Ipsos MORI
Social Research Institute

Patient research into Direct Access

Report for the General Dental Council

14/01/2013

General Dental Council | protecting patients, regulating the dental team

1. Executive summary

Ipsos MORI were commissioned by the General Dental Council (GDC) to undertake a research project as part of a programme of consultation with patients and the public on a proposed policy change: the introduction of Direct Access allowing patients to see a dental care practitioner (DCP) without having a prior consultation with a dentist.

1.1 Introduction

The GDC is responsible for protecting patients and the public through the regulation of dental professionals in the United Kingdom. These professionals include dentists; dental nurses; dental technicians; clinical dental technicians; dental hygienists; dental therapists; and orthodontic therapists, all of whom must be registered with the GDC to work in the UK (referred to as 'registrants').

Since the expansion of the DCP registration in 2006 the practice of dentistry is limited to GDC registrants only, who may carry out only procedures which fall into their scope of practice. All patients are required to get a referral from a dentist before they can be seen by another member of the dental care team, a regulation included in the Standards Guidance issued by the GDC.

Owing to a number of key drivers for change surrounding the current system, the GDC considered and approved a proposal to move away from the current model of access to dental care within the UK. The proposal aims to expand the concept of Direct Access, in which patients are given the option, in certain circumstances, to see a DCP without having first visited a dentist.

Following an extensive literature review, including evidence from other countries where Direct Access is permitted, and a consultation with key stakeholder groups, the GDC is proposing to consult on a possible change to the system for the delivery of dental treatment in the UK:

- DCPs will be able to provide assessments, treatments or procedures which are within their scope of practice, which they are competent in fulfilling;
- Patients will be able to visit a dental care professional without having a prior consultation with a registered dentist.

The evidence from the literature review found that there were no significant issues for patient safety surrounding the clinical activity of DCPs. The evidence also suggested that Direct Access improved access to dental care and offered cost benefits to patients. The further consultation with stakeholders also identified a number of possible benefits, however some potential risks were also acknowledged.

This research project was commissioned as part of the consultation to ensure that a cross section of the public and patients were consulted on the proposed policy change so that that the voice of these groups is heard and considered in the debate. This research project also aims to highlight any issues that patients may have so that these can be considered and addressed should Direct Access be introduced, following the consultation.

1.2 Methodology

Qualitative research methods, which are exploratory in nature and allow for an in-depth understanding of views, were adopted for this study. Participants were given time and information to help them to consider the potential introduction of Direct Access.

Five deliberative workshops, lasting around two and a half hours, were conducted in Belfast (12 participants), Cardiff (9 participants), Edinburgh (11 participants), Leicester (11 participants) and London (9 participants).

In addition, eleven depth interviews lasting around 45 minutes were conducted with older patients (3 participants), nervous patients (3 participants), and patients with more complex dental experiences (5 participants).

1.3 Key research findings

At an overall level, most participants supported Direct Access, with a significant minority opposing the policy. While there may have been a general agreement that the policy would have a positive effect or at least was unlikely to cause any significant harm, participants' levels of support and enthusiasm varied considerably within the workshops and the depth interviews. Most participants saw the policy as being a complex issue to reach a view on as they believed it had both advantages and disadvantages, and the consequences of the policy were hard to predict. Other

participants found it easier to reach a decision believing that there was a single overriding case for supporting or opposing the policy.

1.3.1 How do participants discuss Direct Access?

Participants' views on Direct Access were largely framed by their previous experience and understanding of dental services, as well as the wider economic and political environment in which the research was conducted. Most participants in the workshops and depth interviews had little or no experience of DCPs. This reflected the experience of the general population as measured in previous surveys. This meant that while most participants could imagine visiting a hygienist, for example, they often struggled to think of any circumstances in which they would visit any other DCPs.

The financial climate was also likely to have had an impact on some participants who initially considered the policy as a cost cutting exercise with the aim of reducing patients' access to dentists. This perception had a major impact on some participants' interpretation of, and reaction to the policy.

1.3.2 Where do participants stand on Direct Access?

While many supported the policy at an overall level, participants' level of support and enthusiasm varied considerably. Most participants believed that the policy had significant advantages and disadvantages, making a final decision more challenging. With little prior knowledge of the policy area participants were often reliant on the materials presented to gain an understanding of the possible implications on patient protection.

Our analysis revealed that participants could be divided in to three typologies; members within each typology had similar views about the proposed policy change. The first typology **'Supporters'** supported the policy straight away. These participants were often the most confident about exercising choice. The second typology **'Contemplators'** were also largely supportive of the policy but were less enthusiastic and more likely to consider both the benefits and drawbacks before making a decision. The third typology **'Sceptics'** were the most negative about the policy. Many framed the policy in terms of services (in this case, access to a dentist) being cut.

1.3.3 What do participants see as the main benefits and risks of Direct Access?

Most participants believed that little would change in the immediate term for themselves as patients would continue to go to their dentist for most dental treatments. The main benefits recognised for individual patients were convenience, and for some cost. When prompted wider benefits, such as patient choice and greater access for all, were cited. While some concerns were raised, among the Supporters and Contemplators, most of these were only identified after prompting and were not sufficient to discourage them from supporting the policy.

Increased patient choice was considered the greatest potential benefit of the proposed policy change. Most participants suggested that the policy would increase choice for some, while allowing others to continue to access DCPs through their dentists if required.

Another potential benefit of the policy change was the belief that Direct Access would increase patients' access to hygienists. Some argued that this would reduce dental costs as an increased use of preventative services may mean that patients are less likely to require more costly dental work. On the other hand, Sceptics expressed a concern that more appointments would be needed to see multiple practitioners and therefore the cost would be increased.

The most cited concern with the proposed policy was that patients might struggle to choose the correct DCP for their needs. Some believed this could lead to either misdiagnosis or increased costs if further referrals were needed as a result of patients choosing to refer themselves to the wrong member of the dental team. Participants argued that more information is needed around the role of DCPs, particularly if the proposed policy change was to be introduced.

Participants' limited knowledge and experience of DCPs translated into a lack of trust. People tended to see the dentist as authority on *all* treatments, and questioned the competency of DCPs in some cases. Some participants explained that they would always prefer to place their trust with the dentist as the most qualified member of the dental team no matter what the problem.

Most participants believed that dentists should be involved in managing referrals for more complex treatment. Some participants were concerned that this might not always

happen under Direct Access. Most participants believed that dentists would continue to manage complex treatments as patients would want to visit a dentist if they had a major problem and DCPs would refer patients to dentists where appropriate.

Some participants, particularly those currently receiving reminders when they are due a check-up, were concerned that this service might not continue under Direct Access as there could be less clarity around who should be responsible for providing this service. Some participants were also concerned that patients' records may not always be available to dental professionals should they visit, particularly if they decided to visit a DCP operating in a different practice to their dentist.

1.3.4 What do patients recommend if Direct Access is implemented?

Participants suggested ways in which Direct Access could be implemented should the proposed policy change be accepted. They agreed that there was a need to inform patients of the role of DCPs – as this would enable patients to decide whether or not they would want to access DCPs directly, and which DCP would be the most appropriate person to see. After some consideration, participants suggested that a more gradual campaign of informing patients about the policy through word of mouth, leaflets and posters might be more useful than a national campaign.

1.3.5 Conclusions

Direct Access is unlikely to change the way people access their dental care for the majority of patients and are only likely to access DCPs directly on a needs must basis.

Participants tended to see the policy from both a citizen and as a patient point of view. From a patient point of view, it was likely to be seen as convenient and cost effective. As a citizen, the advantage was that the policy could increase greater access for all by alleviating some of the dentists' workloads.

The Sceptics also correlated with these two different viewpoints. From a patient perspective they were worried about having to use dental professionals less qualified than their dentist and from a citizen viewpoint they saw it as another way of

government attempting to cut services from the public. Therefore, if the proposed policy is to be implemented it is important to communicate its source clearly.

Misunderstanding and lack of awareness of DCP roles also means that some of the patients were concerned about self-referring and knowing which DCP to choose. Participants wanted communication to include posters, leaflets, and a website in the style of NHS Direct.

Concern over the handling of patient records may need to be addressed as this is currently something that cannot easily be addressed and was a real concern for participants when talking about accessing different DCPs, particularly when they are in a different practice to their dentist.

2. Introduction

2.1 Background to the research

Patients needing dental treatment are currently required to see a dentist first, who may or may not refer them to a Dental Care Professional (DCP) for further treatment, according to GDC regulations. Direct Access would mean that patients could choose to see a DCP without having a referral from a dentist first.

DCPs make up 60% of the dental workforce and comprise:

- Dental nurses
- Dental hygienists
- Dental therapists
- Dental technicians
- Clinical dental technicians
- Orthodontic therapists

The proposal would also mean that certain additional safeguards might need to be implemented in order to maintain patient protection, such as:

- Dentists will still be the only member of the dental team with responsibility for diagnosis and for surgery;
- DCPs will be able to refer patients to the appropriate member of the dental or healthcare professional if required, but they will not be able to provide the full range of treatments that dentists provide;
- DCPs will only be able to work within their own scope of practice, which is currently set out in the General Dental Council's Scope of Practice document.

Direct Access already exists in some countries within a certain scope and for certain professionals. In the UK there has also been a growing trend for patients to have greater control and choice in deciding which professionals they can see. Professional associations such as the British Society of Dental Hygiene and Therapy and the Dental Technologists Association have called for patients to have Direct Access to their members' services without requiring a dentist referral.

