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WORKING WELL DOING THINGS DIFFERENTLY FOR GREATER MANCHESTER

Working Well: Roots to Dental
Evaluation findings

February 2024

SQW

Introduction to Working Well: Roots to Dental (WW RtD)

The Working Well: Roots to Dental (WW RtD) pilot:

- Was established to provide NHS dental support to a cohort of Working Well: Work and Health Programme participants
- Was open for 100 participants between July and September 2023
- Is providing ongoing treatment for most participants as of February 2024

The pilot is a collaboration between:

- The University Dental Hospital of Manchester (UDHM) and University of Manchester (UoM)
- The Greater Manchester Combined Authority (GMCA) Working Well team
- The three WWWHP delivery providers: Ingeus, The Growth Company and Seetec-Pluss
- NHS Greater Manchester

Introduction to the Working Well: Work and Health Programme (WWWHP)

Working Well (WW) is a family of services providing employment support across Greater Manchester with a particular focus on the relationship between employment and health. Responsibility for commissioning and oversight of WW programmes is devolved to Greater Manchester Combined Authority.

One of the five live WW programmes is the Working Well: Work and Health Programme (WWWHP) which:

- Started in 2018 and is due to run until 2026
- By the end of 2023 had supported people nearly 27,000 people
- Receives the vast majority of its referrals from Jobcentre Plus
- Supports people with a wide range of barriers to work and support needs, including health conditions, disabilities, long periods of unemployment, low skills, debt and housing, with many participants having multiple inter-related barriers
- Provides personalised, holistic and intensive support to participants intended to address their barriers to starting and sustaining employment
- Is delivered through a Key Worker model and integration with the external support landscape
- Provides up to 15 months of out-of-work support and 6 months in-work support

Please refer to the WWWHP 2023 Annual Report for more information on the programme.

Introduction to the evaluation

These slides draw together evaluation findings for the WW RtD pilot. They were drafted by SQW, the Evaluation Partner for WWWHP, who have drawn together inputs from UDHM/UoM and the WWWHP delivery providers.

The evaluation findings are based on:

- WWWHP monitoring data
- Attendance monitoring by the delivery providers (not comprehensive due to information sharing barriers and reliance on participants self-reporting)
- Participant case studies undertaken by the delivery providers
- An interim anonymised summary of case notes on the cohort's attendance and the nature of treatment

At the time this report was drafted in February 2024 treatment of the pilot cohort was still ongoing. These slides provide an overview of findings at this interim stage.

Oral health and dental access

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Issues with oral health

The 2021 Adult Oral Health Survey highlights:

- The relationship between deprivation and oral health – people in the most deprived quintile are more than twice as likely to rate their oral health as bad or very bad (12%) than the least deprived quintile (5%)
- The impact of oral health on daily life – the prevalence of different impacts of daily life are set out in the table on the right, with the impact on work particularly notable, impacting 3% of all people and 6% of those in the most deprived quintile
- The relationship between visiting the dentist and oral health – people who visit the dentist for a regular check-up are far less likely to rate their oral health bad or very bad (4%) than those who only visit the dentist when they have trouble with their mouth, teeth or dentures (18%) and those who have never visited the dentist (20%)

Impacts of oral health on daily performance (%)

Impact	All people (England)	North West	Most deprived quintile
Difficulty eating	9	8	14
Difficulty speaking	3	4	5
Difficulty cleaning teeth/dentures	4	5	7
Difficulty going out	4	4	8
Difficulty relaxing	6	7	10
Difficulty showing teeth	12	14	20
Difficulty working	3	3	6
Problems with emotional stability	5	5	9
Difficulty with contact with others	5	7	10
At least one oral impact	21	21	31

Source: 2021 Adult Oral Health Survey, Office for Health Improvement and Disparities

Issues with access to dentistry

Limited access to dentistry, particularly NHS dentistry, is a widely recognised national issue. A recent Health and Social Care Committee inquiry on NHS dentistry inquiry concluded, "there is a crisis of access in NHS dentistry" citing evidence such as a BBC investigation finding 90% of practices not accepting new adult NHS patients in 2022, and a YouGov survey finding 22% of Britons were not currently 'registered' with a dentist [1]. The inquiry further reported significant inequality in access to dentistry, with people living in the most deprived areas most likely to miss out on NHS dental provision.

Greater Manchester faces similar challenges although there is a lack of GM-wide data to evidence this. As of January 2023, there were 346 General Dental Service providers [2]. A mystery shopper exercise conducted by Healthwatch Manchester in March 2023 contacted 53 practices across Manchester City and found that just 3 (6%) of those practices were accepting new adult NHS patients and 27 (51%) practices were taking on private patients only [3].

The 2021 Adult Oral Health Survey shows cost is a key factor too [4]. For those in the most deprived quintile who had not visited the dentist in the last two years prior to March 2020, 45% said it was because they could not afford the charges.

