



# SDCEP Prevention and Management of Dental Caries in Children Consultation Interviews

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Heather Cassie on behalf of TRiADS



## **INTRODUCTION**

During the period between April 2009 and July 2009 the consultation draft of the Scottish Dental Clinical Effectiveness Programme's (SDCEP) *Guidance on the Prevention and Management of Dental Caries in Children* was made available for review and comment. The guidance aims to assist and support Primary Care practitioners and their teams to improve and maintain the oral health of their child patients<sup>1</sup>.

Copies of the consultation draft and feedback form were sent to approximately 150 individuals, organisations and associations. This included a random sample of 40 General Dental Practitioners (GDPs), 20 GDPs from an Audit Group in Fife and 24 Dental Care Professionals (DCPs) from across Scotland.

In partnership with SDCEP, the Translation Research in a Dental Setting (TRiaDS) Programme aims to improve the quality of the dental health care of patients in Scotland by conducting and evaluating a programme of integrated, multi-disciplinary translation research. As part of this, one priority is to gather information about current primary dental care practice and how this relates to key recommendations of SDCEP guidance. One stage in the guidance development process where this information can be gathered is consultation.

Therefore, the GDPs and DCPs who were sent the consultation draft of the *Guidance on the Prevention and Management of Dental Caries in Children* were invited to take part in a telephone interview to explore, in greater depth, their views of the guidance. This report provides a summary of the interview findings.

## **AIMS**

The aims of the consultation interviews were to:

- (1) identify current practice when preventing and managing caries in children;
- (2) identify the main barriers and facilitators to implementing the guidance;
- (3) inform the future development of the guidance and its translation into practice.

## **METHODS**

A random sample of forty GDPs was taken from the Management Information Dental Accounting System database (MIDAS), all of whom had been sent the guidance consultation draft and feedback form. Letters were sent to all forty GDPs asking if they would be willing to take part in a short telephone interview that would give them an opportunity to discuss their views of the guidance and its potential impact on their practice in more depth. In addition the same letter was sent to twenty GDPs from an Audit Group in Fife, and to twenty-four DCPs from across Scotland. Only five invitees said that they would be unwilling to take part. More than one attempt was made to contact the remaining 79 healthcare professionals to arrange a suitable time for an interview.

Fifteen interviews were undertaken in total. For the remaining practices who did not take part the main reasons were they no longer worked at that practice or we were unable to contact them by phone within the study time frame.

The interview schedule followed a standardised structure to identify salient beliefs regarding barriers and facilitators and advantages and disadvantages that relate to implementation of the guidance<sup>2</sup>.

A copy of the interview schedule can be found in *Appendix 1*.

## **RESULTS**

### **Demographics:**

Twelve GDPs, one dental nurse and two dental hygienists took part in the interviews. Of the twelve GDPs, the majority have been practising for 10 years or more (10/12) and work in multi-handed practices (10/12). Twelve of the 15 participants reported that their practice employs a hygienist or a hygienist-therapist and the majority see a mixture of NHS and private patients (11/15).

### **General Impressions:**

All participants agreed with the aims of the guidance in principle, however three raised concerns about the practicalities of following the recommendations in NHS dentistry. A few participants reported that the guidance was 'the gold standard' however, it was considered important to 'set the bench-mark higher'. Participants' views varied in terms of what they thought the guidance was trying to achieve. Responses included; simplifying procedures, putting more emphasis on prevention, introducing a more standardised approach, promoting a higher standard of care for children, highlighting the range of treatments available and reinforcing current practice.

The vast majority of participants (12/15) said that they would be in a position to decide whether or not they followed the recommendations in practice. However, one participant said that the dentists in their practice would decide and another reported that the principle dentist would make the decision.

### **Guidance format:**

Participants were generally positive about the format of the guidance document. While it was felt that the order in which the topics are covered is mainly appropriate, it was suggested that the section on 'Helping Children Accept Care' should come nearer the start and that 'Caries Prevention' should come before 'Pain Management'. The vast majority of participants (14/15) agreed that the concept of preventing children developing caries is adequately communicated in the guidance. Only one participant commented that there was too much focus on treatment rather than prevention.

A number of participants commented that the guidance was clear and easy to read. One participant commented:

*"The consultation draft is very clear, straightforward and simplistic. On the outside it appears to tell you what you already know but it is great to have as a reference."*

However, on the other hand one participant commented:

*"As a third BDS manual of children's dentistry this is very good but for the rest of us this is very patronising as we've been doing it for a while. It is teaching granny to suck eggs!"*

Five of the 15 participants said they were likely to use the 'Care Checklist', the 'Prevention Log' and the 'Caries Prevention Reminder by Age' tools, which are contained in Appendix 5 of the guidance. A few participants suggested that they would be more likely to use these tools if they were computerised. The main barriers to using them were time and that they were too complex, however one participant commented:

*"Our practice would love these! These tools are a great idea, you may not need the tables all of the time as it would become second nature."*

### **Specific Behaviours:**

During the interviews participants were asked about four specific behaviours contained in the SDCEP guidance.

