“Recall Matters”

– appropriate dental recall intervals for people with good oral health

Project evaluation document

May 2019

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1. Summary

The purpose of the project was to work with dental practices and the public in West Yorkshire to ensure dental recall intervals between routine dental check-ups for adults fit with the guidance from the National Institute for Health and Care Excellence and to explore whether additional capacity could be freed up in NHS general dental services in for additional NHS patients.

Key points from the evaluation of the Recall Matters Project:

- At the West Yorkshire level average re-attendance intervals and indicated recall intervals for band 1 to band 1 treatments for adults did not significantly change over the period of the project;
- The range of re-attendance intervals increased during the period of the project as did the standard deviation of the average re-attendance interval indicating that practices were increasing recall intervals for some adult patients
- There was an increase of 2% in the number of new patients and a 3% increase in the total number of dental patients in West Yorkshire over the period of the project. However we could not demonstrate a causal link using this method; a number of other related projects were being rolled out at the same time.
- The complexity of the system and limited time frame meant that simple interventions relating to recall and re-attendance were, by themselves, unlikely to have a significant impact on capacity and access;
- Dentists who responded to the on-line survey want to do more preventative work and to take on new patients but perceive that the current dental contract remuneration system limits the full realisation of this intent;
- Many dentists advocate a major programme of oral health improvement that informs and engages patients and supports them to take responsibility for their oral health. (This approach has been incorporated into the piloting and prototyping of a new dental contract for NHS England).
- Many dentists surveyed highlighted issues with the dental contract, the system of Units of Dental Activity and perceived inadequate investment to meet needs;
- Healthwatch organisations were successful in reaching the public with key messages about Recall Matters;
- Board members felt that trying something new was worthwhile and working in partnership was positive, creating opportunities that would not have been possible by one organisation alone.

2. Introduction

This short report presents an evaluation of the pilot project “Recall Matters” which brought together a number of partners to test a new approach to increasing capacity

in general dental services. The pilot project covered general dental practices and patients in West Yorkshire. Full details of the project including the initial business case, scope, the interventions planned and the project structure are set out in the Recall Matters Project Initiation Document, approved by the project board in October 2017.

The body of the report starts with a brief statement of the purpose and governance of the Recall Matters project, describes the interventions and activities of the project and then summarises the numerical data on impact and the perspectives of dentists on recall, re-attendance and access. There is much more detail on the numerical data and the perspectives of dentists attached as sub-reports at appendices A and B. There is also a report of a piece of work researching public attitudes to dental recall conducted by the General Dental Council at appendix C. The report concludes with reflections on Recall Matters from some of the people involved in the project and indicates the next steps planned to date.

3. Purpose of this project and background

The purpose of the project was to work with dental practices and the public to ensure dental recall intervals between routine dental check-ups for adults with good oral health fit with the guidance from the National Institute for Health and Care Excellence and to explore whether additional capacity could be freed up in NHS general dental services in West Yorkshire for additional NHS patients.

Since their establishment in 2013 Healthwatch organisations across West Yorkshire have heard numerous stories from patients about difficulties in accessing NHS dental treatment. The geographic inequality in access and lack of availability of dental care has been a longstanding issue in some places. And Healthwatch remains at the fore front of campaigning for more NHS dental services in areas of need, along with local voluntary organisations, MPs, councillors and local media

The aim of this innovative project in West Yorkshire was to try and free up some appointments for people without a dentist. “Recall Matters” has been a multi-partnership project that has worked with dental practices and the public to ensure that the time between routine dental check-ups (the dental recall interval) for adults with good oral health meets national guidance in every practice across West Yorkshire. The aim was to try and release more capacity in NHS general dental services in West Yorkshire and ultimately improve access for patients. The project has been supported by the Chief Dental Officer for England, NHS England, Public Health England, the General Dental Council, Healthwatch organisations in West Yorkshire and others. A full list of board members appears at section 4. .

Attending the dentist every six months has been a widely disseminated health message for many years. However the evidence base behind this message has long been questioned. The National Institute for Health and Care Excellence (NICE) has published evidence based guidelines for dental recall intervals (NICE, 2004, and reviewed in February 2014). In essence this states that the recommended interval between oral health reviews should be determined specifically for each patient and tailored to meet his or her needs, on the basis of an assessment of disease levels and risk of or from dental disease. Adults should be seen for dental recall at

intervals from 3 months to 24 months and children should be seen for a dental recall at an interval from 3 months to 12 months depending on their level of risk of oral diseases. Patients should understand the clinical decision made to decide their dental recall interval and feel engaged in this discussion with their dentist. Dental record keeping should support this process.

Nationally, in 2015/16, the average re-attendance interval across England between band 1 treatments (examination, diagnosis and advice) was 8.1 months. In West Yorkshire the interval averaged 7.8 months but with significant differences between practices across the region. At the same time, equity of access to general dental services in parts of West Yorkshire had been raised as an issue by a number of stakeholders including Public Health England. The aim of the project was to explore ways of working with dental service users and dental practices to extend dental recall intervals to appropriate intervals for people at low risk of oral disease in line with NICE guidance and explore the impact of this on capacity and access to general dental services.

Local anecdotal information suggested that some patients expected a dental recall interval of 6 months regardless of risk. A research study conducted by the General Dental Council found that, when patients are given information about how their dentist decides when their next check-up should be, more than four fifths of respondents felt comfortable in asking for a recall interval of between 9-12 months. Extending dental recall interval for people at low risk of oral diseases based on the clinical judgement of the dentist in line with the NICE guidance could increase the availability of dental services.

Since September 2017 the project has been working with dental practices across West Yorkshire, sharing information on recall and re-attendance of patients needing a routine check-up with every dental practice in West Yorkshire. In the summer of 2018 there was also a large public information campaign. The main interventions are described in section 4.

4. Board and Governance

People and organisations who have been on the project board for some or all of the project to date are:

- Rory Deighton, Director Healthwatch Kirklees, SRO (until July 2018)
- Helen Hunter, Director Healthwatch Kirklees and Calderdale, SRO (from August 2018 until March 2019)
- Sara Hurley, Chief Dental Officer for England who was represented in teleconference by:
- Shan Ellahi, Office of the Chief Dental Officer
- Janet Collins, General Dental Council
- Sally Eapen Simon, Consultant in Dental Public Health, Public Health England
- Kate Jones, Consultant in Dental Public Health, Public Health England
- Emma Wilson, Head of Co-Commissioning (Yorkshire & Humber), NHS England
- Constance Pillar, Dental Commissioning Lead, (Yorkshire and Humber) NHS England

- John Milne, Senior National Dental Adviser to the CQC
- Mick Armstrong, Chair of the British Dental Association's Principal Executive Committee
- Richard Emms, British Dental Association
- Paul Gray, Senior Clinical Adviser NHS Business Services Authority, Dental Services
- Andrew Jones, Project Manager Recall Matters, freelance commissioned by Healthwatch Kirklees.

The first meeting / teleconference took place in October 2017, meetings were held every two months chaired by the SRO, papers were sent out one week before by the Project Manager and all agreed actions monitored and followed up. The last teleconference was held on Friday 18 January 2019. The project was described in some detail in the Project Initiation Document and was approved by the board in October 2017.

Additional oversight of the project was maintained by the Office of the Chief Dental Officer for England. Shan Ellahi reported back on a regular basis to the OCDO programme board on the progress of the Recall Matters project.

5. Interventions

This section describes the main areas of work carried out as part of Recall Matters.

Intervention 1 – data for dental practices

The core of the project was to send to all dental practices at regular intervals benchmark data on recall and re-attendance intervals at practice level across West Yorkshire. These were the band 1 to band 1 recall and re-attendance intervals for adults for each general dental practice contract. The aim was to enable each practice to understand in a straightforward way their average recall intervals, how this was changing over time and how this benchmarked against other practices. Early in the project NHS England worked with the Local Dental Committee to agree the level and content of the information and how it would be presented to practices. NHS Business Authority (NHS BSA) brought together the agreed data at the agreed timescale. Monthly reports were piloted in the period October 2017 to March 2018, prior to refinement and a formal launch in April 2018. At that point information was included on the area level deprivation (using the Index of Multiple Deprivation 2015) where each practice was located. Although imperfect this gave at least some context to the recall data by giving an approximation to the levels of need of the community served by each practice. The frequency of data distribution was also reduced.

Each month NHS BSA prepared the data, sent it to the SRO, the Project Manager and a Consultant in Dental Public Health in Public Health England who reviewed the data and checked progress. PHE then added in the IMD data for the practices, ranking the area level deprivation from 1 to 10, and forwarded this to NHS England who then sent it to all general dental practice in West Yorkshire.

In addition to the brief data sent to practices the project negotiated and agreed a wider range of more detailed data from the NHS BSA, which enabled PHE and the

Project Manager to keep a view on the impacts of the project and provided more detailed contextual data. This was then used for monitoring reports – see section 4.

Intervention 2 - engagement with the dental profession and NHS partners

Engagement with the dental profession in West Yorkshire was led by NHS England who communicated with practitioners about the aims and objectives of the project, both through the Local Dental Network and the Local Dental Committee, and via emailed papers. An introductory letter explaining the project and including a link to NICE guidance was sent to all general dental practitioners in November 2017. A check list of "modifying factors" was also distributed to all practices. This engagement helped shape the key data set and the presentation of the monthly spreadsheet on recall and re-attendance. Dentists were given the opportunity to feedback comments to the NHSE Dental Commissioning Team with the regular emails and attached performance data. This feedback was used to adapt the data sent to practices, specifically the addition of IMD data and a reduction in the frequency of reports.

To give all dentists in the area an opportunity to give their perspectives on recall, re-attendance and issues around access to primary dental services a confidential on-line survey was produced by the Recall Matters Project Manager. This was sent to all General Dental Practitioners in West Yorkshire by NHS England's Dental Commissioning Lead for Yorkshire and the Humber in November 2018. Please see section 6 for a summary of the perspectives of dentists who responded and Appendix B for the full results of this survey.

