and children's fears
- Professional arrogance and lack of cultural understanding

What do we know about the health of children in care?

- Two thirds of children in care have had at least one physical health complaint.
- The majority adopt unhealthy lifestyles
- Behavioural problems and attachment difficulties are common. Most mistrust adults.
- Higher incidence of mental health problems (45% rising to 72% in residential care, compared to 10% of general population)
- Increase in risk taking behaviour
- Child Sexual Exploitation (CSE) is higher in looked after children
- Substance misuse is high (3 - 55% v 9% - 22%)
- Teenage Pregnancy is higher (30% v 17%)
- There is an increase number of unaccompanied Asylum Seeking children entering the system.

Older Children in care

- At 18 the Care Order ends. Many young people opt out of support.
- Increase in risk taking behaviour, particularly smoking and substance misuse.
- 30% of homeless adults have been in care as children.
- 38% of Young Offenders have been in care.

Overcoming barriers

- Go to the patients – don't always expect them to come into conventional treatment settings
- Respect culture and expectations
- Work with community advocates and hubs
- People will engage in their own way in their own time

Signposting

- For children in care the initial health assessment is completed by a Paediatrician within 20 working days of entering care.
- At this assessment the carer is encouraged to access the dental services.
- Review "Looked After" Health Assessments are undertaken 6 monthly until the child reaches 5 years and then annually. Dental health is assessed at these visits

Workshop 4 Conclusions:

- Children in care don't prioritise oral health
- Children in care can experience disordered eating regimes
- Children may have poor attitude to oral health, due to lack of routine, high use of pacifiers, lack of opportunities to develop self-care skills or frequent movement within the care system.
- Older children leave the care system without care packages for continued dental assessment and may disengage from dental services at this point.

Workshop 5:
Research with socially excluded people

Purpose of workshop:

a. To better understand the barriers to research within marginalised groups

b. Identify solutions to these barriers

c. Understand how to get started in research

Key questions:

What are the challenges of undertaking research with socially excluded groups and how might these be overcome?

Why is research with socially excluded groups important?

Key challenges and barriers

- Financial.
- Not enough time to build up trust
- Maslow's hierarchy of needs – if not receiving basic needs it will be difficult to engage in other things. This will impact on accessing routine services and especially when trying to engage in research.
- Cultural
- Enthusiasm for the research project
- Identifying the correct research question? When designing research within specific communities it is important to identify the questions that require an answer. If the questions wrong there will be a direct impact on both trust and credibility within that community.
- Research ethics. There must be accountability for all researchers working in this field. Poor literacy amongst Travellers, combined with frequent movement, results in limited contact time with the subject. Clear methodology must be adopted and assumptions challenged otherwise it is easy to introduce bias.
- Informed consent: The standard research leaflet is not applicable in the Traveller community due the low level of literacy. Establishing consent for research projects is complex, time consuming and requires establishing a level of trust. Travellers don't accept challenges, so are likely to acknowledge direct questions with either a smile or a head nod. It is important to assess understanding by seeking clarification.

Initiating research in the Traveller community

- Marginalised communities respond to a gentle approach
- Chain referral sampling, sometimes termed snowball sampling, is where the participant group grows as the discussions develop. Once trust is established there is willingness for widened participation from the marginalised communities. This can be enhanced by engaging local community members to collect some of the data, which both increases engagement and is cheaper than employing full-time researchers.
- Use other agencies, for example Health Watch, to identify the patient voice.
- Ensure the study group is representative of the community? For example, if the dental practice is situated in a large polish community area but doesn't have any registered polish patients then the data will be skewed and non-representative.

What would make successful research?