The Office of Fair Trading published a report which argues for deregulation regarding the requirement that patient access to DCP services must be through a registered dentist. The OFT's position is that the current arrangements represent an unjustified limitation of trade, and that it would be in the patients' interest to de-restrict the dental market.

In late April 2012 The General Dental Council (GDC) commissioned the rapid evidence review reported here[1] regarding the likely impact (including benefits and risks) of allowing patients direct access to treatment by dental care professionals (DCPs). The review found no evidence of significant issues of patient safety resulting from clinical activity by DCPs; evidence that access to dental care improved; and that some DCPs might over-refer patients to dentists which could ensure patient safety but also could lead to wasted resources and a high level of 'no shows' on referral.

The General Dental Council also commissioned a Call for Ideas online survey which spoke to both dental professionals and members of the public. It generated 840 responses; however, the majority of these were from dental professionals, with only 91 from members of the public. The GDC consultation on the proposed policy change included research with members of the public to ensure that the public voice was represented in a more substantial and in-depth way. The objective was to use research methods that would enable them to give considered and informed views on the proposed policy using qualitative and deliberative techniques.

2.2 Aims and objectives

The main objective of the qualitative research with patients was to understand patients' views of Direct Access, in particular:

- their initial views on the changes;
- expected future routes to treatment from DCPs;
- perceived benefits or risks they envisage, and the reasons for these;
- advice on how any risks could be addressed; and,

[1] Benefits and risks of Direct Access to treatment by dental care professionals: a rapid evidence review, http://www.gdc-uk.org/Aboutus/Researchandconsultations/Documents/FINAL%20VERSION%20of%20Literature%20Review%20on%20Direct%20Access.pdf, 29th June 2012

- their views on the things that would need to happen alongside the policy change to ensure clarity and patient safety.

The research aimed to be as inclusive as possible to allow the GDC to understand the overall opinion across a broad cross section of patients to complement the online Call for Ideas.

2.3 The report structure

The report has been designed to best represent the views of the participants that took part in the research. The views of workshop participants and those who have taken part in depth interviews have been included together as we found these were similar to each other. The remaining chapters are described below:

- **Chapter 3** involves a consideration of the experiences and views that participants have that frame their discussions of the policy.
- **Chapter 4** describes participants' overall views on the policy
- **Chapter 5** describes the benefits or risks of the policy that patients have identified;
- **Chapter 6** includes some additional participants' observations that the GDC may want to consider, in the event that the outcome of the consultation is to introduce Direct Access.
- The report concludes with a consideration of the implications of the research in terms of participants' views of the proposed policy and its potential implementation should it be approved.

2.3 Methodology

2.3.1 Methodological approach

This study was conducted using **qualitative research methods**. While quantitative methods enable researchers to measure public opinion, qualitative methods were more suitable for this project as they:

- allowed participants to explore issues in greater depth allowing a more nuanced response to complex issues such as Direct Access; and,

- were more exploratory eliciting greater understanding around the attitudes, experience and knowledge driving participants' opinions.

The research also used **deliberative techniques** (providing participants with relevant information) to ensure that participants had a clear understanding of the context surrounding the policy and the arguments supporting and opposing the policy. This methodology ensured that participants had the knowledge needed to give an informed opinion on a subject that might not necessarily be "top of mind." Ipsos MORI worked closely with the GDC to ensure that all the deliberative materials gave factual information in as clear and concise a way as possible. Details of the materials used are available in the appendix.

2.3.2 Methodology: Overview

Ipsos MORI interviewed patients through a combination of deliberative face-to-face workshops and depth interviews.

We used deliberative workshops which allowed a group of participants to discuss a topic and share their views. Workshops were conducted with members of the general public who had visited the dentist in the last two years. The workshops were recruited using demographic quotas to ensure that participants with different characteristics were able to take part. In particular, quotas were included to ensure some of the participants were parents or carers of others, and some had used DCPs in the past. The length of the workshop format and use of break-out groups allowed participants to consider a wide range of evidence and discuss and consider the details of a policy in greater depth.

The depth interviews were one-to-one interviews and conducted face-to-face allowing the participant to provide a detailed account of their views, experiences and behaviours. The depth interviews involved nervous patients who experience anxiety when visiting the dentist, elderly patients, and with patients who have more complex needs (who had seen more than one DCP in recent years). The depth interview allowed us to consider their views in more detail. They also allowed us to talk to participants who may have struggled to take-part in a workshop thus increasing the accessibility of the research consultation.

2.3.3 Recruitment

Recruitment varied by respondent type. Workshop participants, nervous patients and older patients were recruited on the street, while patients with more complex experiences were recruited by telephone. The patients with more complex experiences were recruited from respondents who had taken part in the GDC's annual patient and public survey had used more than one DCP in the past, or a DCP that was not a hygienist, and had given their permission to be re-contacted.

The profile of patients in the workshop was chosen to ensure that the workshops included participants from a variety of social and demographic groups with quotas set by gender, age, social grade and ethnicity. In addition, quotas were placed to ensure that some of the participants had seen a DCP, and some participants were parents or carers. All the participants had visited a dentist in the past two years.

The patients in the depth interviews were recruited from the workshop locations and from a broad range of different backgrounds. Further details are available in Appendix 1.

2.3.4 Workshop/ Depth structure

The workshop and depth interviews followed similar structures.

Each workshop lasted for around two and a half hours, while the depth interviews with patients lasted around 45 minutes each. The workshops and depth interviews began by asking for participants' general thoughts on dentists and the dental profession. Following this, participants were presented with information around the proposed policy change and asked to discuss this and consider their own views. The information was presented in stages to allow participants to fully understand each piece of information before moving on. The workshops and depths collected participants' opinions throughout so that any changes in their opinions or views could be noted.

The focus of the research was to investigate patient views about possible changes in the way in which patients can access DCPs outlined in the Direct Access consultation. We needed to ensure that we explored views on the proposed change, rather than reviewing individual cases or experiences. To address this, and to encourage participants to consider the implications of the policy, a series of case studies

illustrating key aspects of the process was introduced; these were drawn up in conjunction with the GDC. In addition, supporting materials to explain the current system and proposed changes, explain the role and responsibilities of Dentists and DCPs, and describe some of the aspects of the policy and arguments around it were used to allow informed deliberation.

The discussion guide used for each audience can be found in Appendix 2 in this report along with the supporting materials in Appendix 3.

2.3.5 Case studies

There were five distinct case studies, each focused on decisions patients might have to make if Direct Access was introduced. Participants were asked what their thoughts on each case study were and asked what they might do in each scenario. Due to the time restraints in the workshops and depths, participants were generally only asked, on average, two or three case studies each. Moderators worked together to ensure that all the case studies were covered in at least some of the groups and depths.

The case studies were:

- A man needing to see somebody about his dentures. This case study encouraged participants to consider how patients' dental records might be managed;
- A woman with bleeding gums. This case study encouraged participants to consider patient access to a hygienist;
- A young person with braces. This case study encouraged participants to consider patient access to an orthodontist or orthodontic therapist;
- A woman on a low income. This case study encouraged participants to consider the potential cost implications of Direct Access;
- A young girl with pain in her tooth. This case study encouraged participants to consider patient access to a dental therapist for the extraction of primary teeth.

The case studies were deliberately kept brief to encourage participants to think about any additional circumstances or factors that might impact their thoughts about the policy change.

The full case studies can be found in Appendix 3 at the end of this report.

2.3.6 A list of benefits and concerns

In collaboration with the GDC, Ipsos MORI developed a list of potential benefits and concerns that participants might identify around the policy of Direct Access.

The list was developed through an analysis of the following documents;

- Direct Access Call for Ideas;
- Office of Fair Trading (OFT) Review of Dental Industry;
- British Dental Association (BDA) report on Public perception of choice in UK dental care;
- General Dental Council (GDC) Literature Review on the Benefits and Risks of Direct Access
- General Dental Council Patient and Public Survey

A brief 'plain English' summary document outlining the case for and against introducing the Direct Access was distributed to participants (without being separated into benefits and concerns) so that they could make their own judgements around whether factors could be considered to be positive or negative to patients. A full list of the final benefits and concerns presented to participants can be found in Appendix 3.

There were a number of questions about Direct Access that were asked in the quantitative Annual Patient Survey. This piece of qualitative research was designed to complement the existing quantitative research and allow in depth exploration of the issues.

2.4 Interpretation of qualitative data

Unlike quantitative surveys, qualitative research is not designed to provide statistically reliable data on what participants as a whole are thinking. It is illustrative rather than statistically reliable.

Qualitative research is intended to shed light on why people have particular views and how these views relate to the experiences of the participants concerned. The deliberative approach used here enables people to participate in an informal and interactive discussion and to allow time for the complex issues to be outlined and addressed in some detail. It also enables researchers to test the strength of people's opinions. This approach, in other words, facilitates deeper insight into attitudes

compared to the more top of mind responses elicited by quantitative studies. It is important to bear in mind that we are dealing with perceptions rather than facts.

Anonymous verbatim comments made by participants during the workshops and depth interviews have been included throughout this report, attributed by audience type, opinion, location and gender. These should not be interpreted as defining the views of all participants but have been selected to provide insight into a particular issue or topic.

2.5 Publication of the results

Any press or publication of the findings of this survey requires the advance approval of the GDC and Ipsos MORI. Such approval will only be refused on the grounds of inaccuracy or misinterpretation of the findings.