Other key partners were also briefed, either through the Project Manager or with local NHS partners via each of the five Healthwatch organisations in West Yorkshire. Consistency of message was ensured by the provision of a set of standardised briefing papers and letters in the Project Communications Strategy. Briefings were either face to face or via written materials. The following organisations and groups were briefed (although this varied slightly from area to area):

- the Sustainability and Transformation Partnership
- MPs
- Local Authority Overview and Scrutiny Committees for Health
- West Yorkshire Joint Overview and Scrutiny Committee for Health
- Health and Wellbeing Boards
- Public Health
- CCG engagement leads

Community and voluntary organisations and patient organisations were targeted as part of intervention 3 below.

Intervention 3 - patient targeted communications

The public communications strategy of Recall Matters drew on the valuable work of the General Dental Council which conducted a short on-line survey in April 2017 during the period that the Recall Matters project was being set up. The survey asked people's attitudes to the frequency of routine dental check-ups and used a Healthwatch video on appropriate recall. This is reported in section 6 of this report, "Linked work and supporting activities".

A detailed Communication Plan was prepared by the Project Manager and approved by the Recall Matters Board, and this described the aims, communication principles, target audiences, messages and communication channels. It also included a range of communication products, public leaflets, an animated video for patients, social media assets, sample press releases and briefing papers. The patient targeted communications aimed to inform the public about the guidance on appropriate recall, giving them the information to have a conversation with their dentist about extending the recall interval if their dentist thought this was appropriate. The communications also included the factors a dentist would take into account in individual assessments of risk and gave people basic information about what they could do to look after the oral health. A professional creative communications agency called "We are magpie" was commissioned to produce social media assets. These were modified by the board to ensure all partners were happy with the public messaging.

Healthwatch organisations in Bradford, Kirklees, Wakefield, Leeds and Calderdale used common patient focussed communications in their localities. Joint press releases targeted a variety of conventional media to communicate core messages about recall intervals to the public, utilising existing linkages between communications teams and media. Healthwatch organisations used their websites and mailings to reach their memberships, and sent briefings to other partner organisations.

Healthwatch also used social media extensively, again using the assets and communication products provided. Healthwatch Communications Officers reported the following social media output:

Facebook	35 posts
	Reach = 4,569
Twitter	42 different tweets
	Number of Twitter impressions 17,876
LinkedIn	One Healthwatch made one post which reached 1866 contacts
Email briefings	1,900 +

Between them the five Healthwatch organisations sent email briefings to over 1,900 of their supporters on mailing lists, posted information on their websites and shared briefings with other voluntary organisations asking them to share the information with their members. For example one voluntary sector infrastructure organisation did this and reached a further 1,000+ community and voluntary organisations. One Healthwatch had over 1,000 paper copies of their newsletter distributed with the public messages about appropriate recall and oral health. Several newspapers covered the Recall Matters project and the Project Manager did an interview on Recall Matters on BCB Radio.

A patient leaflet was produced and distributed to dental practices for them to give to patients attending. After positive feedback from dentists a second batch of leaflets

was produced. A total of 10,000 patient leaflets were distributed via West Yorkshire dental practices.

6. Linked work and supporting activities

Members of the Recall Matters Project Board were involved in and connected to a number of pieces of linked work and supporting activities. Whilst not strictly part of the Recall Matters project, because of their relevance to access and capacity and their connection to appropriate recall they were reported through the Recall Matters Board at various points of the project and are presented here.

a) General Dental Council survey on attitudes to recall intervals

During the initiation of Recall Matters partners worked with the General Dental Council and drew on the results of their short on-line survey with the GDC's Word of Mouth Panel. 750 panellists completed the survey in April 2017. This survey asked people's attitudes to the frequency of routine dental check-ups then showed a Healthwatch video which gave user friendly information about the NICE guidelines and appropriate recall. After watching the video people were asked how comfortable they would feel with various lengths of gaps between check-ups. Headline results from the survey were:

- 90% were comfortable asking for a 9 month interval, (66% very comfortable plus 24% comfortable).
- 81% were comfortable asking for a 12 month gap.
- Frequency of respondents' own check-ups influenced their response to their attitude to extending the interval beyond 6 months in the future
- 49% were uncomfortable asking for a 24 month gap.
- This was particularly the case with people aged 55+, of that group 21% were very uncomfortable asking for a 24 month interval.

This piece of community research indicated that when the public were informed about the guidance and facts on recall they would be happy to ask their dentist if they could have less frequent routine check-ups if their individual dental assessment by the practitioner indicated a low level of risk. The full report of the GDC community research is attached as appendix C.

b) Contract clawback and the commissioning of additional capacity

Healthwatch and the BDA explored with NHSE the issue of clawback, the annual process of NHSE recouping money from practices that had not used their commissioned Units of Dental Activity (UDAs) or under-delivered on their contract against expected access / activity targets. NHSE clawback had been more than £6million over 3 years and was around £3.2million in 2016/17. Healthwatch have raised the issue of clawback and in particular sought assurance from NHSE that clawback monies would be re-invested in NHS general dental service capacity in areas of need in West Yorkshire.

Discussions were held with NHSE and representatives of the West Yorkshire and Harrogate Health and Care Partnership, an emerging Integrated Care System, to brief them on the work of the Recall Matters project and to explore dental contract flexibility. (There are national requirements and criteria for clawback). One of the key objectives was to develop sustainable transformation partnerships that could support the re-deployment of funding clawback back into local dental access initiatives.

NHSE have invested dental contract clawback in West Yorkshire in 2018/19. Commissioners had carried out a review of availability of access to dental services and developed a strategy to improve this across West Yorkshire and the Humber. The Recall Matters board were briefed on this work and were supportive of it. A range of criteria was developed by NHSE for the allocation of this funding including the UDA per head of population, index of multiple deprivation and percentage of the population accessing a dentist. Additional services started to come on stream in July 2018. The implementation of this programme of "Access Pilots" used clawback monies and was welcomed by Recall Matters partners. Because this was delivered at the same time as Recall Matters this complicated interpretation of data showing increases in new patient numbers – see section 7.

c) Connections with the West Yorkshire and Harrogate Health and Care Partnership

Following up on paper briefings about Recall Matters the Project Manager met with the Director of the Partnership on 18 September 2018 along with the Healthwatch representative on the System Leadership Group, to update on the progress of Recall Matters and explore how the Partnership might be able to support the project. Access to general dental services was not at that time one of the partnership's priorities but it was acknowledged that the inequalities in oral health and access to services were of concern to the partnership. The Director agreed to raise the issue of unequal access and the impacts on the wider health system with Accountable Officers. A meeting in December 2018 agreed to organise a workshop on these issues and identify areas which the health and care partnership could support. This work remains in progress.

A meeting was also brokered between the BDA Chair of the Principal Executive Committee and the Director of the Partnership, a positive interchange which included issues relating to Recall Matters and access. Recall Matters partners have continued to seek the involvement of the Partnership.

7. What the numerical data show

At the mid-point of the project in May 2018 the Consultant in Dental Public Health, Public Health England and the Project Manager analysed numerical data on recall and re-attendance at a West Yorkshire level. This was presented to the board to enable partners to track progress. A similar analysis was carried out at the end of the project - the numerical data report at Appendix A presents monitoring information from the start of the project in September 2017 through to December 2018.

The project board acknowledged that due to the relatively short period that the project was running, changes in actual re-attendance intervals would be difficult to

capture. Also increasing recall intervals for orally healthy people may be offset by a need for any new patients with higher needs to be seen more frequently. Despite these limitations there were positive impacts in terms of the shifting pattern of recall intervals with an increasingly wide distribution beyond six months and an increase in the number of new and total patients seen.

Summary of findings

- At the West Yorkshire level average re-attendance intervals and indicated recall intervals for band 1 to band 1 treatments for adults did not significantly change over the period of the project;
- The majority of practices were still indicating that patients would be recalled within six months at the end of the project. (The modal indicated recall interval across West Yorkshire was consistently 6.0 months and did not change through the duration project).
- The average re-attendance interval for band 1 to band 1 was unchanged from start to finish of the project at 8.1 months.
- With an increase in the range of both indicated and actual recall intervals during the period of the project, and an increase in the standard deviation, the findings underpin a positive change in recall trends. This indication of behaviour change from both patients and practitioners offers scope to build on the initial success.
- The proportion of child patients as a proportion of the total band 1 to band 1 activity decreased from 39% to 37% between September 2017 and December 2018.
- There was an increase in both the number of new patients (2%) and total patients (3%) from September 2017 to March 2018 across West Yorkshire. No definitive causal link with the interventions of Recall Matters can be made because there were several other initiatives running at the same time.

8. Perspectives of dentists

An on-line survey to gain perspectives of dentists in West Yorkshire was produced by the Recall Matters project manager, piloted and refined with the input of a small number of project board members. It was sent to all General Dental Practitioners in West Yorkshire by NHS England's Dental Commissioning Lead for Yorkshire and the Humber in November 2018. Dentists were assured that responses to the questionnaire would remain confidential. A qualitative approach was adopted to gain the perspectives of dentists in the pilot area - the questionnaire included one closed tick box question and five qualitative questions for open text responses. 23 practices responded to the survey.

The full report of the survey results is attached as Appendix B.