#### ***Recording a child's caries risk***

Of the fifteen participants seven said they currently record the caries risk for each child. One participant said that they record it sometimes. Reasons for not recording a child's caries risk included; time, doing it more informally, child co-operation, not being sure how to determine the risk, not being aware that this was something that should be done and 'not seeing the point' in doing it. All of those asked agreed that the guidance gave them sufficient information in this area to start recording a child's caries risk but only one participant said that they planned to change their practice in line with the guidance recommendations.

#### ***Taking bitewing radiographs from the age of four years and then at regular intervals based on caries risk***

Two participants reported taking bitewing radiographs from children aged four and then at regular intervals based on their caries risk. Of those spoken to about half said they wouldn't start taking radiographs until the child was older, the remainder said they currently do it but not routinely. The main reasons highlighted for this were practical ones, with child cooperation and avoiding upsetting the child emerging as the main barriers. However, parent cooperation and distressing the dentist were also raised. Only one participant cited time as a barrier. The age at which dentists would currently start taking radiographs varied between 6 years and 12 years and the frequency also varied. One participant commented:

*"I wouldn't start taking radiographs until 6 years, unless I saw it developing. We are a preventive practice and it is important to keep good observation."*

Another participant reported:

*"I would start taking bitewing radiographs from the age 10-12 and then take them annually."*

None of those spoken to reported that they planned to change their practice in line with the guidance recommendations.

#### ***Applying fluoride varnish to the teeth of ALL children***

Three participants currently apply fluoride varnish to the teeth of all children irrespective of their caries risk. About half suggested that there are no real difficulties in doing this but a few highlighted that children don't like the taste of fluoride varnish and it is hard to keep the tooth dry and moisture free. A few participants were not convinced of the benefits of applying fluoride varnish to the teeth of all children. Comments included;

*"I wouldn't support the application of fluoride varnish to all children as there is a risk of fluorosis in years to come for those at low risk."*

*"There is no harm in applying fluoride to the teeth of all children irrespective of risk but if there is no real risk then there is no real benefit."*

*"I'm not convinced of the benefits of applying fluoride varnish to the teeth of all children irrespective of risk; [we] should spend more time giving tooth-brushing advice and put the onus on the child first."*

Eight of those asked said they would support the application of fluoride varnish to the teeth of all children irrespective of risk and one said they would in low fluoride areas. However, only one participant planned to change their practice in line with guidance recommendations and two said they would consider it.

In terms of measuring the correct amount of fluoride varnish to apply, the majority reported they did not actually measure but instead 'did it by eye'.

### ***Taking action if wilful neglect is suspected***

Three participants reported taking action if wilful neglect is suspected, however seven participants reported never having encountered it. Two participants said that they don't take action. One reason provided for this was the parents' reaction. One participant commented:

*"Writing to a child's doctor or health visitor could aggravate the relationship with a parent or carer and this will put the dentist off taking action."*

A number of other difficulties were also raised including; not knowing the full circumstances, not knowing where to refer, concern that the child may suffer as a result, lack of cooperation from GPs and a fear of getting it wrong. Four participants reported that they planned to change their practice and the majority agreed that the guidance provided adequate information to allow them to do this. In particular the letter templates were considered to be beneficial.

### **Impact on the dental team:**

All of those asked agreed that there are aspects of care recommended in the guidance which are currently or could be undertaken by members of the dental team other than the dentist and the majority were confident about them undertaking these activities. It was suggested that DCP's could undertake oral hygiene and dietary advice, fluoride varnish and fissure sealant application and radiographs. It was suggested that some additional training may be required.

The majority of participants (11/15) didn't think that there was anything in the guidance that would have a negative impact on their relationship with other members of the dental team, in fact it was suggested that it may have a positive impact in terms of enhanced teamwork. In terms of resources, the majority (9/15) of those spoken felt that they did have sufficient resources in place in order to follow the recommendations in the guidance. Where participants felt they did not have sufficient resources the most commonly mentioned were time and funding, as is highlighted by this participant's comment:

*"[We are] still underfunded to comply with the recommendations. Physical resources and manpower are fine but we need more cash to do this properly."*

### **The Childsmile Programme:**

The majority of those interviewed (12/15), reported being aware of the Childsmile programme and what it does and about half (7/15) said that they were clear about how the care provided by Childsmile relates to the care provided in practice. Twelve respondents felt that the caries prevention interventions detailed in the guidance document should be delivered through a

combination of Childsmile and dental practices. One respondent commented: *"the more people the better"*

### **Barriers:**

About half of those asked reported no aspects of the guidance that would be particularly challenging to implement in their practice. Few barriers were identified to following the recommendations in the guidance, however the two most commonly mentioned were time and funding.