2.6 Acknowledgements

Ipsos MORI would like to thank Guy Rubin, Janet Collins and Laura Brown at the GDC for their help and cooperation on this project. We would also like to thank the participants who took part in the research.

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3. How do Participants approach the subject of Direct Access?

This chapter considers the context behind participants' views of Direct Access. This is important as participants' views of the policy are closely related to their wider understanding and experiences of dentistry, as well as the impact of the current 'austerity' climate has on their thinking.

3.1 Participants have limited awareness of DCPs

Most participants had little or no experience of seeing DCPs. This finding is supported by recent GDC quantitative research from the Ipsos Mori Annual Patient and Public survey 2012 suggests that only a quarter (27%) of patients have ever had an appointment with a member of the dental team other than a dentist[2].

Some participants had a good understanding of the role of hygienists, as they had used them before and many others knew somebody who had visited a hygienist in the past. Participants generally had a good understanding of the role of dental nurses from their appointments with dentists.

On the other hand, participants had little prior awareness of other DCPs. This meant that they often struggled to think about any circumstances in which a patient might want to visit a DCP (other than a hygienist) directly.

> ***"I've only heard of an hygienist really"***
>
> **Older person depth, Contemplator, Cardiff**

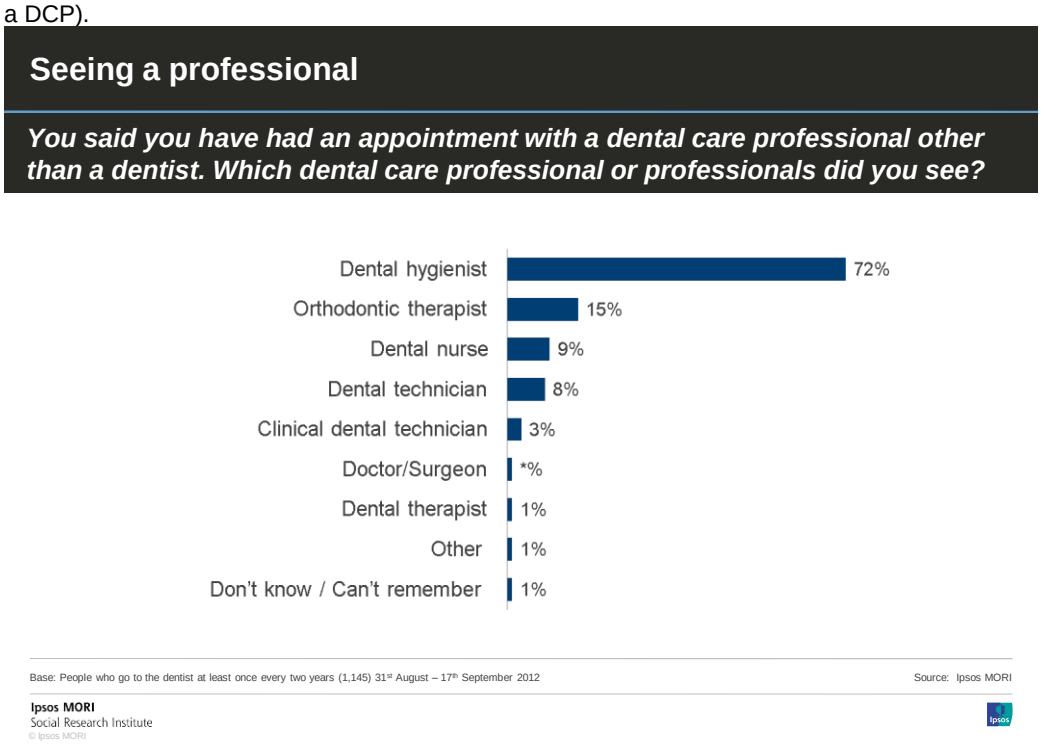
As a result, Ipsos MORI moderators needed to actively suggest ways in which patients might want to visit any DCPs such as dental therapists and dental technicians through the use of the summary of the scope of practice, and the case study materials (appendix 3).

As before, these qualitative findings are supported by quantitative evidence from the Annual Patient and Public Survey. The chart below only includes patients who say they have had an appointment with a DCP. While most of these patients have had an

[2] GDC Patients and Public Survey 2012, Ipsos MORI

appointment with a Dental Hygienist (72%), only a minority have had an appointment with any of the other five types of DCP.

Fig1. The DCPs that patients have seen (only includes patients who recall having had an appointment with a DCP).



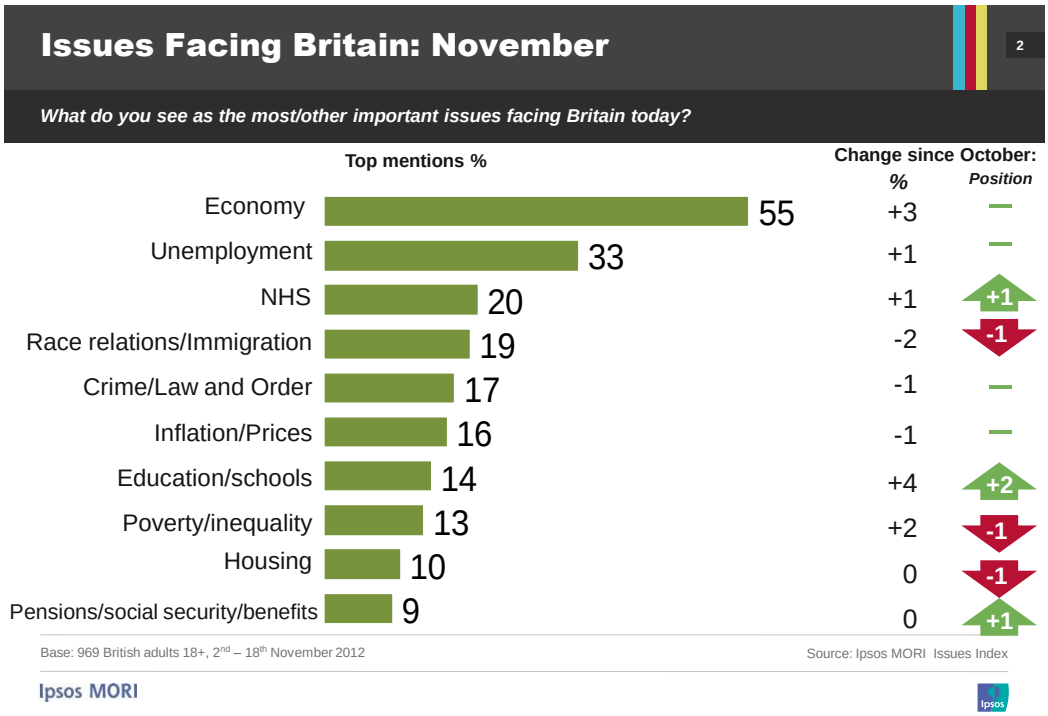
3.2 The financial climate is likely to have had a significant impact in participants' perceptions

The economic and political climate in the United Kingdom seems to have made an impact on participants' perceptions and views around Direct Access. Many participants initially believed that the policy was being proposed as a response to the public sector cuts, with some believing that the Government is suggesting the policy to reduce patients' access to dentists because it would be more expensive to increase the number of dentists than to increase access to DCPs. Participants suggested that the economic difficulties that they were facing have meant that the cost of dentistry is more significant to some people than it would have been in a period of greater prosperity.

The chart below illustrates how important the economy was to the general public at the time the workshops and depths took place. Over half the population cited the economy (55%) and a third cited unemployment (33%) as amongst the most important issues facing Britain. The NHS (20%) was also cited as a major issue at this time when there

were some media stories around cuts. Our research for the Nuffield Trust indicated that the NHS is considered an important spending priority that should be ring-fenced from other public sector cuts[3], suggesting that people are likely to be particularly sensitive to any suggestion of cuts in NHS service provision.

Fig 2. The most important issues facing the Britain based on a survey of the British public



[3] http://www.nuffieldtrust.org.uk/blog/public-spending-and-nhs-what-do-public-think

4. Where do participants stand on Direct Access?

This chapter describes where participants stood on Direct Access. We begin with a brief description of their overall views of the policy before considering the opinions of three specific typologies of participants. We then consider the characteristics of each of these typologies focusing on their overall views and attitudes towards the policy and the potential implications of the policy.

4.1 Participants overall views on Direct Access

At an overall level, most participants supported Direct Access, with a significant minority opposing the policy. While there may have been a general agreement that the policy would have a positive effect, participants' levels of support and enthusiasm varied considerably within the workshops and the depth interviews. Most participants saw the policy as being a difficult issue to deliberate as they believed it had both advantages and disadvantages, and the consequences of the policy were hard to predict. Other participants found it easier to reach a decision believing that there was a single overriding case for supporting or opposing the policy.

4.2 Defining typologies of participants

It became clear in our analysis that there were three overriding attitudes towards the policy across the different people we spoke to. This helps understand the overall patterns of attitudes in terms of explaining and understanding the views of patients. In addition,, following consultation, should the policy be implemented, an understanding of these typologies will also be helpful in the implementation of the policy, and the development of any communication strategies and materials.