Summary of overarching themes from dentists' responses

These are the key themes that cross cut the survey responses which suggest some potential areas for reform and action:

a) There are some positive opportunities in extending recall intervals for adults at low risk of oral disease if based on a rigorous assessment of risks and linked to other areas for action. Dentists want to carry out more preventative work and improve access for all patients.

b) Patient expectations need to be managed through the provision of good information about appropriate recall and clinical risks. There should be transparency that the aim is to free up capacity and improve access to general dental services. A range of public communications should be deployed with innovative use of all media.

c) A number of respondents to the survey suggested that consideration should be given to a broader programme of oral health improvement that informs and engages patients to take responsibility for their oral health has some merit. Some dentists advocated a national programme, (see note below). Opportunities for local partnership working should be explored, with schools, social care and community collaboratives playing a much bigger part in improving oral health. *(*A *national programme would offer consistency of message but may have limitations given the current "place based" and Local Government autonomy. Oral Health improvement at a local level benefits from a bespoke set of messages tailored to the communities served, supported by a range of social, health and educational agencies at all levels.)*

d) There was a significant theme from dental practitioners in the survey regarding the perceived shortcomings of the dental contract and the UDA system. Within this broad theme dentists raised specific issues around the need for the contract to support preventative work, and the desire for a system that supported dentists to take on new patients and addressed the perceived financial risks of taking on new patients requiring significant treatment. There were concerns about the treatment / prevention balance.

e) Linked to this is a wider theme from dentists that responded that there is insufficient funding for general dental services. Underfunding was linked by some to a shortage of dentists, recruitment problems and many dentists moving from the NHS to private practice.

f) From the small number of responses to the open questionnaire comes a sense of the stress some dentists feel and dissatisfaction with the current system. This is not universal but was keenly felt by some; a sense of the mood of some dentists who contributed to the survey is captured in the sub-report on the perspectives of dentists, attached in full as appendix B.

9. Reflections of board members and Healthwatch involved in the project

This section includes comments and reflections from some board members and some Healthwatch staff about their involvement in the Recall Matters project. Whilst everyone had the opportunity to give their views only eight people chose to do so. This selection of views should therefore not be seen as necessarily representative of everyone involved in the project, however there is a fair level of consistency across the comments made and they do give a sense of how it was to be part of the project.

There were a number of positive reflections on Recall Matters:

Several people said that it has been really positive to take a partnership approach to the issue – the project was seen to have benefited from the input of different groups and agencies. Joint working across a number of statutory and voluntary organisations brought added value to the project, enabling approaches that could not have been delivered by a single organisation. It also enabled better cross-sector understandings of the issues around recall, capacity and access.

Board members acknowledged the important contribution of the NHS Business Services Authority to the project. The data provided was of high quality and timely, and the senior information analysts in the Dental Insight team of NHSBSA Information Services were helpful throughout.

Project management of Recall Matters was complimented, with the central running of the project said to be thorough and efficient. Healthwatch organisations found the Communication Strategy helpful, particularly the common communication messages, the provision of briefing papers, press releases and social media assets.

Healthwatch played an important role and were perceived by some board members to be the backbone of the project. Local Healthwatch organisations in West Yorkshire were effective in delivering the messages about appropriate recall to the public using their local networks of patient groups, VCS organisations, supporters, media contacts and connections to local statutory partners. Their closeness to local communities helped get the public messages across.

Other views were more mixed and highlighted the challenges of the project:

Several partners reflected that this has been a really interesting and worthwhile project, but the timing had been unfortunate. Recall Matters began as “Starting Well” was implemented in the same region, (a commissioning approach which aims to reduce oral health inequalities and improve oral health for children aged 0-4 years). It also coincided with NHSE commissioning additional capacity in areas of need in Yorkshire and Humber using contract clawback monies. This meant that NHS England in particular had competing priorities and pressures on capacity.

Although it was difficult to show how the project had impacted on dental recall intervals and capacity, participants felt that it had certainly been worth trying to do something new as a pilot. It was described as a really good learning opportunity for all involved.

The data on recall and re-attendance was said by one board member to be good in its way but limited in that it didn't capture the complexity of the issue.

There has been variable engagement from dental practices, due to other pressures and priorities and established ways of working. Dentists' priorities and ways of working are in turn influenced by the dental contract and current commissioning arrangements.

There has also been variable engagement and input from some of the organisations and professionals involved in the Recall Matters Board. There were capacity issues, changes in personnel and competing priorities some of which were inevitable, but sometimes a partner's inability to participate in meetings, make joint decisions and carry out actions in a timely way delayed the project or diminished its potential impact.

It was challenging to change public perception about appropriate intervals between routine check-ups, in part because of the success of the long term health message that adults should have their teeth checked every 6 months. Even when a patient is better informed about appropriate recall it is not necessarily easy for every patient to have a discussion with their dentist, especially if this is perceived as a challenge to the judgement of their dentist.

Several partners highlighted the complexity of the dental commissioning system and the limitations of focussing just on recall, just one aspect of a whole range of issues that may impact on capacity and access. A much broader set of reforms and changes in both commissioning and practice, plus additional targeted investment would be needed to address the problems of access.

Several partners noted that if a practice does increase capacity and can take on more patients (through increasing recall intervals or in other ways), there is a risk that new patients may have a higher level of needs, require more dental time with the unwanted result of actually *reducing* capacity. One board member described NHS general services as a closed system and that without more investment if it was expanded in one place it would be squeezed in another. A different approach was said to be needed to serve new patients requiring treatment.

One local Healthwatch organisation (each one covers a single local authority) said that involvement in a West Yorkshire-wide piece of work has made them more cautious about joint-working as it is hard for them to point to the difference that has been made specifically in their locality.

Another participating local Healthwatch organisation said that with an innovative approach of this sort it is essential at the outset to carry out a rigorous risk/benefit exercise. They said that the Recall Matters project was a reasonable thing to try, but perhaps we ignored at the outset some of the fairly compelling reasons why it wouldn't work, in the hope that it would. A rigorous risk/benefit would possibly have suggested we didn't do the work; this should always be done at the outset of a project.

Healthwatch colleagues on the project board reflected that, whilst it is difficult to split out the impact that Recall Matters has had alongside other initiatives aimed at improving access, from a patient perspective if access has improved across this period of time, then that can only be a good thing – and a multifaceted approach that highlights barriers and challenges can be an instigator for change. The SRO also said that it was really worthwhile to work together to try something new, and although it is not clear that Recall Matters alone had the impact that was wanted, all partners remain invested in the idea that access to dentistry has to continue to improve in West Yorkshire, and that we will take learning from this process to continue to try to have influence in new and innovative ways, using links built up in the partnership.

10. Next steps

Individual organisations and people involved in the project will share information about this project within their own organisations and in joint forums and working groups on specific topics. For example, the views of dentists summarised in section 8 and reported in more detail in appendix B are highly relevant to work on contract reform, commissioning and the work of the OCDO. The initial list of organisations that will be sent a copy of this report includes:

- NHS England Dental Commissioners for Yorkshire and the Humber
- British Dental Association
- Local Dental Committee for West Yorkshire
- Local Dental Network for West Yorkshire
- Public Health England Dental Public Health Consultants' network
- Healthwatch organisations in West Yorkshire
- Office of the Chief Dental Officer for England
- Dentistry Research and Policy Think Tank (via Dental Clinical Leadership Fellow)
- Dental Contract Reform Programme (testing prototype contracts)
- CQC Dental Adviser
- National Institute for Health and Care Excellence
- General Dental Council
- NHS Business Services
- West Yorkshire and Harrogate Health and Care Partnership (the local STP)
- Directors of Public Health in West Yorkshire
- MPs in West Yorkshire
- West Yorkshire Overview and Scrutiny Committee

The full report can also be made available to all dental practitioners in West Yorkshire on request.

Appendix A

Recall Matters final numerical data report

March 2019

This report presents monitoring information to the Recall Matter Project Board from the baseline of September 2017 through to the end of the project in December 2018. It summarises data on band 1 to band 1 recall and re-attendance intervals for adults across practices in West Yorkshire. The monitoring information is intended to show the following at West Yorkshire and practice level:

- How has the adult band 1 to band 1 indicated recall interval changed from baseline in terms of mean, median and range?
- How has the adult band 1 to band 1 actual recall interval changed from baseline in terms of mean, median and range?
- How has the number of adult patients seen changed from baseline?
- Has the number of new adult patients seen changed from baseline?

The West Yorkshire average data on recall and re-attendance are compared with England averages for the same period.

The report also compares baseline data from September 2017 with data from December 2018 on:

- the overall level of activity in terms of the total number of adult patients seen and the number of new adult patients, based on a rolling 12 month period;
- the split of treatment bands, bands 1, 2 ,3 and “other”;
- the distribution of adult and child patients receiving band 1 treatment, West Yorkshire level data.

Indicated recall interval for band 1 to band 1 adult courses of treatment at West Yorkshire level

There was little change in the indicated adult band 1 to band 1 mean, median, range and standard deviation of recall intervals between September 2017 and December 2018 (Table 1).

Table 1 West Yorkshire indicated recall intervals band 1 to band 1, adults

Measure (months)	2017		2018			
	September	December	March	June	September	December
Average	6.6	6.6	6.6	6.7	6.7	6.7
Median	6.3	6.3	6.3	6.3	6.3	6.3
Range	4.2 to 12.7	3.0 to 13.5	1.0 to 12.6	3.0-13.4	3.0-13.6	1.0-14.7
Standard deviation	2.5	1.2	1.2	1.3	1.3	1.4

Data source: NHS BSA, 2019

The modal indicated recall interval for practices across West Yorkshire was consistently 6.0 months over the period of the study.