[1] Health and Social Care Committee (2023) NHS dentistry inquiry - note patients are not formally 'registered' with a dentist so this reflects respondents' perceptions rather than formal registration status

[2] NHS GM Integrated Care (2023) Integrating health and care in Greater Manchester

[3] Healthwatch Manchester (2023) Mystery Shopper Dental Admissions

[4] Office for Health Improvement and Disparities (2024) Adult oral health survey 2021

Oral health for WWWHP participants

WWWHP collects data on a range of barriers from participants during an initial assessment, including around oral health and dental access. This shows:

- 15% of participants had an oral health issue at the time of their initial assessment, specifically one or both of the following: 'pain/problems in their mouth' and/or 'problems with their teeth/mouth which stop them smiling or speaking without embarrassment' - but monitoring data does not reflect the severity so the scale of participants with more severe oral health issues will be smaller (but is not precisely known)
- 40% of participants reported that they were not 'registered' with a dentist at the time they started WHP – nearly double the 22% of Britons not 'registered' as cited on the last slide [1] (noting that patients are not formally 'registered' with a dentist so both figures reflect perceptions rather than formal registration status)

Oral health issues and dental registration for WWWHP participants

Oral health issues	Participants	% of participants	% not 'registered' with a dentist
No oral health problems	20,904	85%	38%
Problem/pain in mouth	2,497	10%	51%
Problems with teeth or mouth which stop smiling / speaking without embarrassment	2,495	10%	56%
At least one oral health issue	3,828	15%	52%
Both oral health issues	1,128	5%	59%

Source: WWWHP monitoring data

- Participants experiencing an oral health issue were less likely to be 'registered' with a dentist – with 51% not 'registered' compared to 38% of those reporting no oral health problems

Since the first Working Well programme in 2014 oral health issues (and often an inability to get them resolved) have been a recurring barrier to work for some participants. Participants suffering from dental pain have struggled to engage in job searching and maintain employment, and constant or intermittent pain has impacted their quality of sleep, mood and wellbeing. Participants with poor dental hygiene and dental issues, including missing or damaged teeth, have struggled with their confidence in interviews and work, and may have been disadvantaged by negative employer perceptions. As per above, the actual scale of participants with these more severe issues is not known.

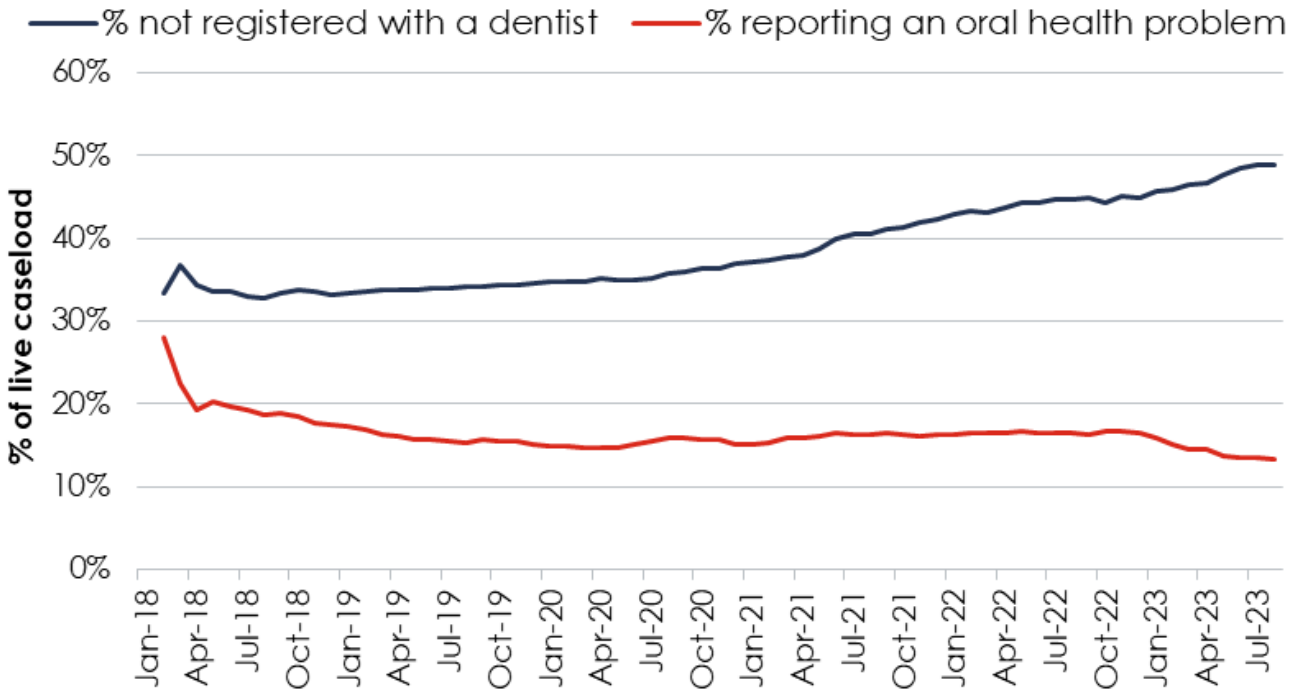
[1] NHS GM Integrated Care (2023) Integrating health and care in Greater Manchester