At the completion of the fieldwork, Ipsos MORI moderators met on a number of occasions to consider and compare the views of different participants who had taken part in the research. After some consideration of the findings we hypothesised that the participants could be divided into three broad typologies – each with a different set of attitudes around Direct Access. This hypothesis was successfully tested by looking back at the notes, transcripts and recordings to determine whether or not it was possible to group participants this way.

While qualitative research of this nature is **not** designed to measure opinion, an analysis of the findings from the workshops and depths revealed that the Contemplators group was the largest group, with a significant number of people falling most comfortably in to the other two typologies (Supporters and Sceptics). As is typical with qualitative typologies, these three typologies are not intended to be completely exclusive, and some participants portrayed some of the characteristics of two different typologies. It is important to note that the typologies can be principally differentiated on attitudinal rather than demographic factors.

The key characteristics of the three typologies are summarised below.

4.2.1 Typology 1: Supporters

The first typology was the most **supportive** of the policy of Direct Access. Participants in this typology were enthusiastic about the policy when first introduced to it and continued to support it when faced with arguments from others that showed support or opposition to the policy. The Supporters saw the logic of the policy clearly, and coupled with a high level of trust in dentists and professionals saw little or no drawbacks to be concerned about.

Participants in this typology tended to be amongst the most **confident** about exercising choice in dentistry. For example, one participant explained that she had investigated a number of options for finding a dentist who could operate on her child who was scared of needles. This confidence sometimes resulted in participants assuming that other patients would also have the confidence to know when to visit the dentist and when to visit a DCP.

> ***"(I would go and see them) If they've been good in the past. If you feel comfortable and safe"***
>
> **Workshop, Supporter, Leicester, Male**

Participants from the Supporters typology were more confident about the policy **safeguards.** For example, participants in this typology tended to be confident that the DCPs would be competent in their job and have the training to manage well within their scope of practice, whilst not taking on treatments they did not have the training or competence to do. They also believed that DCPs would be able to spot potential problems and refer them to the relevant dental or health professional. This was not a view held widely by the other typologies, particularly those in the Sceptics typology.

We found that participants in this group did not have any clear, defining socio-demographic qualities that were shared or common within the group.

4.2.2 Typology 2: Contemplators

Participants from the second typology were also largely supportive of the policy, but less enthusiastic about it. Typology 2 participants were more likely to contemplate both the benefits and drawbacks of the policy in more detail, and as such swayed between supporting and not supporting the policy throughout the deliberations. In addition, many participants believed that their limited direct knowledge and experience of using DCPs made it difficult for them to state a firm opinion.

> ***"I've got no strong feelings on that subject because I've always gone to the same dentist. It means nothing to me to have Direct Access"***
>
> **Older person depth, Contemplator, Cardiff, Male**

Participants in this typology were slightly more likely to be from higher socio demographic backgrounds; though there are no other defining socio-demographic features of this typology.

4.2.3 The sceptical typology: Sceptics

Participants from this typology were the most negative about the policy. This typology instinctively rejected the policy when first hearing about it and remained sceptical throughout the workshops and depth interviews. Most of the participants from this typology continued to oppose Direct Access throughout the discussions.

The Sceptics typology's biggest concern was the misperception that patients may not be able to continue visiting the dentist in the future and would have to visit DCPs instead; consequently receiving (in their eyes) an inferior service rather than as an option to see a DCP instead of a dentist. For some participants, this belief was based on an initial assumption that Direct Access had been put in place to cut costs by encouraging patients to use DCPs rather than the more qualified dentists. Others were more concerned that the policy was the 'thin end of the wedge' and an aspect of more wider-ranging public sector reforms that had led to patients having greater choice within a more commercial environment. Some participants from this typology misread the policy as a seemingly ineffectual response to increasing demand for dentists.

"They need to look at the underlying issue of there's not enough people going into the dentistry profession… if we did have more dentists then people would have the option of going to see them so you wouldn't have to have the option of going to see a hygienist or these other people"

Workshop, Sceptic, Cardiff, Male

The Sceptics tended to trust their dentists and expected them to perform to a high standard. Most of them had never visited a DCP, and most had a dentist who carried out some of the roles that could be managed by a DCP such as scaling and polishing. On the other hand, they tended to have less trust in service providers, and were instinctively concerned about any changes to the way that dental services were managed. Participants in this typology tended to be older, on average, than the participants in the other typologies, and were less likely to be from higher socio-economic backgrounds.

5. What do patients see as the main benefits and risks of Direct Access?

This chapter focuses on participants' detailed considerations of Direct Access. Participants discussed many of the issues identified in the stakeholder groups, Call for Ideas, and in the consultation. We have structured this chapter around these issues (where possible) to enable comparison between the evidence sources. We identified three key areas that surround the issue of Direct Access and explored these in detail: choice and access; scope of practice; and teamwork.

Most participants believed that little would change in the immediate term for themselves as patients would continue to go to their dentist for most dental treatments. The main benefits recognised for individual patients were convenience, and for some cost. When prompted wider benefits such as patient choice and greater access for all were cited.

Some participants had some concerns around issues such as team working and the competency of DCPs, although in most cases these concerns were only brought up after prompting and were not sufficient to discourage participants from supporting the policy.

5.1 Choice and access

5.1.1 Increased choice

Patient choice and improved access to dental care were identified as the key potential benefits of the Direct Access policy[4] by stakeholders. Participants suggested that the policy also has the potential of increasing patient access as an additional number of entry points may make it easier for patients to access dental services as many were aware of the shortage of dentists in some parts of the country.

The Supporters and Contemplators suggested that the potential for increased patient choice and access are key benefits of Direct Access. These were identified as being most important at the beginning of the depths and workshops (before being prompted),

[4] See Direct Access: A proposal for Consultation page 9

and at the end (when they had had the opportunity to consider the policy in more detail).

Some of the Supporters felt that their personal choice and access to dental care would increase with Direct Access. Those participants who were particularly confident about exercising choice were amongst the most enthusiastic about this policy.

> ***"If I need a hygienist I could just look at the phone book, and find out which person I preferred."***
>
> **Workshop, Supporter, Belfast, Female**

Those who had never visited a DCP often felt their own levels of choice and access would not be affected by the policy (in the short-term) as they did not expect to start visiting DCPs in the future. Some also suggested that it could take a while; as access to DCPs improved, more DCPs would have to be trained to meet any additional demand that might develop under the policy.

However, Supporters and Contemplators supported Direct Access for two reasons: firstly, because they believed that increasing *some* patients' access to services was better than not increasing *any* patients' choice and access; and secondly, because they felt Direct Access could increase patients' choice and access in the longer term as a new culture of referrals was embedded.

> ***"It might not benefit most people but for some people this policy means they'll have more choice"***
>
> **Workshop, Contemplator, London, Male**

Trust and continuity of care were important issues for participants. Some from the Contemplator and Sceptic typologies explained that they would continue to visit their dentist as they trusted him or her and so were not keen to see another dental professional. Some participants explained further that they would initially want to access DCPs via their dentists, but would be happy to visit a DCP directly if they had seen that person before and knew a little bit about them.

> **[Citing Case Study A] "*If he's been there* [to the clinical dental technician] *before, and the chap knows him, then I thought it would have been OK to go straight back to him".***
>
> **Workshop, Contemplator, London, Male**

Other participants said they would visit a DCP directly, particularly if their usual dentist was not available. They argued that DCPs have all had to had adequate training to conduct any work within their scope of practice and consequently could be trusted to manage the work.

> **[Citing Case Study C] *"If you were worried about the pain - then I think somebody who was a technician* [the respondent was referring to an orthodontic therapist] *would be OK* [to adjust braces]."**
>
> **Workshop, Contemplator, Cardiff, Female**

Some of the Sceptics were concerned that Direct Access would reduce patients' access to dentists on the NHS. They hypothesised that with more people accessing DCPs directly and less people accessing their dentists, more dentists will be encouraged into practising privately to supplement their income.

> ***"If dentists are seeing less people, they're not going to like getting less money and might go down the private route"***
>
> **Workshop, Sceptic, Edinburgh, Male**

5.1.2 Increased numbers accessing dental care

The proposed change in policy would mean that patients can book appointments with members of the dental team that specialise in preventative care, particularly hygienists. Hygienists were the DCP most recognised by members of the public and so for many they may be the obvious choice when seeking to access DCPs directly. Patients generally thought that increasing preventative treatment would be a positive thing because it would ultimately cost the system less if patients need less major dental work.

> ***"People would see the hygienist more - every six months rather than every year."***
>
> **Complex treatment depth, Contemplator, London, Female**

Some of the participants in the workshops and depths believed that Direct Access might encourage nervous patients to access dental services as they would be able to see a DCP rather than having to see a dentist. They argued that the term "dentist" can

make potential patients nervous as dentists are more closely associated with needles and drilling.

However, this theory was not supported by the nervous patients that we spoke to, who argued that they could be as nervous seeing a DCP as a dentist[5].

> ***"If you're scared of dentists, you won't see anyone about your teeth, it doesn't matter what they're called"***
>
> **Elderly depth, Supporter, Edinburgh, Female**

5.2 The scope of practice

5.2.1 Understanding of the DCP roles

Stakeholders expressed a concern that there could be "confusion among professionals and patients about the roles and responsibilities of the [dental] team"[6]. The research confirmed this; there was low awareness among patients of the different dental care professionals and their roles.

People's lack of knowledge of the different roles of the dental care professionals translated into a concern that they (or other patients) might find it difficult to choose the correct DCP or might even book an appointment with the wrong dental professional under the Direct Access policy. Many participants suggested that this was their greatest concern about Direct Access.