Actual re-attendance interval for band 1 to band 1 adult courses of treatment at West Yorkshire level

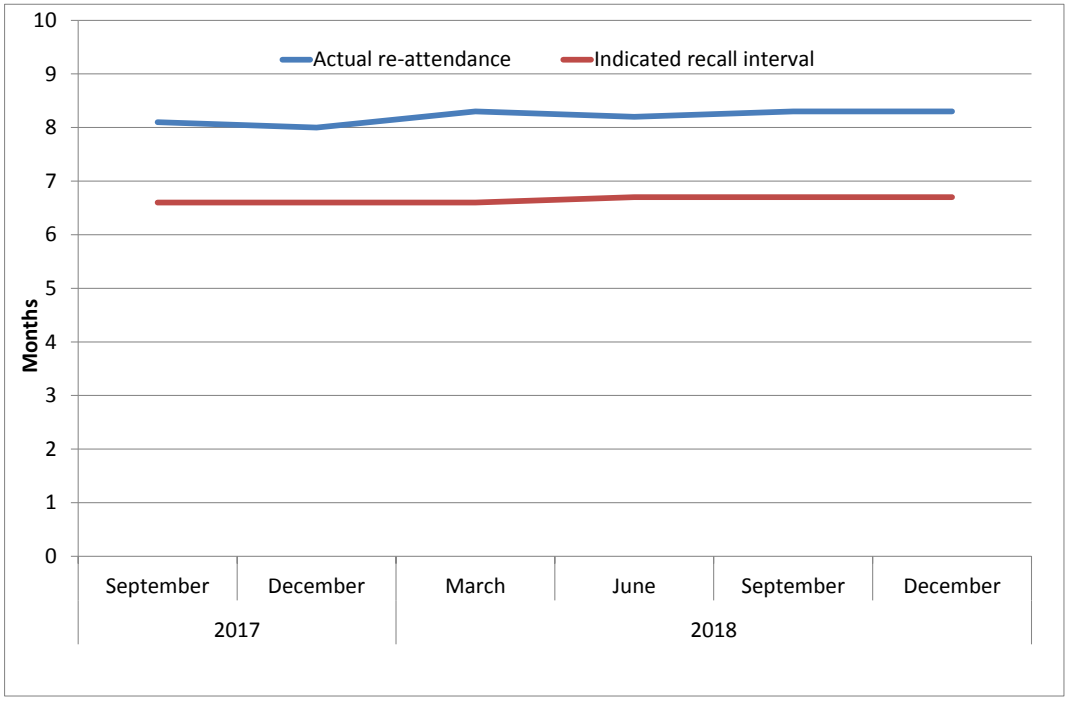
There was little change in the average and median actual re-attendance intervals between September 2017 and December 2018 (Table 2). Hoverer the range of the recall period increased from a maximum of 12.8 months to 36.6 months and the standard deviation increased from 1.4 to 2.9 months demonstrating that recall intervals were being extended as shown in the histograms below (Figure 1).

Table 2 West Yorkshire actual re-attendance, band 1 to band 1 adults

Measure (months)	2017		2018			
	September	December	March	June	September	December
Average	8.1	8.0	8.3	8.0	8.2	8.1
Median	7.9	7.9	8.1	7.9	8.0	7.9
Range	2.3 to 12.8	3.7 to 15.4	3.4 to 33.0	3.5 to 23	0.7 to 24.8	1.0 to 36.6
Standard deviation	1.4	1.4	2.5	2.0	2.2	2.9

Data source: NHS BSA, 2019

Figure 1 Average indicated and actual re-attendance rates, West Yorkshire



Data source: NHS BSA, 2019

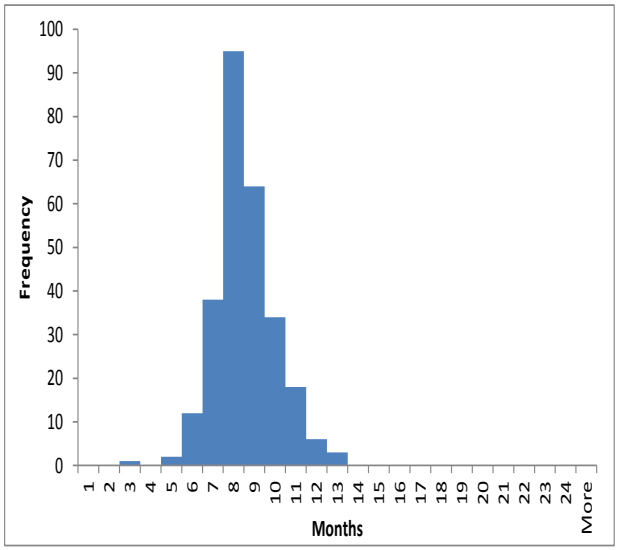
The average monthly re-attendance intervals for band 1 to band 1 adults in West Yorkshire and England were similar (Table 3).

Table 3 West Yorkshire and England actual re-attendance, band 1 to band 1 adults

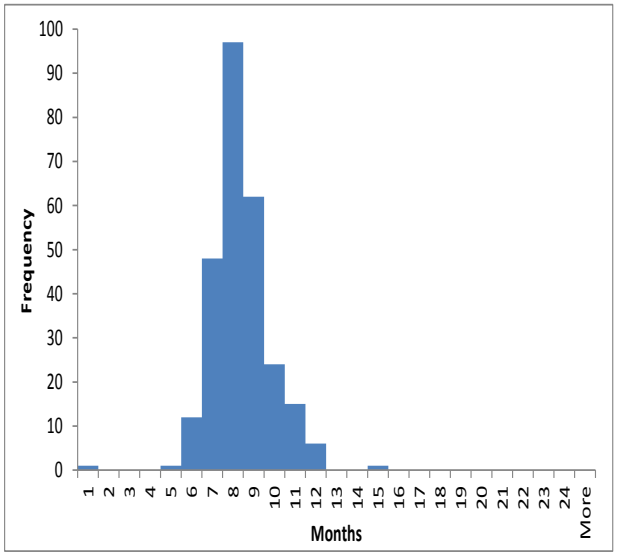
Area	2017		2018			
	September	December	March	June	September	December
West Yorkshire	8.1	8.0	8.3	8.0	8.2	8.1
England	8.5	8.4	8.5	8.3	8.5	8.4

Data source: NHS BSA, 2019

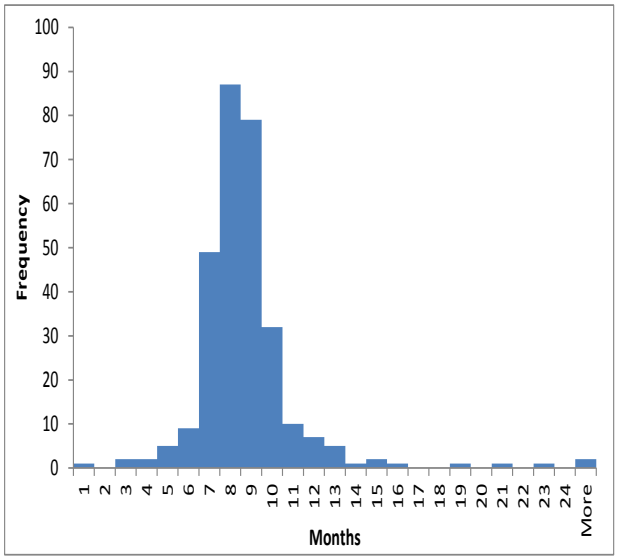
Figure 2 - Histograms of actual re-attendance intervals, band 1 to band 1 adult, West Yorkshire (Data source: NHS BSA, 2019)



September 2017



May 2018



December 2018

Relationship with levels of deprivation

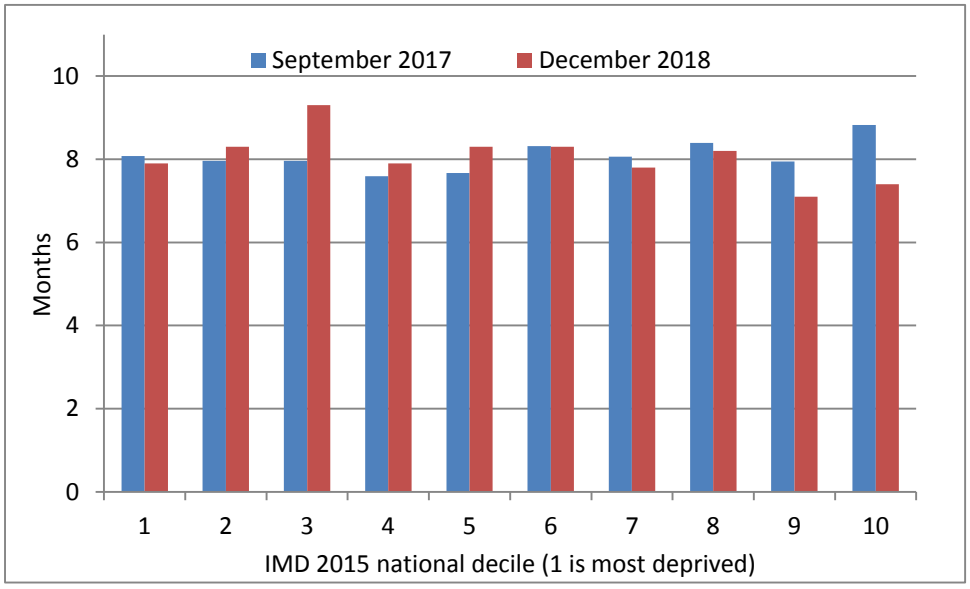
Each dental practice address was mapped against the English Indices of Deprivation (IMD) 2015 national deciles. There was no obvious pattern for the average re-attendance interval for band 1 to band 1 adult patients by IMD 2015 national decile either at baseline or the end of the project (Table 4; Figure 3).

Table 4 Average re-attendance interval in months, by IMD 2015 national deprivation decile

Month	IMD 2015 decile of practice address (1 is most deprived)									
	1	2	3	4	5	6	7	8	9	10
September 2017	8.08	7.96	7.96	7.59	7.67	8.32	8.06	8.39	7.95	8.83
December 2018	7.9	8.3	9.3	7.9	8.3	8.3	7.8	8.2	7.1	7.4

Data source: NHS BSA, 2019

Figure 3 Average re-attendance interval in months by IMD 2015 national deprivation decile



Data source: NHS BSA, 2019

Number of adult patients seen at West Yorkshire level

In the 12 month period to the end of Sept 2017, 794,979 adult patients were seen in West Yorkshire of whom 96,051 (12%) were classed as new patients[1]. The total in the 12 month period to December 2018 was 1,080,624 of whom 105,987 were new adult patients (10%) (Table 5). Whilst numbers vary month by month there has been an increase in both the number of new patients (9%) and total patients (33%) seen over the rolling 12 month periods ending September 2017 and December 2018.