Oral health and dental access for WWWHP participants – over time

The WWWHP monitoring data shows that over time:

- The proportion of participants reporting at least one oral health problem has been remained fairly stable for most of the programme at 10-20% after the first few months of the programme
- The proportion of participants reporting they were not 'registered' with a dentist has trended upwards over time, peaking at 52% of starters in March 2023 (again noting that patients are not formally 'registered' with a dentist so this reflects perceptions rather than formal registration status)

Oral health issues and dental registration over time



Source: WWWHP monitoring data

Oral health and dental access for WWWHP participants – by area (1)

WWWHP monitoring data shows oral health and dental access varies considerably by local authority, with:

- Participants based in Oldham most likely to report at least one oral health problem and Wigan least likely
- Participants in Bolton least likely to be registered with a dentist and Wigan most likely

The next slide presents two maps that use WWWHP monitoring data at the level of postcode districts for a more granular spatial view.

Full postcode data was not available for the evaluation but could be useful for identifying with more precision which areas have higher prevalence of oral health issues and/or lower levels of dental registration for more targeted activity.

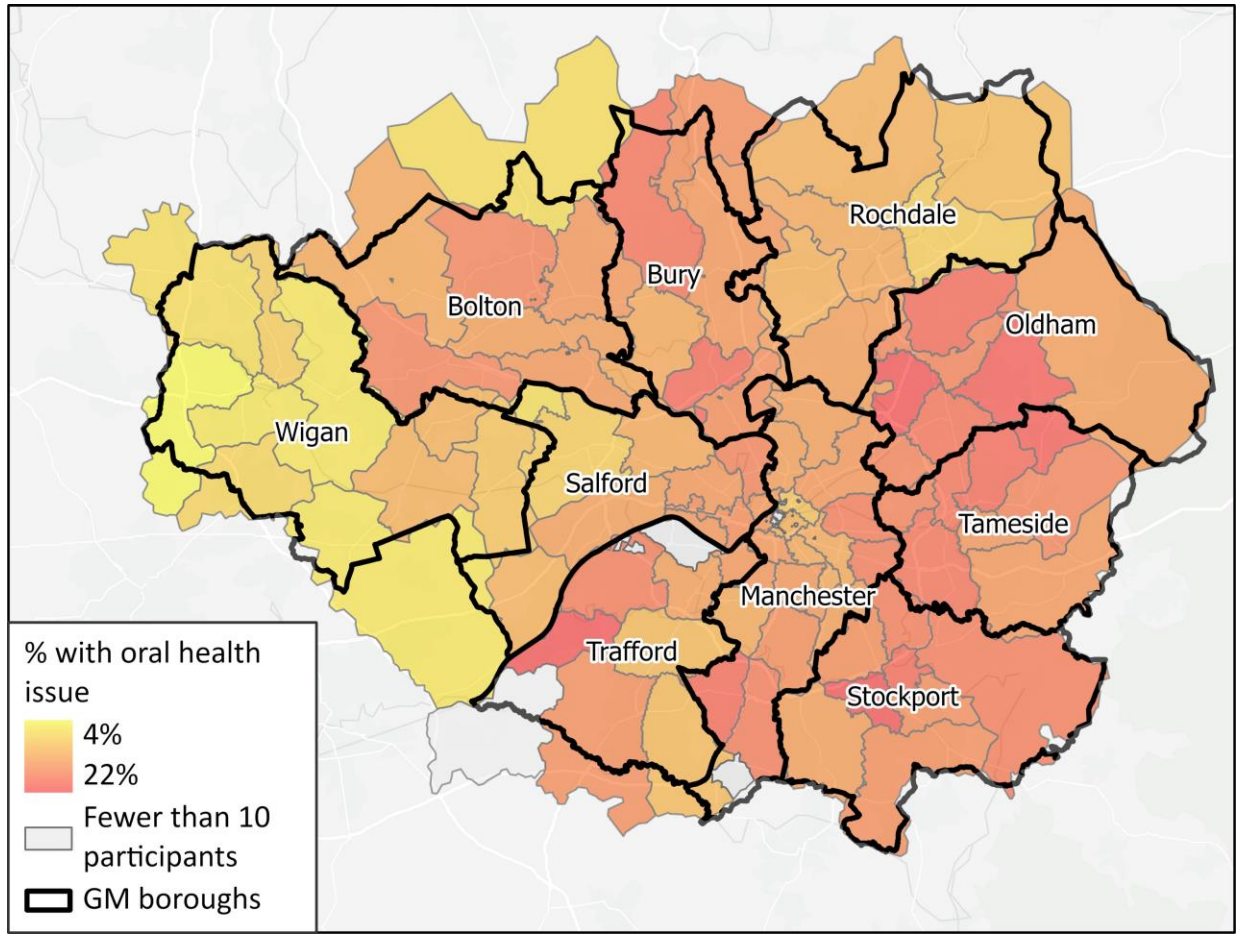
Oral health issues and dental registration by local authority