> ***"It could cause confusion amongst the public around who you are going to see… you could diagnose yourself as having an issue and then see that person [and] very easily get it wrong".***
>
> **Workshop, Contemplator, Cardiff, Male**

Some participants were worried that patients might refer themselves to the wrong DCP if they made a mistake about who the best member of the dental team to see is. Also, if they saw the DCP based on self diagnosis they would be worried that the DCP would treat them based on this diagnosis, even if it is not correct. However, most Supporters

[5] Please note that we only interviewed 3 nervous patients. This may be insufficient to tell what most nervous patients would say about this issue.
[6] See Direct Access: A proposal for Consultation page 6

and Contemplators felt that this would not be a problem as dental care professionals would be adequately trained to know whether a patient had wrongly diagnosed a dental problem and would use their professional judgement in this.

Some of the Contemplators and Sceptics were concerned about paying additional costs if they visited the incorrect DCP as a result of misdiagnosing their own dental needs. Patients believed that they would need to either go back to the dentist, or be referred to another DCP which would cost money. This was a particular concern for several patients on a low income who felt that they would face a difficult choice deciding whether to risk seeing a DCP (where this might save money) or to see a dentist directly. Some participants were also concerned about the effect that an incorrect appointment could have on waiting times. They explained that they would be concerned about making an appointment with the wrong person and finding themselves at the back of the queue to see the correct DCP for their problem.

Some participants suggested that the risk of these problems could make patients more cautious about using the self-referral method with the result that patients would continue to visit the dentist if they were in any doubt about their condition. The Supporters acknowledged these arguments, but were more confident about patients having the ability to know when to go to a DCP and when to go to a dentist. They suggested, as per the proposal that is being consulted on, that patients would continue to see their dentist but have the option of seeing somebody directly if they wanted to, and were confident about self-referral.

> ***"I think as long as we don't see it like we have to give up our normal relationships with our dentist and still have our 6 monthly check ups, if in 3 months time we decide we want to see someone about our dentures it just gives that option"***
>
> **Workshop, Supporter, Edinburgh, Female**

5.2.2 Training and competency

The proposal under consultation includes some safeguards. DCPs will only be able to do work within their scope of practice. They are also required to refer on to other dental or health professionals if they identify something that they cannot treat themselves.
Lack of exposure to most types of DCPs meant that some were not confident that DCPs might be able to identify dental problems when assessing the patient. This lack

of familiarity meant that it was sometimes a stretch for some participants (particularly the Sceptics) to trust DCPs as professionals who are highly qualified to carry out all of this treatment and be able to identify problems.

Knowing that the DCPs are less senior than the dentists sometimes meant that patients were cautious about the policy. For them, the dentist is the one who has the breadth of knowledge in dentistry and is able to diagnose problems. Sceptics were more likely to argue this and thought that people were always better off going to the most senior person first and letting them decide and delegate if necessary to a DCP.

> ***"You won't go to the pharmacist when it could be something where you need to see your doctor"***
>
> **Workshop, Sceptic, Cardiff, Male**

> ***"You go first to the dentist because he is [at the top]"***
>
> **Workshop, Sceptic, Cardiff, Male**

However, other participants were satisfied that the GDC, as a regulatory body, was ensuring that the professionals were receiving the required training and would be confident in their ability to treat or refer if necessary.

> ***"If it's the General Dental Council I assume it's going to be professionally sanctioned. As long as the people on the front line are professionally trained and can refer up if they need to I see no problem."***
>
> **Older person depth, Contemplator, Cardiff, Male**

5.3. Teamwork

5.3.1 Responsibility for contacting patients (regular appointments)

A key concern from stakeholders was "patients 'falling through the gaps' if arrangements between professionals were not adequate"[7]. We wished to explore this in our fieldwork to see if it was also a concern that resonated with patients.

Some participants were concerned that the introduction of Direct Access could mean that there is no clarity around which a dental professional has responsibility for

[7] See Direct Access: A proposal for Consultation page 6

contacting patients to remind them to book appointments. Participants with these views believed that dentists and DCPs may both expect the other professional to take on this role. However, this concern tended to be mentioned after prompting rather than as a spontaneous concern.

Participants who currently rely on their dental practice contacting them to remind them to book in a new appointment were most concerned about this issue. In many cases these participants were Sceptics and had the same dentist for a significant amount of time. Others often stated that the patient should be responsible for booking appointments, with some participants in London saying that if they did not make an effort to contact their dentist to book follow-up appointments they would risk losing their dentist. Some people thought that this responsibility could be managed on a practice by practice basis. Some participants explained that they would prefer both DCPs and dentists sending them reminders than neither professional taking responsibility.

5.3.2 Managing referrals (between professionals)

People were concerned that their medical and dental history might not be effectively passed on from one dental professional to another through Direct Access, particularly if DCPs were operating out of a separate practice to their dentist. Many participants initially assumed that all dentists and DCPs could immediately access patients' dental records on a computer whenever they had an appointment. There were consequently some concerns when it was suggested that this might not be possible. In our wider public sector research we often find that service users assume that services are joined more seamlessly than they are.

Some participants believed that this could be a particular problem for patients who require complex treatment and therefore need to see a lot of different DCPs. There was a concern that when their records need to be spread around several dental care professionals, they might not be managed properly and information could easily be missed or it might not get passed on at all. For many participants this was their biggest single concern with the policy, and one where further reassurance would be helpful.

> ***"If records aren't moved from one practice to another then there's going to be a lot of discrepancy I imagine, and a lot of, well re-explanation and going through the same problems, like telling the professional obviously what the whole past initially is."***

Complex needs depth, Contemplator, Cardiff, Male

A participant who had received complex treatment in London discussed an incident when she mentioned an allergy in passing to a surgeon before treatment took place. She later found out that her life could have been at risk if she had not told the surgeon about that allergy. She believed that patients who are used to seeing dentists on a regular basis may not assume that a new professional might not know their medical history and suggested that efforts should be made to remind patients to inform dental professionals about any relevant history.

Some participants (particularly Supporters) were less concerned about information not being passed on. Some explained that they were used to informing health professionals about their medical and dental history and would do this with any dental professional as a matter of course.

6. What do patients recommend if Direct Access is implemented?

While the workshops focused on the participants' views of the proposals under consultation, patients also talked about what they would like to see happen should the decision to introduce Direct Access be taken. This chapter discusses these recommendations, which would be helpful if Direct Access becomes a reality. Participants' views on the potential implementation are helpful in understanding and contextualising their views more generally to the potential policy change.

Participants discussed how the policy of Direct Access could be best communicated. After a consideration of the complexity of the issue, and the potential cost of a wide-ranging campaign, participants agreed that a more gradual campaign of informing patients about the policy through word of mouth, leaflets and posters might be more useful than a national campaign.

Given their lack of knowledge about DCPs people said the most important information to be conveyed is around the role of DCPs – as this would enable patients to decide whether or not they want to access DCPs directly, and which DCP would be the most appropriate person to call upon.

6.1 What did patients think the perceived impact of Direct Access would be?

Most patients did not think that Direct Access will have a significant effect on the way that they access their dental care. They rarely see DCPs other than a hygienist, and struggle to think of reasons why they would ever want to see a DCP (other than a hygienist) without seeing a dentist first.

Some patients recognised that they would benefit from Direct Access more than others. A minority of people with complex or specific needs might have reason to visit DCPs more often than the average person and so many participants conceded it would be advantageous for these people to have greater ease of access to DCPs. However, a minority of people were concerned about the negative impact that Direct Access could have on the many, as discussed earlier, such as dentists going private.

6.2 How did patients think Direct Access should be communicated?

6.2.1 Rationale

One of the biggest barriers to accepting the policy was having an understanding of the rationale behind it. Therefore it was important for patients to have the reasons behind the policy communicated clearly to them. This was particularly true of the Sceptics who were initially very cynical about the motivation for the policy often wrongly assuming that the potential policy change was government-led, and motivated by the desire to save money by restricting patients' access to dentists.

Some participants suggested that being more overt about this could be critical in encouraging public support for the proposed policy change.

> ***"I think there needs to be a firm commitment from the governing body that this will sort the issue out and everyone will then have access to dental treatment like they do to NHS medical treatment"***
>
> **Cardiff workshop, Sceptic, Male**

6.2.2 Understanding roles of DCPs

A number of the anticipated concerns stemmed from a current low usage of DCPs and thus low awareness of their roles and qualifications. Therefore, the patients were worried about choosing the wrong DCP with a corresponding risk of misdiagnosis or increased costs.

Participants therefore said that the general public should be made aware of the different DCPs. For example, participants in Leicester cited more information as the key change that could make the policy work if it was introduced. There were quite a few suggestions that a scope of practice, similar to what we showed them in the workshops and interviews, could be displayed on the wall of the practice as information to read while patients are waiting for their appointments.

> ***"If you had it up in the wall in the waiting room of the surgery you could just look at that while you're waiting and know who does what"***
>
> **Leicester workshop, contemplator, Male**

More specifically, they thought there needed to be more detailed information about DCP's qualifications, skills, current role in the dental system and the benefits of accessing a DCP directly which needed to be communicated clearly, preferably with someone the patient already trusts, such as their own dentist.