[1] This is the number of unique adult patients where the patient is counted once even if they attend more than once in the 12 month period. New patients are defined as those where the previous FP17 was over 24 months ago or where there is no previous course of treatment

New patients increasingly accounted for a smaller proportion of all patients over the same periods.

Table 5 Number and proportion of adult patients seen in rolling 12 month period up to and including each month in West Yorkshire

Patient type	2017		2018			
	September	December	March	June	September	December
New adult patients (n)	96,051	96,828	98,182	94,778	102,348	105,987
All unique adult patients (n)	794,979	809,396	822,330	820,931	832,640	1,080,624
New adult patients as a proportion of all unique adults (%)	12	12	12	12	12	10

Data source: NHS BSA, 2019

The proportion of band 1 courses of treatment has reduced slightly over the period of the project (Table 6).

Table 6 West Yorkshire profile of adult FP17s by treatment band expressed as a percentage of total adult FP17s

	Band 1		Band 2		Band 3		Other		Total
September 2017	61,678	56%	30,651	28%	5,390	5%	12,687	11%	110,406
December 2018	54,043	53%	29,785	29%	5,828	6%	11,564	11%	101,220

Data source: NHS BSA, 2019

West Yorkshire distribution of adult and child patients, band 1 treatment

The proportion of child patients as a proportion of the total band 1 to band 1 activity decreased between September 2017 and December 2018 (Table 7). The 60:40 split is close to the England average.

Table 7 FP17s by age group

Age group	September 2017		December 2018	
	FP17s (n)	FP17s (%)	FP17s (n)	FP17s (%)
Adults	40,527	60	35,948	63
Children	27,009	39	20,753	37
Total	67,536	100	56,701	100

Data source: NHS BSA, 2019

Practice level information

Re-attendance interval

The average re-attendance interval for 119 contracts was shorter in December 2018 than September 2017, a similar length for 97 contracts and longer for 62 contracts.

Indicated recall interval

The average indicated recall interval was shorter in December 2018 for 25 contracts, no different for 165 contracts and longer for 45 contracts than in September 2017.

Fifty-eight per cent of practices had an average indicated recall period of six months or less at the end of the project compared with 60% at the start of the project.

The changing pattern of recall intervals at practice level could not be explored due to limitations of the data.

Limitations of the data

Due to the relatively short period that the project was running, changes in actual re-attendance intervals have been difficult to capture. Also increasing recall intervals for orally healthy people may be offset by a need for any new patients with higher needs to be seen more frequently. Hence average recall intervals would be unlikely to change significantly. Despite these limitations there were positive impacts in terms of the shifting pattern of recall intervals with an increasingly wide distribution beyond six months and an increase in the number of new and total patients seen.

Summary

This report presents monitoring information to the Recall Matter Project Board from the start of the project in September 2017 through to its completion in December ‘18.

At the West Yorkshire level average re-attendance intervals and indicated recall intervals for band 1 to band 1 courses of treatment for adults did not change over the period of the project.

The range of both re-attendance intervals and indicated recall intervals increased during the period of the project as did the standard deviation of the average re-attendance interval indicating that practices were increasing recall intervals for some adult patients.

The majority of practices were still indicating that patients would be recalled within six months.

There was an increase in both the number of new patients (2%) and total patients (3%) seen from September 2017 to March 2018 across West Yorkshire.

Appendix B

Recall Matters - Seeking the perspectives of dentists on recall, re-attendance and access to general dental services

Introduction

This on-line survey was produced by the Recall Matters project manager, piloted and refined with the input of a small number of project board members. It was sent to all GDPs in West Yorkshire by NHS England's Dental Commissioning Lead for Yorkshire and the Humber on 22 November 2018 and the survey closed on 18 December 2018 after a reminder email had been sent. Dentists were told that responses to the questionnaire would remain confidential. There was an opportunity for dentists to include their email address if they wanted a copy of the resulting report but these addresses would not be connected with responses. The questionnaire included one closed tick box question and five qualitative questions for open text responses. 23 people responded to the survey, nearly 10% of the practices in the West Yorkshire area.

The report starts with a summary of overarching themes that emerge from an analysis of all of the dentists' responses; there follows a more detailed analysis of responses to each question.

Summary of overarching themes from dentists' responses

This section pulls together the key themes that cross cut the survey responses and suggest some potential areas for reform and action.

1. There are some positive opportunities in extending recall intervals for adults at low risk of oral disease if based on a rigorous assessment of risks and linked to other areas for action. Dentists want to carry out more preventative work and improve access for all patients.
2. Patient expectations need to be managed through the provision of good information about appropriate recall and clinical risks. There should be transparency that the aim is to free up capacity and improve access to general dental services. A range of public communications should be deployed with innovative use of all media.
3. There should be a major programme of oral health improvement that informs and engages patients and supports them to take responsibility for their oral health. This needs to be national in scope and delivered through many different agencies at all levels. Opportunities for partnership working should be explored with schools for example playing a much bigger part in promoting oral health.
4. There was a significant theme about the shortcomings of the dental contract and the UDA system. Within this this broad theme dentists raised specific issues around the

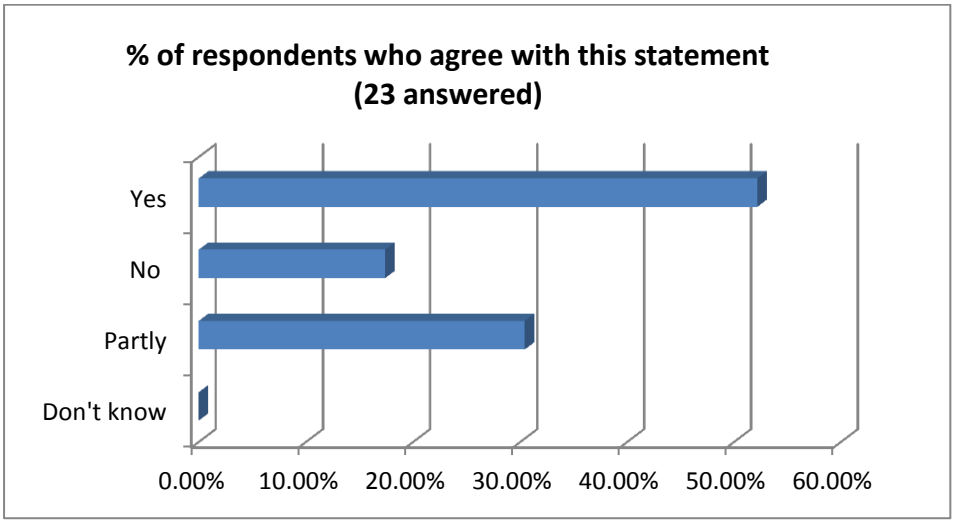
need for the contract to support preventative work, and the desire for a system that supported dentists to take on new patients and addressed the financial risks of taking on new patients requiring significant treatment (currently felt not to be adequately funded). There were concerns about the treatment / prevention balance.

5. Linked to this is a wider theme about inadequate funding for general dental services and the view that this is an underfunded system which has been continually eroded in the form of clawbacks which are then not re-invested in dental services. Underfunding was linked by some to a shortage of dentists, recruitment problems and many dentists moving from the NHS to private practice.

6. From the responses to this open questionnaire comes a sense of the stress many dentists feel and the dissatisfaction with the current system. This is not universal but was keenly felt by some; a sense of the mood of some dentists who contributed to the survey is captured in the extended quote that appears on page 7 of this report.

Detailed analysis of responses to each question

Q1 Extending recall intervals levels appropriately for some patients in line with NICE guidance could free up capacity for new NHS patients in general dental services. Do you agree with this statement?



ANSWER CHOICES	%	RESPONSES
Yes	52.17%	12
No	17.39%	4
Partly	30.43%	7
Don't know	0.00%	0
Total respondents		23

Q2 What do you think are the opportunities for dental practices to extend recall intervals beyond 6 months for adults at low risk of oral disease?

20 people responded, 3 skipped this question.

Nearly half of respondents came up with broadly positive opportunities. Some said they had already extended recall intervals for adults at low risk and said this worked well. For example, "We already do extend intervals for low caries risk patients, they are seen 12/12". Others saw positive opportunities if they could extend intervals: "This would free up time to see new patients". Another said that it would also make for a more varied and interesting working life, "Less tedious repetition of basic examinations with little or no simple scaling and polishing". "We could take on new patients, concentrate on prevention and treatment of oral disease for those a higher risk".

A small number of respondents said they thought there were some potential opportunities but emphasised that this had to be based on an assessment of risk for each patient. "It depends on the patient's oral health. If it is low risk there is no reason why the recall interval cannot be extended".

A quarter of respondents thought there were low opportunities to extend recall intervals appropriately or qualified their response. "[It would] free up more clinical time to see new patients, but the current system based around units of dental activity does not support clinicians to accept new patients with complex treatment needs." Another said "it really depends on the area and patient base, in this particular area the patients have a poor understanding of their responsibility in terms of looking after their own health and oral health is low priority in a community where sugar content is high."

One dentist noted that, "Even when we recommend recall periods and implement recall processes like text message reminders and emails many slip past their recommended recall anyway! The dental profession widely criticises the preposterous idea of having 2 year recalls for some "low risk" patients - when we are told we must screen for oral cancer every 12 months."