Local Authority	At least one oral health problem	% reporting at least one oral health problem	Not 'registered' with a dentist	% not registered at a dentist
Bolton	450	15%	1428	49%
Bury	238	17%	560	39%
Manchester	820	16%	2,137	42%
Oldham	518	20%	1,181	47%
Rochdale	248	12%	783	38%
Salford	336	13%	824	33%
Stockport	350	19%	702	38%
Tameside	385	18%	919	43%
Trafford	219	17%	424	33%
Wigan	185	8%	720	32%

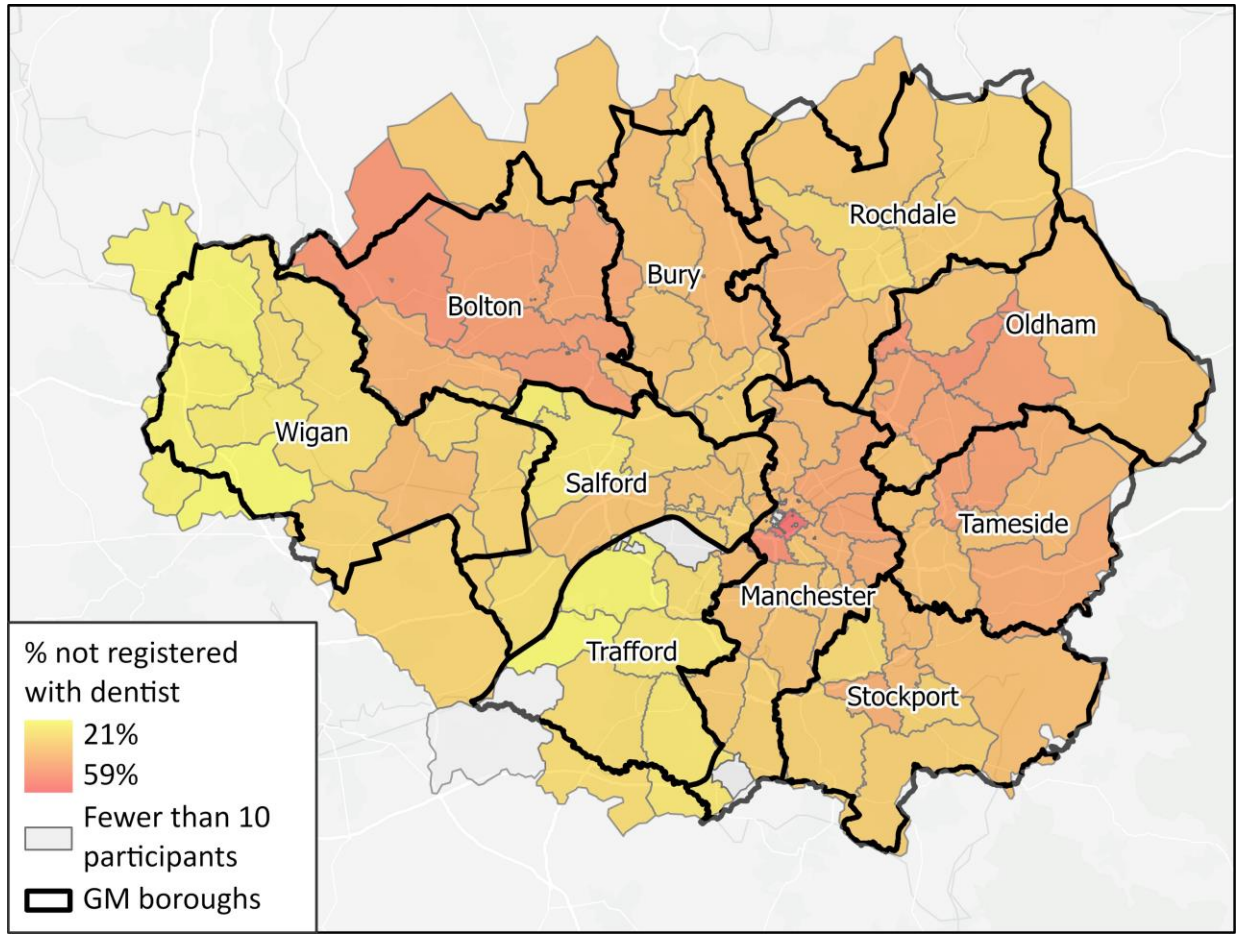
Source: WWWHP monitoring data

Oral health and dental access for WWWHP participants – by area (2)

Oral health issues by postcode district



Not 'registered' with a dentist by postcode district



Source: SQW 2024. Licence 100030994. Contains WWWHP monitoring data and Ordnance Survey data © Crown copyright and database right 2024.

