The world looks *different* from my ivory tower

During late summer 2019 **Cary Cray-Webb** decided to change jobs. Says Cary: 'I had been dental nursing for the Ministry of Defence in the Defence Dental Service, which was great in many ways. But when a former colleague told me about a new role at Cambridge Community Dental Services I was intrigued'.

The role

The role was (is) to manage referrals into a special care dentistry service. It's a new service to Cambridge CDS (CCDS), allowing all the referrals for CCDS to be centralised and handled by one hub, and for the initial pre-assessment appointments to be made by one team.

Taking on a newly created role has meant facing the challenge of learning new IT systems, developing the procedures needed to run the service every day, and then teaching it all to two junior staff. I'm also responsible for advising people with problems accessing the service, dealing with complaints, and some telephone triage of my service and the minor oral surgery service.

The attitude

I'd never really thought much about the administration of secondary services. I think that's the case with most nurses. You're never exposed to it – it just 'happens' in the background. And if things are running correctly, isn't that how it should be? But I've found a lot of nurses in particular don't understand our role. Some don't understand why I should move from nursing to admin, like I've betrayed them. I've nursed at CCDS before, and still occasionally work bank. One or two seem to think I've 'changed sides' and gone to sit in an ivory tower. But that's not the way I see it.

I like to use the analogy of a sports team. Whether you're talking netball, rugby or Formula One, somebody needs to arrange the competitions. Somebody needs to arrange transport. Somebody needs to decide who's playing and who's a substitute, who's driving and who's changing the wheels. And someone needs to organise training. And the best coaching and back-room staff are often (but not always) former competitors, because they understand what's needed.

So, while all sports fans will know Toto Wolff and José Mourinho, not many can name the dozens of staff who work for them. Yet if those roles don't get carried out efficiently, Lewis Hamilton and Harry Kane will stand there, drill and mirror in hand, rapidly getting bored.

In other words, administrators – certainly in secondary care services - are as much part of the team as nurses, dentists and oral surgeons.

So, why switch from dental nursing?

I love nursing. But I'm in my 40s and I'm diabetic. Nursing leaves me emotionally and physically exhausted. I concluded I need to do something that uses my technical knowledge but which wasn't so tiring. Another reason for my switch is an ongoing interest in public health. This was sparked years ago while working in mental health as an art therapist.

I am saddened by the gaps in provision of primary dental services that I see every day. I frequently come across people too old and frail or too ill to access a primary care dentist. Often they can't even register. But without a referral from a general dental practitioner it is often difficult for us to help them. This is because the access pathways to our services were designed under the assumption that primary care dentists would be helping such patients.

Another concern of mine is the number of children with serious dental problems who we see for procedures. My husband and I have five children between us, between 13 and 27. All have exceptionally good teeth, so we know it's possible to bring up children with good oral health. That's probably why I find it traumatic to see some of the cases that come to our service.

Is it right for children as young as two-years-old to need an extraction because of decay? And what about young teenagers who will live their lives with natural teeth missing? I'm sure some of these cases are bordering on parental neglect. But at what point do you involve social services, and could they do anything anyway?

What actually is special care dentistry?

In special care dentistry (SCD) I see referrals for those who have specific needs that are beyond a general practitioner skill set. This may be because of complex health issues or learning disability. But there are also many children who have never visited a dental practice before, and their first experience of dentistry is when they are in pain.

Children are often uncooperative and scared while in pain, but it's a lack of oral hygiene that has put them in that situation in the first place. In my view, this is rarely down to the child and usually the direct fault of the parent.

As a dental nurse working in 'community' I often find that a child's oral hygiene reflects the parent's. As an administrator I can see that these parents and children often fit certain demographics and geographic clusters. Logic should dictate that it's these groups who are most in need of targeted education. But how to reach them?

The problem of access to a general dental practice is often most acute is these areas, and those practices serving the area are rarely taking on NHS patients. So where does that leave the most in need and the most vulnerable of our society?

'OHE has now become a segment in the PSHE curriculum in schools, but can a teacher provide adequate advice to a young person who is developing oral hygiene and health problems?'

Oral health and education

One of the services that I work alongside is our Oral Health Improvement Team. The Oral Health Improvement Team go out into the community to train people in how to teach oral health – usually school teachers. It's a logical way to maximise the reach of the service, though the approach does rely on being able to persuade hard-pressed educators of the need to teach yet another 'important' thing to their pupils. But if it makes oral health education more widespread and accessible, from a dental healthcare professional perspective has to be a good thing a good thing.

Something that helps is that oral health education has now become a segment in the PSHE curriculum in schools, so the class teacher now has to include oral health. Great you may think, but can a teacher really learn enough to provide adequate advice to a young person who is developing oral hygiene and health problems?