- Start by deconstructing the question (is it the right question?), but identifying areas that would improve engagement (ie; what matters to that community).
- Must identify barriers that might exist that prevent dental services from achieving what matters to that community.
- Reward: it is possible to give rewards for participation in research projects. This may not have to be financial, although vouchers can be useful for some communities. Any reward must be meaningful to that group, remembering that access to dental care may not be a key priority and therefore low value.
- Signposting to key services is valuable to someone in a vulnerable situation – the reward is therefore totally separate
- Determine what data is being collected.
- Ensure compliance from the Traveller community

Extract from a Traveller:

"I'd love a travelling dentist to come out and get more Travellers working for better health" – at same time every patient should be able to go a Traveller dentist and every Traveller should be able to go to an ordinary dentist – should be engagement and interaction

Understanding current Traveller research

- Current research with Gypsy Travellers (g/t) was commissioned by Department of Health
- g/t are one of four groups identified by the English National Inclusion Health Board with the poorest health outcomes
- The weakest evidence around health improvement in g/t is around life expectancy. Currently they have a life expectancy 10% less than the general population. They have high infant mortality rates, lower childhood immunisation uptake, high prevalence of mental health issues, substance misuse and diabetes. They also have a very high rate of dental disease with significant unmet oral health needs
- The challenges of accessing health services are around NHS registration as this requires proof of identification and address (utility bills etc). This lack of identification combined with low literacy levels, fear of discrimination and general distrust of authority leads to disengagement with health services. Not surprisingly this can lead to over reliance on emergency care and late presentation in the Emergency Department.
- There is evidence that service providers lack cultural awareness and for commissioners there is no real incentive brought into the system for providing high quality care for vulnerable group.
- Research is therefore focussed on 3 priority areas: maternity services, early years child services and child dental health services.
- A key element is public/patient involvement (PPI)
- Much of the poor understanding of Travellers stems from the massive lack of data around g/t experiences. g/t still aren't in the NHS data dictionary and it has been identified that there is no box that identifies their origin, which means they are a hidden population
- g/t were included in the 2011 census for first time.
- Community members found it important to tell their story, especially if that story would be of benefit to their community in the long run. One learning point was that the community felt very strongly about the need for greater equality between them and the researchers. They also felt that the biggest downfall in their experience of research was lack of feedback. One community member described it as "like having a conversation without saying goodbye". They reported being heavily engaged and then the researcher disappeared. As a result they never found out what happened to things they said to that person.
- A useful research tool is asset mapping. This starts with identifying people's strengths, in particular work with socially marginalised people who have experienced negative stereotyping. Asset mapping requires focus groups to look at specific situations and to start with the assets they have and used in that situation. Recent health asset mapping focussing on g/t and healthcare access in Leeds has found a wide range of community members identifying different ways of locating health information. This message is disseminated through the different communities as a valuable local resource.

PPI

This has identified a further 4 priority areas:

1. Health,
2. Accommodation,
3. Education,
4. Social inclusion.

This allows access to essential service such as youth worker input, healthcare access projects, community development work, strategic/policy work and financial support.

case study

There is a regular outreach programme that is under-resourced (lack of funding, short staffed) and won't be available until the following month. There has been positive engagement with the Traveller community although they remain wary of new researchers and reticent when disclosing information. One woman (Margaret) agrees to talk to you. She is living on the roadside and due to be evicted next week. She doesn't know where she is going after that, struggling financially and concerned that her children keep missing school because of the frequent evictions. Margaret asks if you could ask her to apply for child benefit as she can't read and write. You tell Margaret you are a researcher. She tells you that she is living on a camp with 20 trailers, all of whom have travelled together for a while. While she is happy to talk she seems stressed/preoccupy. After 30 minutes two neighbours appear and ask you politely to leave as she has things to get on with. As you leave she asks you your job role.

- **Challenges?**
- **Assets needed to draw on in designing research?**
- **What is required to make research a success?**

a. Challenges

- Time constraints
- Short-staffed
- Skill levels – who can assist with the benefits claim?
- Clarity of researchers role
- Building trust
- Research isn't a high priority for Travellers
- Confidentiality

b. Assets needed

- Before starting research always try to pre-empt potential problems and solutions, eg; know about the local citizens advice bureau, opening times, key contacts.
- Identify appropriate costing to support the project
- Avoid repetition of work that's either been undertaken or on-going
- Clarity of relationship helps to build trust
- Use local knowledge and contacts, including other Travellers

c. Successful research

- While initially defensive, it is normally the more engaged Traveller who would be one of the first to speak to researchers. Us this initial contact to spread messages. It is generally the women who are responsible for general health in Traveller communities so they should be specifically targeted.
- Females researchers tend to more widely accepted into the Traveller camps
- Ensure active consent to research. Assess understanding of any information given. Concentrate on determining the level of literacy.
- Avoid barriers. For example, don't record information onto laptops as Travellers become frustrated by this barrier.
- Identify travel arrangements so can maintain contact when they are on the road.