Oral health and dental access for WWWHP participants – improvements

WWWHP monitoring data shows participants who have oral health issues and not 'registered' with a dentist upon joining are unlikely to have experienced a positive change in these situations while on the programme. These questions are re-asked at intermediate assessments which occur approximately every three months while out of work. For the 66% of participants with an intermediate assessment the average time between initial assessment and most recent assessment is a mean of 278 days / median of 295 days, and they show…

For changes in oral health:

- Just 45 out of 1,661 participants (3%) reported that they no longer had a problem or pain in their mouth at the time of intermediate assessment
- A further 29 participants without an issue at the start had developed an issue by the intermediate assessment

For changes in access to dentistry:

- Just 83 participants out of the 9,964 (1%) not 'registered' at the start had since 'registered' with a dentist
- A further 22 participants who were 'registered' at the start were no longer 'registered' by the intermediate assessment

This shows that to date participants have been very unlikely to experience an improvement in their oral health issues or to have 'registered' with a dentist while on the programme – which highlights an unmet need.

Relationship with employment outcomes

Participants who report no/fewer problems with their oral health and who are 'registered' with a dentist are more likely get a job and hit earnings thresholds measured using HMRC data. However, previous econometric analyses of Working Well monitoring data has not found a statistically significant relationship between oral health / dentist 'registration' and employment outcomes.

The figures below may therefore reflect the relationship between oral health and other characteristics – older participants and those with more health conditions are more likely to have oral health issues – which econometric analyses have found reduce the likelihood a participant achieves an employment outcome. Other factors found to be significant to employment outcomes include length of unemployment, confidence in starting work and engagement with the programme.

Each participant has a range of issues and corresponding support that contribute to them achieving (or not achieving) employment outcomes, of which dental issues will be just one factor, and this is complex to unpick.

Participant's dental situation upon joining	% achieving £1k milestone	% achieving EO	% achieving HEO
Oral health			
No oral health problems	37%	24%	17%
Problem/pain in mouth OR problems which stop smiling / speaking without embarrassment	33%	22%	16%
Problem/pain in mouth AND problems which stop smiling / speaking without embarrassment	30%	20%	14%
Dentist 'registration'			
'Registered' with a dentist	37%	25%	18%
Not 'registered' with a dentist	34%	22%	15%

Source: WWWHP monitoring data

EO and HEO definition

An Earnings Outcome (EO) is triggered when a client is employed and meets the accumulated earnings threshold – equivalent to working for 16 hours per week for 182 days at the adult rate (aged 25 or over) of the Real Living Wage – within 15 + 6 months of starting the programme. A Higher Earnings Outcomes is triggered when a client reaches the Earnings Outcome threshold within six months of starting work.

The WW RtD support offer

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How/why WW RtD was established

WW RtD resulted from separate approaches to NHS GM by WW team and UDHM about their respective needs which led to a link being made between UDHM and GMCA. The key rationale/contributors are summarised below.

Rationale/contributors for WWWHP

Oral ill health can be a barrier to finding and sustaining employment – but some participants faced difficulties in accessing dental care to address these issues due to:

- Being unable to afford treatment costs and associated costs such as travel and childcare
- Challenges around travel (e.g. anxiety, mobility issues)
- The broader challenge around availability of dental treatment, particularly in deprived areas, as cited earlier

Problem identified via:

- WW team's commitment to intelligence gathering and evaluation via WW monitoring data
- WW team undertaking site visits and speaking with KWs as an active and involved commissioner of WW programmes

WW team leveraging GMCA relationships to create solutions – in this instance via relationships with NHS GM

Rationale/contributors for UDHM

Students need to complete a range of procedures to graduate but it was challenging to provide sufficient numbers of patients requiring this range of straightforward treatments – with typical patients reached by UDHM having good dental hygiene

Students would benefit from engaging with people from a wider range of backgrounds

Desire for UDHM's offer to reach people who face challenges in accessing dental care and would benefit the most – and new General Dental Council requirement to factor social responsibility into teaching/assessment

Low attendance rates had led to previous projects targeting disadvantaged groups being stopped – WWWHP's offer of overseeing referrals, accompanying participants to appointments and financial support (e.g. for transport) reduced this risk

About the WW RtD support offer

The UDHM offer consists of:

- A digital pathway for direct referrals to UDHM
- Initial assessment and triage by qualified dental staff such as tutors
- A course of routine general dental care treatment which could last 12-18 months
- Treatment provided by undergraduate dental and hygiene therapy students, supervised by qualified tutor
- Ambition that participants will be able to access a local dentist after treatment when dentally healthy
- An information session for KWs on appropriate referrals and what the support offer would be

With WWWHP expected to support delivery by:

- Identifying appropriate participants for referral
- Sharing information about the offer with participants
- Providing transport planning for participant if needed
- Providing funding to remove costs as a barrier to access e.g. for transport, childcare
- Accompanying participants to appointments if they wished e.g. due to anxiety or sight/hearing impairment