#### ***Time***

Time was considered a barrier in terms of longer appointments, the time to write care plans and also for providing oral hygiene and tooth brushing advice. One participant commented:

*"It's not so much the actual dentistry that takes the time, it's the education".*

It was suggested that the additional time required to follow the guidance recommendations would not be practical in general practice. In particular it was highlighted that dentists are not paid for prevention. However, participants made contradictory comments;

*"In practice the time to do this will be a problem. We are not paid to give preventive advice."*

*"The increased time to follow recommendations isn't necessary a disadvantage."*

#### ***Financial Remuneration***

It was felt that fully complying with the recommendations in the guidance would not be financially viable in NHS dentistry. This was in terms of longer appointment times, referring to DCPs and the fact that the NHS does not fund some of the treatments recommended in the guidance. Participants commented;

*"To follow these recommendation properly more funding and support would be required, it isn't impossible but there are restrictions applied in general practice."*

*"...the problem with referring children to DCPs is that it may make things harder in terms of seeing another strange person. They do have more time to build a rapport with the child but it isn't financially viable."*

Other barriers included; child compliance and cooperation particularly in terms of taking bitewing radiographs, dealing with wilful neglect, persuading parents and carers of their responsibilities in terms of their child's dental health, dentists perceptions as to whether the recommendations are actually necessary e.g. applying fluoride varnish to all children irrespective of their caries risk and surgery space for DCPs to work in, as highlighted by these comments;

*"Hygienists can do fissure sealants and fluoride varnish. Childsmile nurses can do fluoride varnish. The problem is that we don't have a spare room in the surgery."*

*"The biggest problem with DCPs taking on some of these tasks is surgery space."*

### **Suggestions for Implementation:**

Introducing appropriate funding was highlighted as the main facilitator that could assist in the implementation of the guidance. Other suggestions included training for dental nurses in providing oral hygiene advice, training for dentists in the Hall Technique and adding fluoride to the water supply.

## SUMMARY

Based on the sample interviewed, the findings were mixed. Feedback was generally positive in terms of the content and format of the guidance. Comments included;

*"It is an easy read, I liked the highlighted aims and it is very concise."*

*"It is an easy read and well laid out which will help with implementation."*

It was felt that implementation may be difficult and few suggestions to facilitate this were suggested. Whilst participants were positive about the role which could be undertaken by DCPs perhaps additional training would help reinforce this as means of taking the recommendations forward. Collaboration between dental practices Childsmile nurses may also be a means of facilitating implementation of the guidance. One participant commented;

*"I am quite impressed with the guidance but implementation may be initially difficult. [We] need to bend some minds"*

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<sup>1</sup> Scottish Dental Clinical Effectiveness Programme. *Guidance on the Prevention and Management of Dental Caries in Children*. Consultation Draft, April 2009.

<sup>2</sup> Michie S, Johnston M, Abraham C, Lawton R, Parker D, Walker A on behalf of the "Psychological Theory" Group. Making psychological theory useful for implementing evidence based practice: a consensus approach. *Qual. Saf. Health Care*, Feb 2005; 14:26-33.

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## Appendix 1

### Consultation Interview Schedule – The Prevention and Management of Dental Caries in Children.

*Interviewer:*

*Name of Dental Practice:*

*Name of participant:*

*Job title:*

*Length of time in post:*

*Date of interview:*

#### Discussion checklist:

- researcher introduction – advise not a clinician!
- purpose of the study: to inform the future development of this guidance
- aim of the interview: to get a more in depth feedback of dentist's views of the guidance and it's potential impact on practice.
- practicalities / timescales:
  - brief list of questions by telephone ~ approx 20 minutes
  - interviewer taking written notes
- assurance of confidentiality

#### Questions:

1. Before we discuss the guidance it would be helpful if you could tell me:
  - a) How many dentists work in your practice?
  - b) Does your practice employ a hygienist or a hygienist therapist?
  - c) Is your practice fully NHS?