> ***"People that are dealing with these people [DCPs] need to be assured that these people do have the qualifications"***
>
> **Edinburgh workshop, contemplator, Male**

6.2.3 Formats of communicating

Patients discussed the level and formats of communicating a change in policy, but this varied widely from large national TV campaigns to leaflets in libraries supplying the public with information.

The value of word of mouth was recognised as something that could really help the policy, particularly when it comes from trusted sources such as dentists because they would be able to appease worries patients might have about the change, particularly to the Sceptics.

One workshop group recommended against rolling out Direct Access with a big fanfare, which might be off putting to those who are adverse to change. Instead they suggested that people should find out about the policy change as and when needed, and through information in their dental practice.

> ***"Gradually the dentists could turn round and say you can book that directly"***
>
> **Edinburgh workshop, Contemplator, Female**

6.3 How did patients think Direct Access should be implemented?

6.3.1 Bringing dental services together

When visualising how Direct Access might work in practice participants talked about ways of accessing the different DCPs and how barriers to accessing them such as trust and information could be overcome. The idea of a 'one stop shop' practice came up several times in both the groups and the interviews. They saw it encompassing all the different DCPs alongside resident dentists. One patient likened to a 'GP super surgery'.

"They **[DCPs]** *would have to be linked to a dental surgery…and have the information linked with the dentist and the DCP as well and then I think people will be less confused. Then they could say I think you just need the hygienist. [If services were] under one roof, then you would feel more comfortable because they're attached to something"*

Nervous depth interview, Supporter, London, Female

This idea seemed to resonate with participants strongly because having everything under one roof was deemed to have several advantages:

- Trust of the DCP would be increased as they have been vetted already;
- Records would be kept in the same practice and wouldn't need to be transferred;
- It would be easy for patients to go 'down the corridor' to the next member of the dental team;
- The receptionist at the practice could direct patients to the most appropriate DCP to see for their problem;
- There could be a chart on the wall which explains roles and qualifications of the members of the practice;
- This might improve team working, particularly crucial for patients with complex needs who need to see several members of the dental team.

6.3.2 Introducing a website along the lines of NHS Direct

When talking about how to implement the policy, a few people also suggested that a website should be developed (similar to NHS Direct) which patients can use to decide which DCP to see.

"You [need] an NHS style website… if you say my gums are bleeding it tells you where to go, so it leads you to the right professional."

Cardiff workshop, Contemplator, Male

6.3.3 Private insurance schemes

During the discussions some participants were concerned with the costs of paying for dental services and how Direct Access could affect them financially. Participants in London who used private insurance schemes were particularly concerned that their

insurance might not be willing to pay for the cost of additional visits to a hygienist if patients had referred themselves directly. Participants were concerned that this could restrict their ability to benefit from Direct Access, and suggested that the GDC could have a role in discussing this issue with insurance companies, if the proposed change was implemented.

6.3.4 A pilot trial of Direct Access

Participants in Cardiff and Belfast suggested that Direct Access could be piloted in a single area to ensure that it works, and that patient safety is not put at risk. One potential risk of a trial is that it reveals little evidence either way as patients suggest it may take some time for patients to access services directly.

"They could take a study group and then you could see how it works."

Cardiff workshop, sceptic, Male

7. Conclusions

This chapter concludes the report with a consideration of the implication of participants' discussions around the policy.

The research suggests that the general public would support the proposed policy change with most participants' agreeing with the policy, both before, and after a deliberation of its potential benefits, risks and impact.

Direct Access is unlikely to a big game-changer for the majority of patients that access dental care. Patients are likely to access DCPs directly on a needs must basis and so might only find out about the change on a gradual basis.

The policy is likely to increase choice for the minority who have specific needs and are comfortable with approaching DCPs themselves to arrange appointments and their treatment. Those most likely to find out first would be the Supporters as they are the most confident group in terms of finding out new ways of accessing services. Having people find out on a needs must basis would also satisfy concerns from the Sceptics group and those who are more nervous about change.

Participants tended to see different benefits and concerns when considering the policy from both a citizen and a consumer point of view. From a patient perspective, Supporters and Contemplators were quick to see that the policy is likely to be more convenient and more cost effective. Thinking more widely, as a citizen, they recognised that the policy could take some of the workload from dentists, resulting in greater access for all.

The Sceptics were vocal in their concerns. From a patient perspective they were worried that they would be forced to use sub-standard professionals which could result in additional costs due to additional appointments. They had a very cynical citizen viewpoint, seeing this as another way for government to cut costs, services and standards. If the policy is implemented it will be important for these fears to be allayed by making it clear that Direct Access is a policy which is being brought about in the patients' interests, and by the GDC and not government.

Some of the criticism the policy attracted was as a result of misperceptions of how the policy would work, and envisaging a radical new way of accessing dental care. In reality it is likely to be a "soft touch" approach. As such it is unlikely to attract the kind of criticism it does in the deliberations within the research programme.

Furthermore, a misunderstanding and lack of awareness around the roles of DCPs undermined the level of support for the policy, particularly for the Sceptics and the Contemplators. If people are to be able to self-refer themselves to DCPs it will be important for them to understand the types of professionals they can see, and their roles. People largely wanted this through posters and leaflets in the dental practice, and a website in the style of NHS Direct.

A real concern that patients had was that their dental records may not always be available to dental care professionals if they were to visit them, particularly if the DCP is not in the same practice as their dentist. This was particularly the case again for Sceptics and Contemplators. Some Supporters also expressed this concern although many had blind faith that their records would automatically be available to all health professionals, or that they would be happy to relay their dental and relevant medical history. This is an important point for consideration as there is no easy resolution for cross practice record sharing.

An ideal approach to accessing multiple dental professions would be a 'one-stop-shop' approach where one clinic in the area offers the services from a range of dental professionals. While this might not be practical there is a sense that practices that offer multiple services would be welcomed as it would overcome record data sharing concerns, increase trust levels in different DCPs, and be particularly convenient. However, practices might want to considering offering a wider array of services, if they do not already, or build networks with local DCPs, where a dentist would have a network DCPs that they trust and could recommend to patients.

Appendix

Appendix 1: Details of the workshops and depths

The following table details the five workshops that took place across the United Kingdom

Location		Number of participants
Belfast	Northern Ireland (urban)	12
Cardiff	Wales (urban)	9
Edinburgh	Scotland (urban)	11
Leicester	England (rural)	11
London	England (urban)	9

In addition we conducted 11 **depth interviews** across the United Kingdom with participants who may not have been able to take part in the workshops. Depth interviews were used to talk to;

- 3 older patients (aged 70+) who are less likely to have the mobility and health to travel to and attend a longer workshop than younger people;
- 3 nervous patients who may have struggled to talk about their experience of dentistry in a larger group; and
- 4 patients with more complex experiences (using at least one DCP) who may have had more to say about the policy and consequently might have dominated a workshop by virtue of their greater experience of using dentists and DCPs.

Further details are available in the following table.

Type of patient	Number of participants
Older patients	3
Nervous patients	3
More complex experiences	4

Appendix 2: Discussion guides

GDC Direct Access Workshop Guide FINAL

The main objective of the qualitative research with patients is to understand patients' views of Direct Access, in particular:

- their initial views on the changes;
- expected future routes to treatment from DCPs;
- views on the safeguards that are proposed;
- perceived benefits or risks they envisage moving forward, and the reasons for these;
- advice on how any risks could be addressed;
- the information necessary to accompany the policy change

- To understand the overall opinion across a broad cross section of patients to complement the online consultation.

Activities / aims	Exercises	Materials needed
18.30-18.45 **15 mins** **Introduction** *Get drinks / food* *Relax participants and get them thinking about the issues*	**PLENARY** INTRODUCTION • Introduce the moderators • Introduce Ipsos MORI: independent research company • Introduce the GDC: organisation that regulates dental professionals in the UK and its purpose is to protect the patient • Introduce the research project: the GDC have commissioned Ipsos MORI to talk to the general public about some new changes to dentistry and how people access dentistry • MRS rules and housekeeping: No right or wrong answers, no prior knowledge expected,	Abstract images

Activities / aims	Exercises	Materials needed

	please speak one at a time due to recording, may move you on, I need to hear from all of you.
	
	• Participants introduce themselves. We would then ask them to tell us something about themselves using cards with abstract images as prompts. The aim will be to warm up the group and get a sense of participants' personalities and attitudes and what makes them tick.
	  ○ Why did they choose that card?
	  ○ What does it say about them?	