The wider WW RtD and dental support offer to WW participants

There is a wider WW RtD offer and set of activity to support WW participants with dental needs, which has included:

- Involvement of WWWHP staff in local dental networks in each local authority that bring together local dental providers and stakeholders. These have since stopped due to ICP capacity to continue running the meetings.
- Referrals to Community Dental Service pathway for WW participants requiring access to a specialised setting for dental care (e.g. those with learning disabilities)

There had also been plans for training for Key Workers (KWs) from GM NHS around advocacy – raising awareness of oral health issues, empowering staff to advocate for oral health improvement using a behaviour change model, and helping KWs understand the dental landscape. A key aim for this strand was to embed a focus on prevention within WWWHP. Progress with this strand has been limited due to capacity and the cost implications of delivering a bespoke package for Working Well staff.

These evaluation slides are primarily concerned with evaluation of the UDHM WW RtD offer albeit some of the findings / recommendations may be relevant to these other activities.

Referrals and initial attendance

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Referral process for WW RtD

Identification

Key Workers identified appropriate participants informed by knowledge of participants and data on oral health issues from initial assessments.

Referral process

Referrals to WW RtD were made via an online form. This was established to enable easier monitoring and processing of the referrals by UDHM.

Numbers referred

WW RtD was opened for referrals in July 2023. The initial pilot was for **100 participants** and in **total 101 referrals** were **made. The pilot closed** for referrals in **September 2023 once this number had** been reached.

Initial triage

Once referred, qualified dental staff such as tutors triaged participants. It was felt that the initial triage needed to be undertaken by competent and confident staff to ensure the initial decision was correct, and participants were referred elsewhere if more appropriate.

Referrals to WW RtD – reasons for referral

Collected by WWWHP

- Reasons for referrals recorded by WWWHP staff are shown in the table. They were open text and of varying quality, but provide some illustration of the prevalence of different issues. That said, the true prevalence of each issue is likely higher as some reasons were as brief as 'bad teeth' – with no acknowledgement of whether the participant was experiencing pain, missing teeth, in need of particular treatment, could not access a dentist, etc.
- Where more detailed reasons were given they illustrate the issues and impact well: pain and embarrassment impacting on mental health; participants having resorted to removing their own teeth; issues with communication; and struggling to eat. For one participant, dental issues were the first thing they talked about when joining the programme.

Reason for referral	Count
Pain/ache	45
Bad teeth	22
Missing teeth	19
No access to dentist	15
Need fillings	12
Gum issues	11
Embarrassment	7
Broken teeth	6
Issue with fillings	3
Teeth extraction	3
Oral hygiene	2
Dentures	1

Note some participants had multiple issues

Collected by UDHM

Data collected by UDHM on participants' primary complaint found identified two themes: (1) complaints relating to physical issues causing pain and difficulties and (2) and aesthetic complaints.

Based on UDHM's review of case files it was concluded that the quality of referrals was good. All except one referral who attended the triage appointment were accepted and treated. The one participant not accepted was more appropriate for the Community Dental Service pathway so was referred onwards to this special care instead.

A baseline questionnaire run to capture the impact of oral health issues on participants' lives (using OHIP-14) and use of medical services suffered from low completion. This additional dataset would provide significant insight so exploring how to increase completion for any future schemes should be a priority.

Challenges around referrals

Delays to referral process launch

Delays in setting up the referral process delayed launch of the pilot. As a result: participants who had been identified for WW RtD by WWWHP staff (and in some cases told about the scheme) faced a long wait or in some cases had left the programme and were therefore ineligible; and time elapsed between the training for KWs and push on identifying referrals that happened when the launch was first anticipated, so that by the time of the actual launch it was possibly less of a priority in the minds of KWs. This was reported to be challenging at the time but is no longer an issue now that the referral process has been set up.

Early challenges

The level of referrals at the outset were not at the level expected. UDHM had capacity for 8 triage appointments per day which were not being filled, causing some frustration – particularly as some of the appointments were only available because staff were working during their holidays. To an extent this appears to have been due to misaligned expectations which points to a need for expectation management around potential referral numbers and flow of referrals. The allocation of staff resource was subsequently recalibrated over time to reflect the actual numbers/flow.

Of the 4,469 participants on WWWHP's caseload in Aug-23 there were just 619 participants who: (1) had reported an oral health issue upon joining and (2) were actively engaged. Furthermore, some of these participants will have been in work and so less actively engaged. There was therefore a fairly limited pool to source 100 referrals from. Some participants who were appropriate for the support declined it, including due to time/travel requirements and anxiousness (despite support available for these issues).

