Professional Society for Dental Nurses

Response to questions in relation to the Remote and Rural Health Care Inquiry

Prepared by Executive Director Fiona Ellwood and Scottish Branch Representative Mhairi Templeton 30th January 2024

1. The Society of British Dental Nurses is acutely aware that the provision of dental and oral care is dependent on meeting the needs of the population/local communities and the challenges that they often face being part of a remote or rural community. It is paramount that those individuals can access care as locally as possible. Many of the challenges of the provision of care is the need for more local and sustainable services. The added complexity of travel and further financial burden simply serves to create more inequalities in these communities. We also recognise that looking at such communities through the lens of the urban mindset is troublesome and that oral health needs can often be different across the life-course of these communities. Services for remote and rural communities are to some degree supported by mobile provisions, accepting that they bring with them their own challenges, they do take care to the communities – such as the Child Smile Program and the Caring for Smiles programs. We are fortunate that one of our Scottish Representatives has been part of this mobile working. Of course, when it comes to sustainability, there are some interesting facts to work through, but by taking care of the community, at the Society we would look at the perspective of reducing the carbon footprint, but the Chief Dental Office for Scotland is the best placed to speak to on this at a national level.
2. The provision of dental and oral care is dependent on having the right people in the right place, at the right time, with the right skills, and in general terms, whilst dental nurses generally come from the local community other members of the dental team have a different route to qualification. This has the potential to encourage people to move away to train and then potentially means that they may not return to serve their original community. As with many areas, dentistry is introducing and incorporating vital technological and digital improvements and ways of working, but we also

recognise that not all rural and remote communities have the same level of access to the internet that they may need to be part of the more modern ways of working, again adding to inequalities. Finally, we recognise that the standard curriculum for dental nurses and the wider dental team does not specifically have a focus on remote and rural ways of working and how to adapt to working in these areas and this we feel may be a barrier to attracting professionals to the area who are not natives to the community. We strongly believe from the Society's perspective that there is a different role needed, with greater autonomy through digital working, where possible, not for a dental nurse with additional duties, but an oral health practitioner. This is something that is being considered elsewhere and should include social prescribing, we must add this is an aspiration and not something that the Society has gained much appetite for, but it should not be dismissed. For those moving to remote and rural areas it is worth noting that we believe that there may be a need to help such individuals to adapt to remote and rural life and living in these communities if we are to maintain a sustainable provision of services.

3. The key to the Society is to see a service that reaches the local communities that is fit for purpose and accessible. Good, efficient, and effective services to refer individuals to, when necessary, but with a consideration of the challenges and impact of individuals having to travel long distances to access some services. As far as dental nursing goes, we would like to see a supply of local people being trained and a better utilisation of the wider dental team where possible. It is also important that training is readily available to the whole team to both maintain and gain skills that are required not only in the workplace but also by the professional regulator. A recent conversation has also been brought to our attention about potential regional language barriers and we would like to explore if this is dialectal or if this includes regional languages they may need to be taught to best communicate with the local people.
4. The dental profession continues to struggle to attract new people to the profession and attracting people to remote and rural areas seem to come with additional challenges. Having to travel to train if the internet is an issue can be an added burden as can the additional cost. The opportunities to progress may well be hampered for the very same reason and looking at ways around this has to be a priority. In terms of current workforce numbers, we can see those on the General Dental Council (GDC) register in Scotland below (DEC 2023). Each professional group has a different scope of practice, with elements of overlap in some cases. We do not have sight of the breakdown of numbers serving the remote and rural communities, but the Office of the Chief Dental

Officer for Scotland is likely to have these figures. An annual report from the GDC gives further detail on gender age etc. We see the issues as being able to provide care differently by the wider dental team and through co-working as part of multi-disciplinary teams and the need to maintain a workforce that is engaged and fulfilled. Further data can be obtained from the General Dental Council website.

Scotland	Orthodontic Therapist	92	3	89	0
	Dentist	4145	1858	2287	0
	Dental Therapist	455	44	411	0
	Dental Technician	422	299	123	0
	Dental Nurse	6315	79	6236	0
	Dental Hygienist	696	38	658	0
	Clinical Dental Technician	23	18	5	0

It may be of interest to know that in dental nurse training, the profession has no record of how many dental nurse students enter training and indeed how many complete their training and then how many go on to register. Their education is commonly vocational and work-based learning, whilst employed/working in the dental setting and so work-placement/employment is essential if we are to train more dental nurses. There are a number of higher-level courses evolving and Scotland is a leader in this work, the issues of equity and parity in education and learning for dental nurses is a discussion in our eyes, that is long overdue.

5. We believe it is paramount to co-work and co-design practices and care, what we cannot navigate is local priorities, political and socio-economic issues that affect decisions, and local buy-in. We certainly foresee having local people providing care as an ongoing challenge and of course, navigating the remote areas away from centres of population. We are keen to stress the need for a recognition of the wider determinants of health in such remote areas and how a focus on the 'whole person' health is often affected by the food that can be accessed and eaten well. Lastly, a need for joined-up provision of care in illness, acknowledging that wider illness can affect the mouth and all too often the mouth is not a consideration in illness. It would be invaluable we believe to have a service user evaluation and explore all of these issues from a person-centred perspective.

This commentary is from the British Society of Dental Nurses perspective and from both a member of the Scottish Branch and from experience from the Executive Board. We would do not speak from or on behalf of the Chief Dental Officers' perspective or from our professional regulators' perspective, the General Dental Council, but from the perspective of a professional body that works within the regulated guidance.

Chief Dental Officer Dr Tom Ferris (Scotland)

General Dental Council https://www.gdc-uk.org/

Society of British Dental Nurses www.https://www.sbdn.org.uk

We thank you for the opportunity to contribute to the inquiry and to provide the dental nursing perspective.

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