18.45-19.15 **30 mins** *Understand views and knowledge on current system*	**PLENARY** PARTICIPANTS' UNDERSTANDING OF CURRENT SYSTEM: **2.1 Warm up: Top of mind thoughts about dentists and dental health professionals** (10 mins) • **When I say dentist or dental health professional, what do you think about?** • Ask each participant to write three thoughts (using very short and precise answers) on separate post-it notes. The thoughts could include emotional responses, past experiences, or even sensations such as the sights and smells. E.g. "Scary", "I don't mind but my kids make a fuss", "something you have to do", "fresh teeth feeling", "professional staff" etc. • Get participants to stick the post-it notes on flipchart and explain them PROBE IF NECESSERY ○ Why did you write/ think of that?	Post-it notes and pens Flipchart Scope of practice Explanation of Direct Access policy

Activities / aims	Exercises	Materials needed
	○ What did you mean by that? ○ What do other people think? • IF TIME: Participants to group the responses into themes on the flipchart **2.2 Knowledge of dental care professionals and the current system of access** (10 mins) • What types of dental care professionals have you heard of or seen? ○ What kind of things do you think they do? ○ Use scope of practice document to clarify their roles • PROMPT WHERE NEEDED. **And what about?** ○ Dentists ○ Dental nurses ○ Orthodontic therapists *Please note: orthodontists are different to orthodontic therapists. Orthodontists are not DCPs but dentists who have had further training. Any dentist can legally practice orthodontics as it is part of the practice of dentistry, but if you want to call yourself a 'specialist' in orthodontics then you have to be on the specialist list which requires*	

Activities / aims	Exercises	Materials needed
	a further qualification over and above the normal dental degree ○ Dental hygienists ○ Dental therapists ○ Dental technicians ○ Clinical dental technicians ○ What kind of things do you think they do? ○ Use scope of practice document to clarify their roles • Explain that all dental health professionals apart from dentists are known as DCPs (Dental Care Professionals). • How do you get an appointment with a DCP • Prompt: Would you go directly or through a dentist? **2.3 Introduce the policy** (10 mins) • Hand out an explanation explaining Direct Access (the same for every group) • Read the explanation out • Participants can highlight or circle anything that is unclear, or anything that stands out as particularly positive or negative. If the policy is changed… • Patients will be **able to decide** which member of the dental team they wish to have an appointment with. They will still be able to have an appointment with their dentist if they want to.	

Activities / aims	Exercises	Materials needed
	• Dentists will still be the **only member** of the dental team with responsibility for diagnosis and surgery. • DCPs will **not** provide the full range of treatments that dentists can but **will be able to refer** patients to the appropriate dental or healthcare professional if required. • DCPs who are contacted directly will make their own assessment of the patients' needs without using a prescription issued by a dentist informing them of any work that needs doing.	

19.15-19.30
15 mins
Understand initial views of the policy including envisaged benefits and concerns
	BREAK OUT GROUPS
	Discuss the proposed policy
	• Check understanding of the policy – is there anything that is unclear?
	• What are your initial thoughts?
	• How might direct access affect that way you use services?
	• How might it affect the way other people use services?
	• Probe on patient protection: Do you think the patient is protected? How? What else could be done? What impact would this have?
	• List potential **benefits** of the policy on a flipchart
	• PROBE IF NECESSARY
	  ○ **Why** is this a benefit?
	  ○ **Who** would benefit?
	  ○ **How important** is this?
	  ○ **What impact** would this have?
		Explanation of policy
		Flipchart

Activities / aims	Exercises	Materials needed
	○ What about children, elderly people, nervous patients, those with complex cases? • List of potential **concerns** about the policy on a flipchart • PROBE IF NECESSERY ○ **Why** is this concern? ○ **Who** would lose out? ○ **How important** is this? ○ **What impact** would this have? ○ What about children, elderly people, scared patients, those with complex cases?	
19.30-20.00 **30 mins** *More considered views on the policy with case study flashcards*	**BREAK OUT GROUPS** Case studies **4.1 Discussion of the case studies** (25 mins) We will rotate the case studies – so they are all covered. The number covered in each group may vary but we expect to cover around 2 case studies on average. • Imagine each person in the case study is a friend asking for your advice. Read out case study and check understanding. Talk through the options presented in each case study. PROMPT WHERE NECESSERY	Case studies Flipchart

Activities / aims	Exercises	Materials needed
	○ What advice would you give [case study person]? PROBE FULLY FOR THE THOUGHT PROCESS BEHIND THE DECISION ○ What questions would [case study person] have? ○ What would reassure [case study person]? ○ What messages should be communicated to [case study person]? ○ Who should deliver these messages? ○ How should they be communicated? ○ Would this apply to you or people you know? **4.2 Prompted responses** (5 mins) IF TIME: Go back to the flipchart and briefly add any additional thoughts based on the case study • List any additional **benefits and concerns** PROBE AS BEFORE (see previous page) • Ask for a volunteer to present the groups' findings in the plenary IF THERE IS LIMITED TIME THE MODERATOR CAN WRITE UP ADDITIONAL BENEFITS AND CONCERNS AS THEY EMERGE FROM THE GROUPS DISCUSSION - CHECKING WITH THE GROUP TO ENSURE THEY ARE HAPPY.	

Activities / aims	Exercises	Materials needed
20.00 – 20:15 **15 mins**	**BREAK** Moderators to check the groups' lists of benefits and concerns and prepare prompt cards. These will include both benefits and concerns as identified by the groups alongside any additional benefits and concerns that have been identified by stakeholders and through the desk research.	Prompt cards
20.15-20.35 **20 mins** *Prioritising benefits and concerns*	**PLENARY** Finalising benefits and concerns **5.1 Present and discuss benefits and concerns** (10 mins) • Each group to present their list of benefits and concerns to the other group • Did the different groups think of the same things or different things? • Do they agree or disagree about the benefits and concerns listed? **5.2 Prioritisation exercise** (10 mins) • Moderator to hand out prompt cards with a list of benefits and concerns to be discussed and sorted. • Explain that these thoughts are taken from people working in dentistry and patients with different views about the policy – some more positive and some more negative. These are just suggestions – you do not have to agree with them. • Ask the group to comment on any new benefits and concerns that were not identified in the earlier discussions.	Flipchart Stickers

Activities / aims	Exercises	Materials needed

	• Thinking about all the cards….
	  • What are the most important benefits? – i.e. top 5 Why?
	  • What are the biggest concerns? – i.e. top 5 Why?	

20.35-20.50
20 mins
What advice and information would they need?
	BREAK OUT GROUPS (20 mins)
	• Each group to act as an advisory panel to the GDC.
	• The groups should have access to any flipcharts and other materials used in the workshop as evidence. They should also consider the wider discussions that they have had throughout the workshop.
	
	• Ask each participant to think about their current views of the policy.
	• Would they be likely to access directly if new policy was introduced? Why?
	• Draw a line representing a scale from completely supporting the policy on one end to completely opposing the policy on the other.
	• *If direct access was introduced tomorrow – where would you be on that scale?*
	• Ask participants to place themselves on that scale. Discuss as a group
	
	PROBE
	  ○ Why would you put yourself here?
	
	  ○ What would ***encourage*** you to be *more supportive* of the policy?
	  ○ Ask them to think about the implementation of the policy/ how it might work/ how it might be communicated etc.
	
	  ○ What would ***discourage*** you from *supporting* the policy?
		Flipchart
		Support/ oppose scale

Activities / aims	Exercises	Materials needed
	○ Ask them to think about the implementation of the policy/ how it might work/ how it might be communicated etc.? ○ CHECK IF NECESSERY Do they think patients' safety would be protected under Direct Access? Do you think any additional safety measures are necessary? PROBE on additional safety measures. • Use this discussion to develop **recommendations** for improving the policy • The moderator should play the role of devil's advocate to tighten up the recommendations – i.e. is this practical? Is this affordable? How would this help? • Ask for another volunteer to report back the groups' recommendations	
20.50-21.00 **5 mins** *Final conclusions on policy overall*	**PLENARY** Conclusions • Each group to present back their findings • What are the key findings from the workshop? • What should we be feeding back to GDC? • IF TIME: Each participant suggests 1 key message for GDC	Flipchart

GDC Direct Access Depths Guide FINAL

The main objective of the qualitative research with patients is to understand patients' views of Direct Access, in particular:

- their initial views on the changes;
- expected future routes to treatment from DCPs;
- views on the safeguards that are proposed;
- perceived benefits or risks they envisage moving forward, and the reasons for these;
- advice on how any risks could be addressed;
- the information necessary to accompany the policy change

- To understand the overall opinion across a broad cross section of patients to complement the online consultation.

Activities / aims	Exercises	Materials needed
3-5 mins **Introduction**	INTRODUCTION • Introduce self • Introduce Ipsos MORI: independent research company • Introduce the GDC: organisation that regulates dental professionals in the UK and its purpose is to protect the patient • Introduce the research project: the GDC have commissioned Ipsos MORI to talk to the general public about some new changes to dentistry and how people access dentistry • MRS rules and housekeeping	

Activities / aims	Exercises	Materials needed
	• Participant to introduce themselves and what their hobbies are, who they live with, occupation (if relevant), who they're close family are, if they look after anybody else (particularly if they organise dental appts. for them etc.).	

10 mins	Experiences
	1.1 Warm up: Top of mind thoughts about dentists and dental health professionals
	• When I say dentist or dental health professional, what do you think about?
	• Get participant to explain what they meant and experiences that have made them feel like this
	
	1.2 Last visit:
	• Could you just talk me through your last visit to the dentist?
	  ○ Probe around these: Had you been there before? How did you book the appointment? Why were you booking the appointment? Who was it for? How was the experience once you were there? How did you feel?
	
	1.3 General visits:
	• Is this visit typical of your normal visits to the dentist?
	  ○ Probe around these: Is it normally better or worse? Would you only go for that reason? Would you normally see that dentist? Was there anything that was different to normal?
	• Have you ever had a particularly painful experience? …a pleasant experience?	

5 mins	**2.1 Knowledge of dental care professionals and the current system of access** • Check which types of dental care professionals they have heard of	Scope of practice

Activities / aims	Exercises	Materials needed

	• PROMPT WHERE NEEDED. **And what about?**
	  ○ Dentists
	  ○ Dental nurses
	  ○ Orthodontic therapists[8]
	  ○ Dental hygienists
	  ○ Dental therapists
	  ○ Dental technicians
	  ○ Clinical dental technicians
	• What kind of things do they do?
	• How do you get an appointment with them?
	• Prompt: Would you go directly or through a dentist?	