Of the four respondents who said there were no or very limited opportunities, two specifically mentioned the contract as an obstacle. "Prevention carried out effectively requires appropriate time which is not considered in current dental contract."

Q3 What do you see as the obstacles for dental practices to extend recall intervals beyond 6 months for adults at low risk of oral disease?

21 people responded, 2 skipped this question.

The most common obstacles highlighted by dentists were patient expectations and the difficulties in changing perceptions. There were different facets to the theme of patient expectations: patients want to remain on a 6 month recall because they remain more

motivated in their oral health because they know they will be critically assessed, they are more comfortable with 6 months, they complain if recall is increased, patients are concerned that there will be changes in their mouth, they perceive an increased interval as a cut and a reduced quality of support from the dentist. Two respondents noted that many families like to be seen together and don't want different recall intervals from their children; also this can lead to children missing appointments and most children in the area served by this dentist are said to be a high risk of caries. One respondent noted the risk of complaints and litigation by patients if a GDP is thought to have missed something.

Five respondents said that there were financial risks in extending recall under the current contract and taking on new patients and/or doing more preventative work. "Taking on new NHS patients under current system can cost a practice a substantial amount that is not recovered in payments from the NHS. This deters practices taking on unknown treatment needs for few UDAs." Another said, "Extending appointments is not the way forward, the dental bands and contracts have caused these issues!" One dentist who highlighted the financial risks said that there was a risk of bigger gaps in the diary in the short term and that new patients regularly miss appointments.

A variety of clinical risks were highlighted as obstacles to safely extending recall intervals: missing caries, the possibility of missing early signs of cancer, periodontal disease, the risk of missing rapid tooth decay in children with developing dentition and changing diet, the higher risk of oral carcinoma amongst edentulous patients.

Extending recall was said by some to reduce the opportunities for prevention and to revisit oral health messages and encourage greater compliance with healthy practices. "Prevention is better than cure and it's proven that the patients who don't attend regularly require more invasive work". One respondent said that to extend intervals would require patient education but noted that this would take time and would not have an immediate effect.

Two respondents said they didn't see any obstacles, one saying because they assess every patient at every visit.

Q4 What would support dental practices to extend recall intervals beyond 6 months for adults at low risk of oral disease?

19 people responded, 4 people skipped this question.

The most common support identified was further funding, either to fund preventative work and/or to fund extra treatment sessions. There were concerns about the costs of complex work for high risk patients not being funded through the current system. "If we pushed lots of patients into longer recalls just so we can squeeze more new patients in - because the

NHS won't fund it properly - so basically want more work doing and more people treated for the same money - what then happens if those patients then return as medium or high risk patients and need treatments doing that could have otherwise been avoided???"

Linked to this were several criticisms of the current UDA system and contract. For example one indicated the need for, "a better contract based on capitation and acknowledging the high needs of many infrequent attenders". Another said "The current UDA system is terrible….. It is clear that NHS England is putting huge pressure on us to see patients less and a lot more new ones……. NHS England continue to save money in the short term however GDPs like myself move to a private scheme and leave the NHS. There is now a huge shortage of dentists wanting to work in the NHS."

There was also a theme about the need for greater public awareness of appropriate dental recall with respondents saying it would be helpful to dental practices if there was more information provided to the public and a summary of the NICE guidance, using different media. Relating to this but on a broader point some respondents highlighted a need to extend and improve oral health education nationally, making people more aware of their responsibilities. One suggestion made is that schools could play a much bigger role in establishing a morning routine of children brushing their teeth (a continuation of the practice carried out in many private nurseries with pre-school children). They went on to say, "The majority of children we see at our practice are in need of treatment on their first appointment; if there was support at school maybe it wouldn't get to this stage?"

There were some other more specific ideas for support to practices: a structured way of assessing risk, a quick and simple algorithm that supports practices in developing different recall periods; clearer guidance for practices; fees for cancelled or missed appointments; a fixed NHS recall interval of 12/12 for all patients and linked to this a few per item services to incentivise patients to take responsibility for their oral hygiene.

Q5 - What would support patients to accept extended recall intervals beyond 6 months for adults at low risk of oral disease?

19 people responded, 4 skipped this question.

There were two significant and linked themes raised by dentists - the need for more information on appropriate recall at low risk of oral disease and the need to increase knowledge and understanding on how to prevent oral disease. It was said that there needs to be information about the clinical risks the dentist is assessing, the situations where it is appropriate to increase intervals. It was said to be important that patients understood that, if their risk levels have been assessed as low, they are not being disadvantaged. It was felt that there needs to be clarity that the aim of extending recall where appropriate is to try and improve access and is not a "cut back". Patients with no teeth should be told that they

just need to come annually for an assessment of soft tissues. Different media should be used innovatively. An innovative national programme of oral health was said to be needed.

A number of dentists highlighted difficulties however. One respondent said that patients are rejecting the concept as a money saving exercise by the NHS, and that many patients have a very negative perception of NICE. Another said, "I don't think patients would be happy to be seen beyond a 6 month recall. Leaving check-ups to beyond the usual recall time is not cost effective as the patient may require more extensive treatment".

One respondent suggested there should be a letter from the NHS saying it is no longer funded for low risk patients. Another dentist working in a high need area said that most of their patients need to be on a 6 month check-ups but they have a high failure to attend. They highlight the need for significant investment in recall systems to get these patients back in.

Q6 – What other approaches, changes and ideas do you think would contribute to freeing up capacity and improving access to NHS dental services in areas of need?

18 responded, 5 skipped this question.

This question elicited a wide variety of ideas and individual suggestions with only a couple of common themes across several respondents. One of these themes was around the need for more funding and an end to removing funding from dentistry through clawback. Several respondents said this could and should instead be re-invested in new local practices in areas of high need. Other specific reforms to funding arrangements were proposed: several said there should be enhanced payments for taking on new patients requiring multiple treatments. The dental contract was said not to be workable – reform of the contract and addressing some of the issues around funding could help address the issue of dental recruitment.

Other individual ideas and suggestions from dentists to improve access were:

- Targeted fluoridation for areas of higher need (said to require political courage)
- Recommission DwSI Endo and Perio services for all of West Yorkshire
- Patients need to engage and take responsibility for oral health
- More school involvement, lessons in oral health, tooth brushing routines, annual visits from fluoride varnish teams to all age children
- Incentives for oral health education in the wider community linked to public campaign on oral health
- Allowing therapists to do periodontal treatment via direct access
- Charging patients for missing appointments

- Making extensive dental treatment contingent on patient clearly showing improvements in their oral health
- Contractual freedom to allow practices to target resources at the most vulnerable groups.

A sense of the mood of some dentists is captured in this extended quote from one respondent:

> "……. Dentists feel under enough stress from "bureaucracy", DAF reports and other statistics are being used to harass GDP's into compliance with national norms which may or may not be appropriate. The Dental Recall project could be interpreted by a stressed out GDP as more of the same. I would like to think it was not intended like this but as a guide to allow a GDP some introspection about their working practices. I appreciate the deprivation index which gives some (crudely?) balanced perspective. I heard today of a dentist being asked to explain why he's doing too few extractions. Is he leaving untreated teeth in need of extraction? Could it be he's doing a good job and looking after his patients so well they don't need them? Without him seeing the work done or working in a supposedly "average" practice how does he have the comparators to know why? Is this fair? From the dentists perspective; lurking behind this question is the anxiety of the real threat of sanction. There are inadequate dentists out there. Perhaps these investigations could be saved for blatant "outliers" about whom a pattern of substantiated complaints are received. What happened to the friendly supportive "Dental Practice Advisors"? Yes, they had a stick but this only came out after repeated carrots were rebuffed. Now they only carry a stick. Thanks for that. Fear of litigation, fear of GDC, CQC and NHS "investigation", hugely increased regulatory workload, massive clinical workload with limited time to completely address the needs of every patient and write fully detailed contemporaneous (lawyer proof!) notes, lack of / or withdrawal of specialist support from the NHS (DwSI) , poor or withdrawal of funding for educational, training and occupational health support. Derisory and late or staged pay/funding awards. I could go on."

Conclusion

This report will be sent to all dental practitioners who responded and specifically requested a copy. It will also be reported to the Recall Matters Project Board where decisions about wider distribution to other agencies and groups that would find the findings of value. I would like to thank all dental practitioners who took the time to respond and contribute their views to this study.

Andrew Jones
Project Manager, Recall Matters Project
January 2019

Appendix C – General Dental Council community research into public attitudes to recall (report slides)

Slide 1.

Slide 2.

Slide 3.