Application to dentistry and providing accessible care

Travellers experience significant issues when attempting to access dental care. This is multi-factorial:

- Frequent travelling and changing location
- Difficulty accessing information. Travellers rarely have access to the internet.
- Funding issues
- Difficulty registering for NHS treatment eg; if Traveller from Southern Ireland
- No postal address for reminder letters
- Normally won't access S&S/Text reminders (lack of credit, weak signal when travelling)
- Normally it's the women who make appointments but how do they ensure the men attend? How do they maintain diaries?
- Dental teams need to be culturally aware and sensitive to the Travellers unique requirements. Must establish relationships and boundaries.
- Developing rapport when having to arrange appointments via the women can be challenging
- Culture of accessing care through the Emergency Department
- Do dental practices signpost that emergency appointments are available? Do practices have walk-in slots from Travellers?
- Research shows that Travellers tend to arrive at a practice and take a seat without confirming with the reception staff. This can be perceived as late attendance. This requires staff training.
- Literacy support cards: Leeds have trialled literacy support cards. These are supplied to community members who don't read or write. Requires training of reception staff at GP and dental practices. Feedback is mixed, especially of reports of cards being given in an open waiting room.
- Supported needed for completing forms.
- Travellers don't have an understanding of medical terminology. This is especially noticeable when asked about medication, as they are unlikely to know the current list. They may deny taking medications to avoid embarrassing questions. Practices should refer to the drugs.com app, which helps identify medications based on colour / shape etc, as this would improve compliance.

Cultural aspects: Why do women make the appointments?

- Men work 9-5
- Women stay at home
- Practice opening times conflict with working pattern, therefore booking appointments can be complex
- Men tend not to be prepares to wait for phone calls to be answered
- Men tend to lose track of time when working and have a high chance of missing appointments.
- projects, community development work, strategic/policy work and financial support.

- Be aware that attendance tends to be reactive and not proactive, but will expect treatment at that appointment.
- One way to avoid regular review is to teach self-examination and educate regarding healthy eating (MECC). While this is not an ideal solution it may encourage early attendance.
- Dentists should consider out-reach programmes, although this is rare outside of the voluntary sector.
- Commissioning services. This must be reviewed in order to improve equity for Traveller communities.

Workshop 5 Conclusions:

- Traveller communities experience inequity and inequality due to their cultural difference, social circumstances, lack of education and migratory behaviour
- Barriers to care are multi-factorial but include lack of postal address, lack of trust in professionals and perceived poor communication between professionals.
- Research is essential but difficult to achieve
- Dental teams need education regarding cultural understanding

Acknowledgements

Salma Ainine
Postdoctoral Dentist, University of Dundee

Yasmin Allen
National Leadership Fellow / Specialist Registrar in Special Care Dentistry

Bhavik Patel
Clinical Fellow in Special Care Dentistry, Health Education East Midlands

Sarah Baughan
Dental Core Trainee, Health Education East Midlands

Stan Burridge
EbE Project Lead, Pathway

Jodie Bustin
Specialist Registrar in Special Care Dentistry, Health Education East Midlands

Janet Clarke MBE
Deputy Chief Dental Officer

Richard Cooper
Rowans Consultancy Ltd, Cockermouth

Andrew Dickenson
Postgraduate Dental Dean, Health Education East Midlands

Janine Doughty
NIHR Academic Fellow in Special Care Dentistry, Eastman Dental Hospital

Oliver Dugena
Core Trainee, Health Education East Midlands

Andrew Evans
Dentaid

Anna Friej
Team Leader, Pen Green Centre for Children and their Families, Northampton