***Thank You. As you will be aware this guidance document is at the consultation stage and still under development. I will pass on the feedback you provide today to the Guidance Development Group, who will use your feedback to inform the future development of the guidance.***

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***What I'm going to do now is ask you some general questions about the guidance document and so it may be helpful to have the document to hand. I will then touch on a few aspects in more detail.***

2. To start off, from looking at the guidance what do you think the guidance is trying to achieve?

3. In general, do you agree with the aims of the guidance?  
(The aims can be found on page 7 of the guidance)

*(Prompt - why?)*

4. Are you in a position to decide whether or not you (your practice?) follow(s) the guidance recommendations?

*(Prompt – if no, who makes this decision?)*

***There is a lot of information in this guidance so what I'd like to do now is ask for your views on a number of specific aspects.***

5. Looking at the format of the guidance do you feel that the order in which the topics are covered makes logical sense?

*(Prompt - if no, how could it be improved?)*

6. Do you think that the concept of preventing children developing caries is adequately communicated within the guidance?

7. The guidance uses the terms Standard Prevention and Enhanced Prevention. Can you tell me what you understand these terms to mean?

*(Ideal answers are:*

*Standard prevention is interventions which are provided to ALL children (irrespective of risk).  
Enhanced prevention is additional interventions to be provided for children assessed as at increased caries risk)*

***What I'm going to do now is ask 3 or 4 questions about 4 specific aspects of the guidance.***

8.

a) Do you currently record a child's caries risk?

*(Prompt - If not, why not? Do you think it is something that needs to be done? Why?)*

b) What might be / What are the difficulties in doing this?

c) If not currently following guidance recommendations, do you plan to change your practice?

d) Does the guidance give you sufficient information in order to do this?

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9.

- a) The guidance recommends taking bitewing radiographs from the age of 4 years and then at regular intervals based on caries risk. Do you currently do this?

*(Prompt - If not, why not? Do you think it is something that needs to be done? Why? Is it just the age that concerns you? If so, at what age would you start/ at what frequency)*

- b) What might be / What are the difficulties in doing this? *(May be covered by question above)*
- c) If not currently following guidance recommendations, do you plan to change your practice?
- d) Does the guidance give you sufficient information in order to do this?

10.

- a) Do you currently apply fluoride varnish (aka Duraphat) to children?

*(Prompt - If yes, which children (e.g. all? only those at increased risk? If no, why?)*

- b) What might be / What are the difficulties in doing this?
- c) How do you go about measuring the correct amount of fluoride varnish to apply?
- d) At what age do you think it is reasonable to start applying fluoride varnish to children's teeth?
- e) Would you support the application of fluoride varnish to the teeth of all children, irrespective of their caries risk?
- f) If not currently following guidance recommendations, do you plan to change your practice?
- g) Does the guidance give you sufficient information in order to do this?

11.

- a) Do you currently take action if wilful neglect (as described in guidance pp 58-59) is suspected?

*(Prompt - If not, why not? Do you think it is something that needs to be done? Why?)*

- b) What might be / What are the difficulties in doing this?
- c) If not currently following guidance recommendations, do you plan to change your practice?
- d) Does the guidance give you sufficient information in order to do this?

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***What I'd like to do now is just finish by asking a few questions about some more general aspects of the guidance.***

12. Appendix 5 of the guidance includes three tools to help implement the recommendations, a Care Checklist, a Prevention Log and a Caries Prevention Reminder by Age. Do you think you are likely to use any of these in your practice?

*(Prompt - If so which? (rank order?) Would they be useful as separate documents which could be downloaded and laminated?)*

13. Are there any aspects of care recommended by the guidance that are currently or might be undertaken by another member of the dental team e.g. dental nurse/hygienist or hygienist-therapist?

*(Prompt - If so, which areas? If not, why not?)*

14. Would you feel confident about another member of the dental team undertaking this activity?

*(Prompt - If no, why? lack of training/knowledge? What might help?)*

15. Is there anything in the guidance that you think may have an impact on your relationship with the child or their parent/carer?

16. Is there anything in the guidance that may affect your relationship with other members of the dental team?

*(Prompt – In terms of whether there may be tensions between colleagues about whether a recommendation should be followed or not/ if behaviours could be undertaken by other members of the dental team)*

17. Do you think that you (your practice) have (has) sufficient resources in place in order to follow the recommendations in the guidance?

*(Prompt – In terms of physical resources, staff, funding, managerial support?)*

18. Are there any aspects of the guidance that you think will be particularly challenging for your practice to implement?

*(Prompt – Why? What might help?)*

19. Are there any aspects of the guidance that you think will be less challenging for your practice to implement?

*(Prompt - why? is this because you are already carrying them out?)*

20. What do you think are the main advantages of following the recommendations in this guidance?

21. What do you think are the main disadvantages of following the recommendations in this guidance?

22. Are you aware of the Childsmile Programme and what it does?