Background, Objectives and Methodology

- According to NICE guidance, the intervals between oral health reviews should be tailored for individual patients and there is no clinical evidence that, for adults in good health, reviews more often than every two years are clinically effective.
- The GDC, together with NICE and NHS England, wanted to obtain some data on current patient experience relating to recall i.e. how frequently oral health reviews are typically scheduled.
- A short online survey was conducted with the GDC's Word of Mouth Panel.
  - In total 750 panellists completed the survey between 10-19th April 2017.
  - They were asked for their spontaneous views and then shown the Healthwatch video clip which gave information about the NICE guidelines in a user-friendly and balanced way.
  - A respondent profile is shown in Appendix A.

community research

Slide 4.

community research

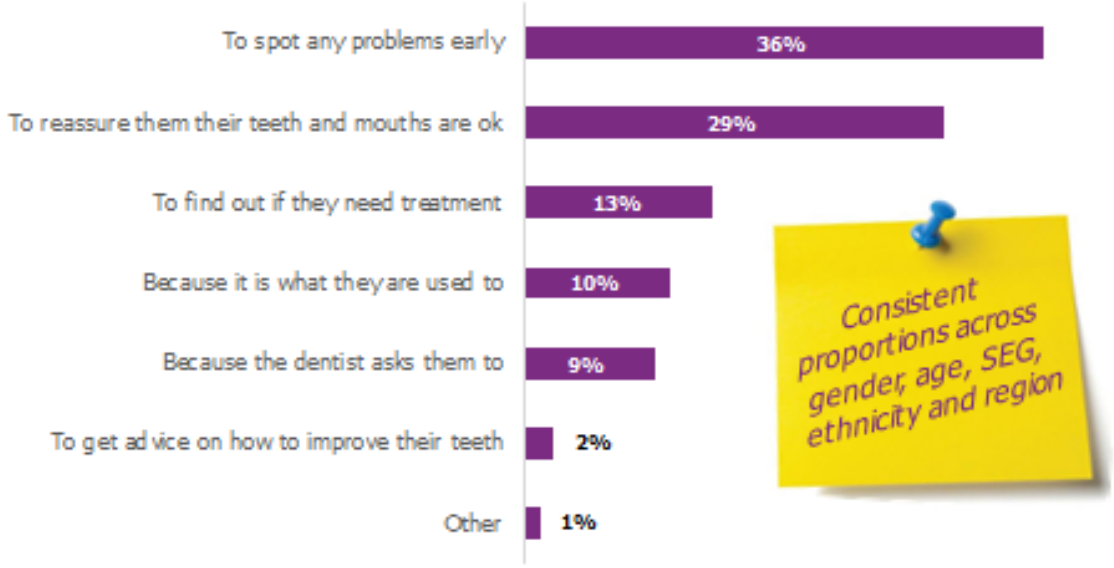
Research Findings

Bringing the voices of communities into the heart of organisations

Slide 5.

Reasons for going to the dentist for a check-up

Spotting problems early and **reassurance that everything is OK** stand out as the two main reasons why people go to the dentist for a regular check-up

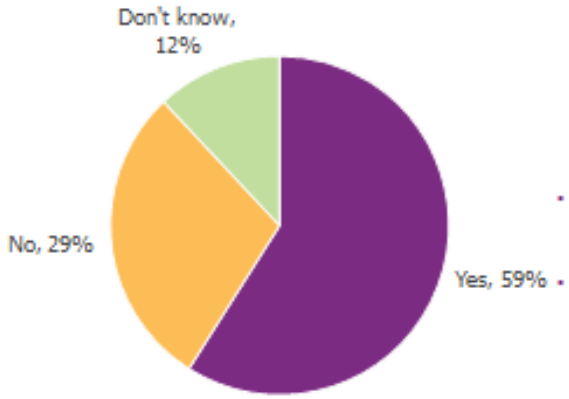


Which of the following best describes why people go to the dentist for a regular check-up?
Base: 750

community research

Slide 6.

Feeling comfortable asking dentist for a longer gap than six months between check-ups



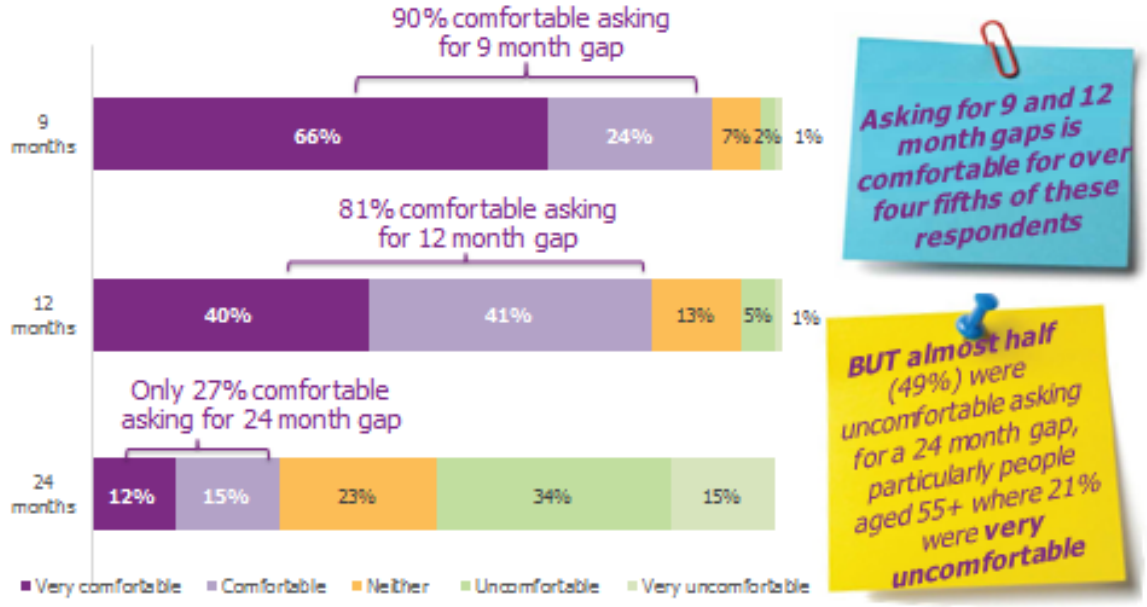
- Respondents **who had dental check-ups less frequently** were more likely to say Yes:
  - 72% of people who had check-ups at least once year said Yes (base: 251)
  - 75% of people who had check-ups at least once every two years said Yes (base: 76)
  - Compared with 49% of people who had check-ups at least once every 6 months (base: 423)
- Respondents **who described their dental health as 'very good'** were also more likely to say Yes (71% - base: 129) then those who did not
- A slightly higher proportion of respondents in the East of England and South West said Yes (71% - base: 56 and 67% - base: 94 respectively) compared to the national average (caveat small base sizes)
- No significant differences in terms of age, gender, SEG and ethnicity

If you were at a check-up and your teeth were healthy with no problems, would you feel comfortable asking the dentist whether you could have a longer gap than six months between check-ups? Base: 750

community research

Slide 7.

Respondents comfortable with asking for a longer gap: attitudes towards asking for various lengths of time



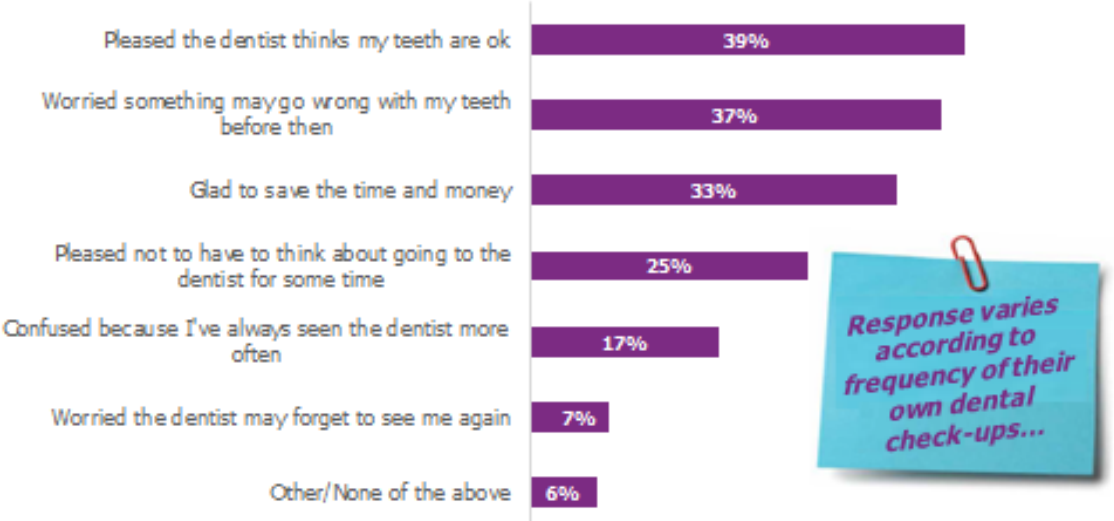
How comfortable would you feel asking your dentist whether you could have a gap of a) 9 months, b) 12 months and c) 24 months between check-ups?
Base: All comfortable asking for more than 6 months between appointments n443

community research

Slide 8.

Response to dentist suggesting a gap of up to 2 years between check-ups

Reactions were mixed: whilst over a third would be pleased, a similar proportion would be worried that something might go wrong with their teeth before then



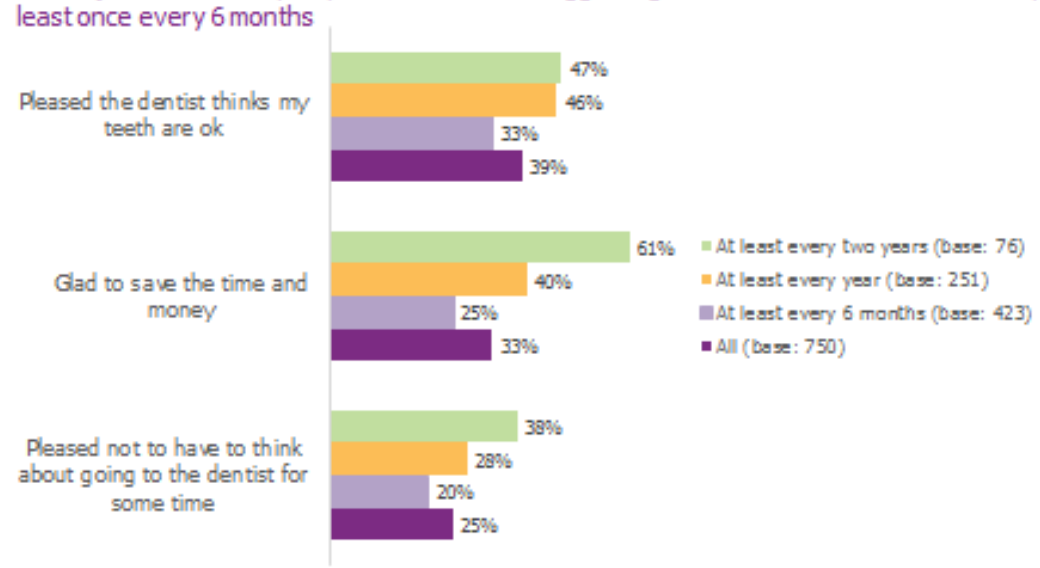
Which of the following would you feel if your dentist said you could have a gap of up to 2 years between check-ups? (tick as many options as apply) Base: 750

community research

Slide 9.