Cathy Godfrey
Community Development Office, Plymouth University, Peninsula Schools of Medicine and Dentistry

Alison Hodgkinson
Clinical Nurse for Children in Care

Jane Lelean
International Dental Business Coach, Trainer and Speaker, Aylesbury

Alison McFadden
Midwife / Researcher
Mother and Infant Research Unit at the University of Dundee

Adrian 'Bean' Noctor
Pathway Care-Navigator

Maria Noguerado
Clinical Fellow in Community Paediatric Dentistry, Health Education East Midlands

Fran O'Leary
Core Trainee in Special Care Dentistry, Health Education East Midlands

Angela Prodger
Joint Head of Centre, Pen Green Centre, Northampton

Ellie Rodgers
Partnerships Manager, Leeds Gypsy and Traveller Exchange

Louisa Rose
Core Trainee in Dental Public Health, Health Education East Midlands

Wendy Smith
Community Development Office, Plymouth University, Peninsula Schools of Medicine and Dentistry

Elizabeth Such
University of Sheffield School of Health and Related Research (ScHARR)

Christine Utting
Clinical Director of Salaried Primary Care Dental Services / LDN Chair

Julia Wilkinson
Oral Health Promoter, Nottingham City Council

Devina Worsley
Specialist Registrar in Dental Public Health, Health Education East Midlands

Key References

Collins, J. and R. Freeman, R. (2007) Homeless in North and West Belfast: an oral health needs assessment. British Dental Journal, 202: E31

Cusick, L., Kinnell, H., Brooks-Gordon, B. and Campbell, R. (2009) Wild guesses and conflated meanings? Estimating the size of the sex worker population in Britain. Critical Social Policy, 29, pp. 703.

Department for Communities and Local Government (2016) Count of Traveller caravans, January 2016 England. London: Department for Communities and Local Government.

Department of Health (2010) Primary Care and Community Services. Inclusion health: Improving primary care for socially excluded people. London: Department of Health.

Doughty, J. (2015) Dental volunteering with Crisis at Christmas. BDJ Team, 2, Article number: 15144. doi:10.1038/bdjteam.2015.144

Doughty, J., Simons, D., Pearson, N., Evans, P. and D. Wright (2016) Challenges identified in a pilot outreach dental ser¬vice for Traveller children in Hackney, East London. Community Dental Health, 33, pp.185–188.

Homeless Link (2016) Homelessness in numbers. How many people sleep rough in England. [Accessed 24th January 2017] http://www.homeless.org.uk/facts/homelessness-in-numbers/how-many-people-sleep-rough-in-england

Inclusion Health (2010) 'Inclusion Health: Education and Training for Health Professionals. London: Department of Health.

Kinnell, H. (1999) 'Sex Workers in England and Wales: Europap-UK Briefing Paper for Department of Health, National Sexual Health Strategy'.

National audit office (2015) Care leavers' transition to adulthood. London: National Audit Office.

National Institute for Healthcare Research and Excellence, NICE (2014): Oral health: approaches for local authorities and their partners to improve the oral health of their communities. London: NICE.

ONS (2011) What does the 2011 census tell us about the characteristics of Gypsy or Irish Travellers in England and Wales. London: Office for National Statistics. [Accessed 23rd January 2017] https://www.ons.gov.uk/peoplepopulationandcommunity/culturalidentity/ethnicity/articles/whatdoesthe2011censustellusaboutthecharacteristicsofGypsyoririshTravellersinenglandandwales/2014-01-21

Simons, D., Pearson, N. and Movasaghi, Z.(2012). Developing dental services for homeless people in East London. British Dental Journal 213, E11. doi:10.1038/sj.bdj.2012.891

Smile4Life (2009) The oral health of homeless people across Scotland. Dundee: University of Dundee.

World Health Organisation (1986) The Ottawa Charter for Health Promotion. Ottawa: WHO.

World Health Organisation (2008) Social Exclusion: Meaning, measurement and experience and links to health inequalities, a review of literature. Lancaster: University of Lancaster. l

NHS

Health Education England

Developing people
for health and
healthcare