Factors that affected referral flow and numbers included:

- The delays to launch of the referral process (set out above)
- Launching around the summer holidays when historically participant engagement has been lower
- Referrals to new schemes often take time to ramp up (early positive feedback / good news stories are particularly important in generating subsequent referrals)
- Resource intensiveness of identifying and contacting appropriate referrals on the caseload

Attendance at initial appointment

Non-attendance rates
Of the 112 participants referred 76 attended their initial triage appointment (meaning an initial non-attendance rate of 32%). Positively, the rate of non-attendance reduced over the span of time the referral pathway was open.

How attendance rates were supported
Attendance rates were a focus of regular communication and close working between the partners. This included:

- Identifying and remedying issues driving non-attendance (set out on the next slide)
- Sharing information on appointment dates with WWWHP KWs so they could remind participants

Other activity to improve attendance included:

- UDHM provided information on the participant journey to KWs (in initial training and info leaflets) and participants (in info leaflets) to help them understand what attendance would entail.
- WWWHP's offer of KWs attending the initial appointment with participants
- WWWHP's support with travel, including travel planning and paying travel costs (this included paying for taxis) to avoid travel and cost being barriers to access
- WWWHP's financial support for other barriers to access, such as childcare

This was all resource intensive but initial attendance was identified as key to the success of the pilot. Previous schemes targeted other disadvantaged groups (such as homeless people) had been closed due to low attendance rates.

Reasons for non-attendance (1 of 2)

The table on the right sets out the reasons captured for participants not attending or rescheduling an initial appointment. Please note these are self-reported by participants and so are not necessarily accurate and/or true reflections of issues with the referral process e.g. around appointments not being issued.

Reason for DNA	Count
Unwell	14
Uncontactable	6
Work issues	5
Other	3
Forgot/not reminded	3
Exited programme	2
No appointment issued	2
Didn't want to attend	2
No childcare	2
Couldn't wait	1
Travel issues	1

Further issues around attendance identified through evaluation interviews include:

- Restrictions, inefficiencies and lags in sharing of attendance and treatment data caused by information governance and resourcing of the monitoring within UDHM have limited the ability of WWWHP staff to support attendance with reminders (noting the ambition to address this for future delivery)
- Difficulties for WWWHP staff collecting accurate attendance information through participants instead to support with reminders
- UDHM contacted participants on an unidentifiable caller ID which could perturb some participants from answering (noting texts were also sent to participants)
- The location of UDHM just south of central Manchester meant some participants had to travel far, with implications for time, those with anxiety around travelling and costs (noting the WWWHP offer of paying for travel costs) – gaps in tracking of attendance at initial appointments due to information sharing barriers makes this difficult to test however

(Continued on next slide)

Reasons for non-attendance (2 of 2)

(Continued) further issues include:

- No participant uptake of offer for KWs to accompany them – could this have been offered to participants differently to increase uptake?
- The push to reach 100 referrals is understood to have led to participants being referred with lower levels of need for dental treatment, who therefore have relatively less incentive to attend – this highlights the risk that focusing on the number of referrals can create
- Lack of clarity around roles and responsibilities between partners at the outset, and a need for more frequent direct communication between the provider and UDHM around the launch of the programme to partnership working and the prompt resolving of issues

Other reflections on referrals and attendance

WWWHP participants often face challenges that can make their lives less predictable. These include health issues and family problems. There does therefore need to be recognition and/or planning for an attendance rate that might be below that of the traditional UDHM patient.

There were plans to create a video for participants showing what attending an initial appointment would be like. This could be beneficial but may require funding.

Subsequent engagement and treatment/support

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Subsequent engagement

Subsequent engagement has been very good. UDHM's review of case files found that the 62 participants who had by that time progressed to treatment had received an average of 4 appointments each, with just 3 appointments (in total) not attended. This is equivalent to a non-attendance rate of just 1% for all treatment appointments. Participants who needed to re-arrange appointments had all provided sufficient notice.

As treatment is ongoing and more participants are expected to progress into treatment this could change – but for now the high subsequent engagement suggests that amongst those who attend their initial appointment there is good buy-in to the scheme and satisfaction. The feedback from participants to data supports this.

Treatment and support delivered

UDHM undertook an interim review of case files to understand the treatment delivered. As treatment is ongoing this was just an interim summary update. Participants will continue to receive treatment for around 12-18 months until they have good, stable oral health, at which point it is hoped general dental practices will be more willing to 'register' the participant (noting challenges in accessing NHS dentists for new patients might prove a barrier to this).

The treatment and support that had been delivered as of the end of January 2024 included:

- Instruction around oral hygiene and prevention (including prescription of high fluoride toothpaste, education on brushing teeth, discussion of diet)
- Treatment for gum disease with a three-month review cycle
- Treatment for dental decay e.g. fillings, addressing broken teeth
- Tooth extractions
- Dentures
- Root canals
- Crowns and bridges
- Information around smoking cessation
- Cancer screenings
- Onward referrals to dental surgery team

Supporting ongoing engagement

Monitoring engagement

The monitoring of ongoing engagement by UDHM and WWWHP has been challenging to date. Similar to data on initial attendance, there have been restrictions, inefficiencies and lags caused by information governance and resourcing of the monitoring within UDHM. It has relied on manual case reviews, and participant-level information on ongoing attendance could not be shared with WWWHP. WWWHP attempted to monitor attendance by relying on participants to self-report which has meant the data is unreliable and patchy.