Frequency of respondents' own dental check-ups has impact on response to question (1)

Respondents who currently had dental check-ups **less than once every 6 months were more positive** at the prospect of the dentist suggesting this than those who had check-ups at least once every 6 months



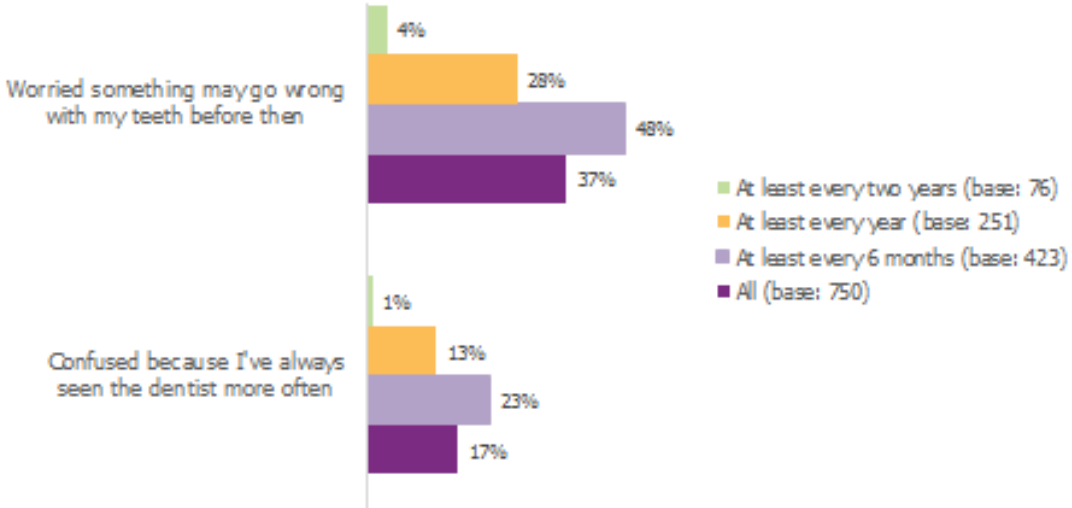
Which of the following would you feel if your dentist said you could have a gap of up to 2 years between check-ups? (tick as many options as apply) Base: 750

community research

Slide 10.

Frequency of respondents' own dental check-ups has impact on response to question (2)

Respondents who currently had dental check-ups **at least every 6 months were more negative** about the dentist suggesting a gap of up to 2 years between check-ups in comparison to those who had less frequent check-ups

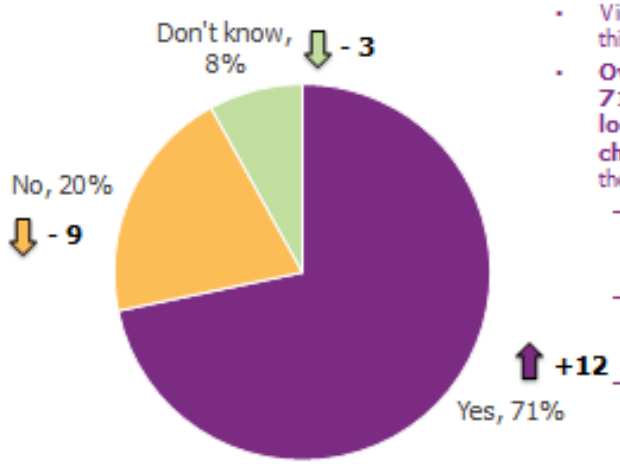


Which of the following would you feel if your dentist said you could have a gap of up to 2 years between check-ups? (tick as many options as apply)

community research

Slide 11.

After watching video clip: increased comfort with asking for a longer gap between check-ups



- Video clip has some impact on responses to this question
- **Over two thirds of all respondents, 71%, now comfortable asking for a longer gap than six months between check-ups** compared with 59% who said they would feel comfortable before
  - 84% of people who had check-ups at least once a year now said Yes – an increase of +12 points (base: 251)
  - 89% of people who had check-ups at least once every two years said Yes – an increase of +14 points (base: 76)
  - 61% of people who had check-ups at least once every 6 months now said Yes – an increase of +12 points (base: 423)

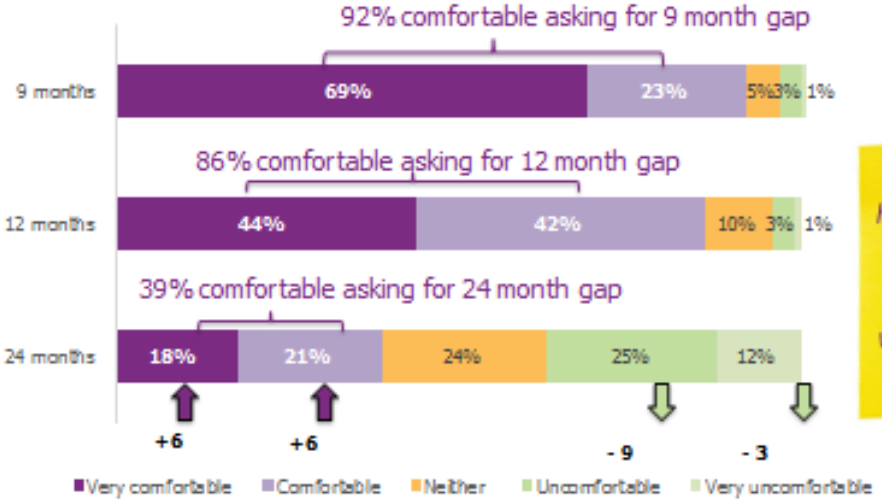
Now that you have seen the video clip - if you were at a check-up and your teeth were healthy with no problems, would you feel comfortable asking the dentist whether you could have a longer gap than six months between check-ups? Base: 750

community research

Slide 12.

After watching video clip: attitude towards asking for various lengths of time

- No significant change in % comfortable with a 9 month gap (+2%)
- Slight increase of +5% now comfortable with a 12 month gap
- Greatest increase of +12% **now more comfortable with 24 month gap** than before



*However, 18% of people aged 55+ remained **very uncomfortable** with a 24 month gap (only 3% less than before)*

How comfortable would you feel asking your dentist whether you could have a gap of a) 9 months, b) 12 months and c) 24 months between check-ups?
Base: All comfortable asking for more than 6 months between appointments n536

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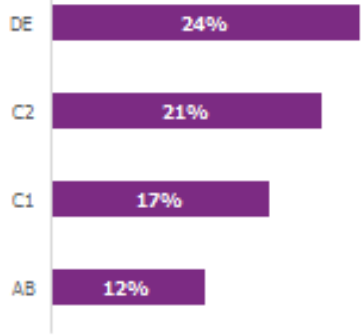
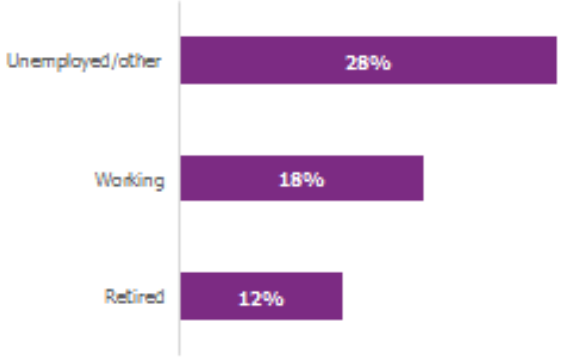
Slide 13.

There are some significant differences by SEG and working status regarding a 24 month gap

The chart shows the % of people by SEG who were **very comfortable** with asking for a gap of 24 months between check-ups after having seen the video clip.



The chart shows the % of people by working status who were **very comfortable** with asking for a gap of 24 months between check-ups after having seen the video clip.

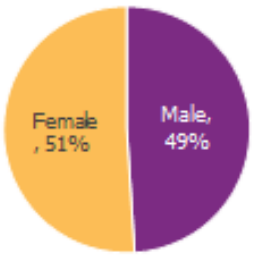


How comfortable would you feel asking your dentist whether you could have a gap of c) 24 months between check-ups?
Base: All comfortable asking for more than 6 months between appointments n536
Base: DE=126, C2=113, C1=173, AB=124
Base: Unemployed/other=105, Working=302, Retired=120 (nb Studying excluded because of low base size = 9)

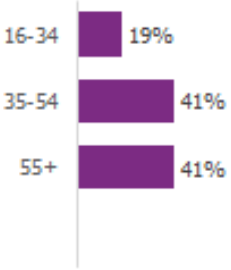
Slide 14.

Respondent demographic profile

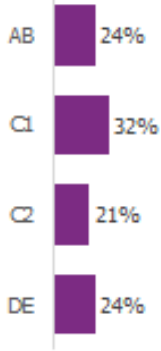
- Gender



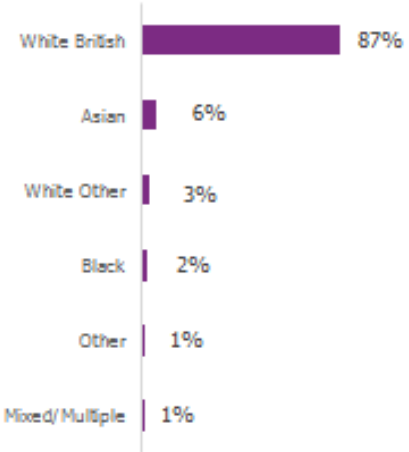
- Age



- Socio Economic Group



- Ethnicity



All respondents visit the dentist for a check-up at least every two years and live in England.

Base: 750

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