As dental health professionals, we know oral health is an important part of our overall health. It impacts on our well-being more than most of the general

population realise. My personal opinion is that leaving it to teachers to deliver rather than a qualified dental nurse is a bit of a compromise. But the resources needed to provide a dedicated full-scale direct service are simply not available at a community service level, and initiatives by primary care dentists are uncoordinated and provision is therefore patchy.

Can't be bothered?

Some referrals leave me wondering what GDPs think they are playing at. Are they only interested in money and UDAs?

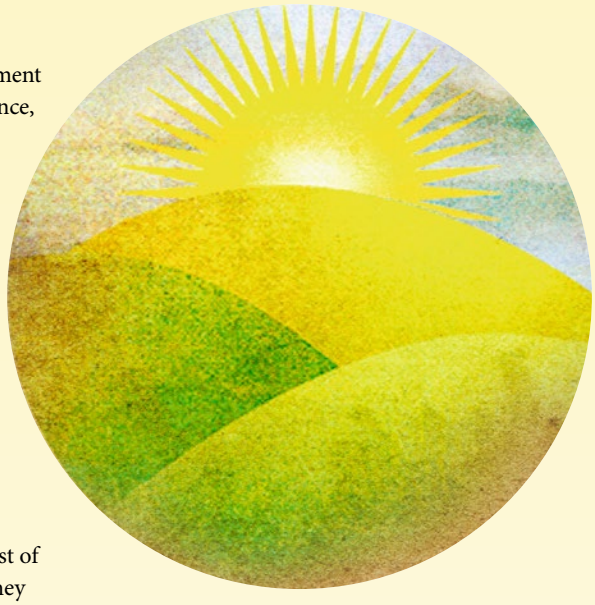
We see GDPs who refer children to community because they either lack the skills to deal with behavioural or physical issues, which is understandable. But we also see referrals that I'm certain are because of time and UDA targets – frequently from the same few dentists. It is true that community services have more time, and our dentists are not under pressure to earn UDAs. Is this the way for GDPs to create a life-long relationship with their patients?

we can't do that. But as some of our treatment locations are booked five months in advance, there's nothing I can do.

Even worse are the parents who, having allowed their children to get to the point of needing extractions, decide they won't bring their children in for treatment at all because the appointment is inconvenient – but that's probably a whole different article.

Why do people outsource their own oral hygiene?

I've written before about people's perception of oral health. Many people seem to think that it is separate to the rest of their health, and even to their bodies. They almost seem to feel that it's someone else's responsibility. Good oral hygiene and a will to comply would solve a lot of the problems we see in our service. However, with a lack of easy access to primary dental care and oral hygiene advice, I don't think the oral health problems we see will be resolved for at least a couple of generations, if ever.



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Get used to handling complaints

We are a successful service, so much so that demand far outweighs our capacity, and this causes a few parents (and relatives of older, disabled patients) to get angry. Because their child is in pain they understandably want to be seen in the next couple of days. I have to explain about the acceptance criteria for the service. We are not an emergency service and the GDP that refers in still has a duty of care until the patient is seen in clinic by one of our clinicians – something that a few GDPs don't always remember. If they are struggling to access primary care in the first place people can find this frustrating.

Another source of complaints is the appointment booking process. I'm often faced with people who want to move an appointment at short notice and who don't understand why

It makes me really sad that something so simple and fundamental to overall health, self-esteem and confidence is becoming more remote for groups within our communities who need it most, through simple lack of education and access. Solving this problem is probably going to take a bigger person than me, but GDPs and those working in enclosed practice environments (such as military or private practice) also have a role to play.

Note - NATO service personnel usually have quarterly dental check-ups and free follow-up treatment. Nursing in the DDS, I saw retiring soldiers who had good oral health as a requirement of their job, but who were about to leave the Army without any realistic hope of accessing the quality of dental services or care they were used to.

My plans for the future

I love my new job. I am still providing part of an important health service, but as I rarely nurse I don't feel emotionally wrung-out or physically exhausted. It is also allowing me to 'see the bigger picture', and learn more about public health.

My ambition as an administrator is to eventually move into a position where perhaps I can use my coalface knowledge to help shape the wider dental service in East Anglia, or even the UK. I would like to ensure that there is wider access to primary and secondary services, and clearer, more logical access pathways to secondary care services.

No doubt, if I reach such a position, someone will write an article about a gap in the system that they have found. But hopefully, if more dental professionals take their experience into administration, we will see secondary (and primary) dental care developing incrementally for the good of patients and dental health professionals alike.

In the meantime, I'm off, back to my ivory tower so I can look down on you all and tell you how things should be done down below.

Further information

Would you like to write an account of your perspective on dentistry? Do you have an opinion you would like to share with your dental colleagues through the virtual pages of BDJ Team? We would love to hear from you. Email bdjteam@nature.com.

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