5-10 mins	**3.1 Introduce the policy** **Introduce the policy** • Hand out an explanation explaining Direct Access • Read the explanation out stage by stage • Participant can highlight or circle anything that is unclear, or anything that stands out as particularly positive or negative. **READ OUT:**	Explanation of Direct Access policy Pens, highlighters

[8] . *Please note: orthodontists are different to orthodontic therapists. Orthodontists are not DCPs but dentists who have had further training. Any dentist can legally practice orthodontics as it is part of the practice of dentistry, but if you want to call yourself a 'specialist' in orthodontics then you have to be on the specialist list which requires a further qualification over and above the normal dental degree*

Activities / aims	Exercises	Materials needed
	Currently patients need to see a dentist before being referred to a dental professional. Direct Access changes this so that patients can go directly to a dental professional without a referral from a dentist. If the policy is changed… • Patients will be **able to decide** which member of the dental team they wish to have an appointment with. They will still be able to have an appointment with their dentist if they want to. • Dentists will still be the **only member** of the dental team with responsibility for diagnosis and surgery. • DCPs will **not** provide the full range of treatments that dentists can but **will be able to refer** patients to the appropriate dental or healthcare professional if required. • DCPs who are contacted directly will make their own assessment of the patients' needs without using a prescription issued by a dentist informing them of any work that needs doing. • Initial thoughts about the policy • Check understanding • What do you like about this? • What do you not like about this? Do you have any concerns? • PROBE: Do you think that this policy could affect patient safety? How? What impact could it have?	
15 mins	**4.1. Impact on their journey** • With these changes in mind, how do you think the way you access your dental care professional and/or dentist will change? • What do you think about these changes to the way you access your dental care professional?	Case studies

Activities / aims	Exercises	Materials needed

	• If relevant: Probe on how Direct Access might change what they previously experienced.
	• Concerns about the impact on their journey.
	• Probe if relevant:
	  ○ How would it impact on [bring up previous people they've mentioned in intro]?
	  ○ How would it impact… elderly people? People that are more nervous of seeing the dentist? People with children? People with complex needs?
	
	IF TIME- BRING OUT CASE STUDIES:
	4.2 Discussion of the case studies
	• Imagine each person in the case study is a friend asking for your advice.
	Read out case study and check understanding.
	
	  ○ What advice would you personally give [case study]?
	  ○ What questions would [case study] have?
	  ○ What would reassure [case study]?
	  ○ What messages should be communicated to [case study]?
	  ○ Who should deliver these messages?
	  ○ How should they be communicated?
	  ○ Would this apply to you or people you know?
	
	• Prompt on any additional benefits and concerns that have been raised during this section	

Activities / aims	Exercises	Materials needed

10 mins	**5.1 Prioritisation exercise**
	
	• Hand out prompt cards with a list of benefits and concerns to be discussed and sorted.
	• Explain that these thoughts are taken from people working in dentistry and patients with different views about the policy – some more positive and some more negative. These are just suggestions – you do not have to agree with them.
	• Prompt around any new issues raised
	• Check if cards cover previous discussion. If not write any additional issues on blank cards
	
	• Thinking about all the cards….
	  • What are the most important benefits? – i.e. <u>top 5</u> Why?
	  • What are the biggest concerns? – i.e. <u>top 5</u> Why?	

5 mins	**6.1 Overall response**
	• Ask the participant to think about their current views of the policy.
	• Would they be likely to access directly if new policy was introduced? Why?
	• Draw a line representing a scale from completely supporting the policy on one end to completely opposing the policy on the other.
	• *If direct access was introduced tomorrow – where would you be on that scale?*
	• Ask participant to place themselves on that scale.
	
	PROBE
	  ○ Why would you put yourself here?
	
	  ○ What would ***encourage*** you to be *more supportive* of the policy?	

Activities / aims	Exercises	Materials needed
	○ Ask them to think about the implementation of the policy/ how it might work/ how it might be communicated etc. ○ What would ***discourage*** you from *supporting* the policy? ○ Ask them to think about the implementation of the policy/ how it might work/ how it might be communicated etc.? ○ CHECK IF NECESSERY Do they think patients' safety would be protected under Direct Access? Do you think any additional safety measures are necessary? PROBE on additional safety measures.	
3-5 mins	**7.1 Wrap up** • What suggestions would you make to policy makers about adapting this policy? • How would you like these changes communicated to you? • Is there anything else you wish to discuss? • Wrap up and thank you	

Appendix 3: Supporting materials

Appendix 3.1 Scope of practice handout

Dental nurses	Help the dentist or DCP care for the patient Give oral health advice
Orthodontic therapists	Assist dentists/orthodontists Fit braces Take impressions
Dental hygienists	Treat and prevent gum disease Scaling and polishing of teeth Apply topical fluoride and fissure sealants
Dental therapists	Treat and prevent gum disease Simple fillings Extract primary (baby) teeth
Dental technicians	Make dental devices including dentures, crowns and bridges Repair dentures
Clinical dental technicians	Make and fit dentures for patient with no teeth Make crowns, bridges and dentures for patients with some teeth

Appendix 3.2 Case studies

Case Study example A

1

Tom has been going to the same dentist for 20 years. He has had a number of problems with his teeth over the years.

Tom often needs to see a clinical dental technician when he has problems with his dentures. His dentist has always made sure that his clinical dental technician is informed about his medical history. This reassures Tom as he sometimes worries that his clinical dental technician might make a mistake.

Tom has been told that he can now see a clinical dental technician without having to visit his dentist first. Should he:

a. Visit his dentist first to ensure that the clinical dental technician is aware of his previous problems.

b. Visit the clinical dental technician directly and trust that (s)he will have access to any relevant information.

c. Visit the clinical dental technician directly and inform him or her of any dental problems that he has previously had.

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Case Study Example B

2

- Nancy is very concerned because her gums have started to bleed every time she brushes her teeth.
- She tried to book an appointment with her normal dentist but has been told she would have to wait for several months there is a large backlog of appointments at the surgery.
- She could try and find another dentist but thinks this would be difficult as the nearest alternative practice is a long way away.
- Alternatively, she has been told that her hygienist can see her straight away.

She knows about the changes to referrals in dentistry but doesn't know whether she should:

a. Wait several months to see her normal dentist who knows her well.

b. Go to the hygienist to save time and convenience.

c. Book an appointment with another dentist and put up with the inconvenience of a much longer journey.

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Case Study Example C

3

- Sam is 15 years old and wears braces on his teeth.

- He has pain in his teeth but isn't sure whether it's related to his braces, which have recently been tightened or because of an underlying issue with his teeth.

- His mum knows about the changes to referrals in dentistry but doesn't know whether she would be best to take him to:
  a. the orthodontist who deals with his braces.
  b. the dentist.
  c. an orthodontic therapist.

Case Study Example D

4

Sarah has just got her first job. She has little disposable income, and little free time.

- She likes the idea of accessing dental care professionals directly without having to see a dentist first as this could save her time and money.
- On the other hand, she is worried that not having her treatment through her dentist would mean that not all dental professionals would have her best interests at heart, and might try to sell her unnecessary and expensive treatments

- In the future, should she:
  a. Always visit her dentist before seeing any other dental care professionals
  b. Visit dental care professionals directly

Case Study Example E

- Lucy is three years old and is experiencing a lot of pain in her tooth which has now gone black

- Her parents are not regular attendees at the dentist but need to someone to get Lucy's tooth seen to and possibly removed. They have been told the dentist is not available but the tooth could be extracted by the dental therapist

- Should they:
  a. Keep trying all the local practices until they can get an appointment with a dentist
  b. See the dental therapist for the extraction
  c. Try to see the emergency dentist

Appendix 3.3 List of potential benefits and concerns

Patients may be able to see a member of the dental team at a more convenient time
Patients will be able to choose the member of the dental team that they see
Patients may save money by having fewer appointments
It may be easier to book appointments
Waiting times may be reduced
There may be less time waiting between needing and getting treatment done
Patients will have more direct access to preventative treatment by a hygienist
The dentist may be able to spend more of their time focussing on patients with greater/more complex needs
It might increase the number of people accessing dental treatment
Some patients might feel more comfortable about seeing a DCP than a dentist
If patients need a lot of intensive treatment in a specific area it may be better for them to have direct access to a DCP
More nervous patients might be encouraged to get treatment
Only dentists have the breadth of knowledge to diagnose, treat, prescribe and carry out the initial examination although DCPs have the knowledge needed to spot the signs of potential dental or oral health problems.
Direct Access may lead to misdiagnosis or delayed diagnosis
DCPs might not take a thorough medical history of the patient and could miss something
Some believe that the current system is already working efficiently and there is no need for change.
Patients may be confused as to what each dental professional can and cannot do
Patients may be treated on the basis of their own self-diagnosis and receive the wrong treatment or see the wrong dental professional
DCPs might encourage patients to go through them because it is cheaper but it might not necessarily be the right treatment for them
Some patients may never visit a dentist due to the added expense or inconvenience.
There may be less clarity around who has responsibility for contacting those patients who stop visiting dentists
Complex treatment may not always be planned in conjunction with the referring or referred to dentist
More vulnerable patients or those with less access to information are amongst those most likely to be confused by the policy.
Nervous patients might avoid the dentist and decide to see a hygienist instead