Action is underway to improve this but the findings around subsequent engagement to date suggest that monitoring initial attendance should be the priority for monitoring if WWWHP or UDHM staff time needs to be prioritised. That said, if UDHM can monitor attendance in a streamlined/efficient manner and share results WWWHP efficiently this would enable WWWHP to better support attendance.

Supporting engagement

Reasons given for the small number of instances of non-attendance and re-arranged appointments have been difficulties with transport and childcare. This is despite the WWWHP support offer around these so KWs may need to better communicate any ongoing support offer. There are questions around the ongoing support offer though, specifically:

- Resource and cost implications: There is a time/cost implication to KWs attending subsequent treatments and providing ongoing financial support for transport (especially taxis) and childcare. Other WW programmes may be less able to provide this.
- Time limited support: Participants are potentially going to receive treatment beyond their time on WWWHP. Even if referred at the start of WWWHP some participants could receive around 18 months of treatment from WW RtD. Other Working Well programmes are considerably shorter than WWWHP so could not support attendance over a prolonged period.

Satisfaction

KW feedback on participant experiences is reported to be very positive to date. Some case studies of participants (on later slides) illustrate a couple of instances of this.

There are plans to capture participant satisfaction via a follow-up questionnaire delivered by UDHM around exit from WW RtD. Any complaints from WW RtD participants will also be monitored.

KWs have reportedly been keen for the scheme to re-open so additional participants can benefit, as there is a genuine need for it amongst their caseloads.

Impact and benefits of WW RtD

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Outcomes for participants (1)

Possible outcomes from WW RtD treatment include the following which we have categorised as either 'dental-related' or 'wider' and 'direct' or 'indirect':

Dental-related

Direct:

- Oral health/pain
- Appearance of mouth and related embarrassment

Indirect:

- Ability to access general NHS dentistry
- Use of health services

Wider and indirect

- Confidence
- Mental health and wellbeing
- Quality of life
- Employment outcomes
- Engagement with WWWHP (previously shown to have a significant relationship to employment outcomes)

As treatment is ongoing it is for the most part too early to capture these outcomes. The next slide sets out the options and feasibility for capturing the different outcomes.

Outcomes for participants (2)

Options for evidencing outcomes

- The follow-up questionnaire delivered by UDHM around exit from WW RtD which uses OHIP-14 and asks about employment outcomes (noting this will be anonymised and is not linkable to the baseline data to demonstrate distance travelled at the level of individual participants, nor to WWWHP monitoring data to augment it)
- Case studies by WWWHP providers highlighting WW RtD within participants' broader WWWHP journey (see following slides)
- UoM research teams interviewing participants
- WWWHP monitoring data covers employment outcomes (using HMRC data), confidence, mental health & engagement, however:
  - Monitoring by UDHM is anonymised so cannot be used to identify those receiving treatment – and gaps in attendance monitoring by WWWHP means just 51 participants can be identified as receiving treatment (of which 13 have hit a £1k earnings threshold
  - Scope for robust analysis of impact is further limited by: the small scale of the programme; lack of data on the severity of dental issues; the complex combination of issues and support that influence outcomes for participants; and the relative importance of oral health issues to employment outcomes compared to other factors.

Suggested approach

The direct outcomes such as reduced oral pain and embarrassment in appearance of teeth should be straightforward for UDHM to evidence using OHIP-14. Indirect and especially wider outcomes such as employment outcomes and mental health are less straightforward given the range of contributing factors. While it is reasonable to assume that addressing dental issues will contribute towards these outcomes, and for some participants it will be particularly important, we think the most viable approach to capture this would be via qualitative research rather than quantitative analysis.

Tamzin's story

When Tamzin joined WWWHP she was suffering from low confidence in her appearance. This was the result of anxiety, past issues with a skin condition, and issues with the appearance of her teeth. This had all impacted on her mental health. Tamzin expressed concerns to her Key Worker that she did not feel comfortable attending the WWWHP office and workshops due to her appearance, and felt it was impacting on her job prospects too. Tamzin was also suffering from pain when eating and sensitivity in her teeth.

Tamzin's Key Worker referred her to WW RtD to get support with her dental issues. She has started to receive treatment which will include roots canals, fillings and veneers over the course of 12 months. She is attending appointments for her WW RtD treatment every week and was also able to get her father a referral for new dentures.

The treatment has improved her self-confidence and overall quality of life. She explained what WW RtD had done for her, and the impact it was having:

> *"Previously I struggled with pain when eating and sensitivity all the time. I could not drink without a straw, and this makes people look funny at you. Now I have had two root canals on my front teeth, I can bite better and eat better, and it's not sore. I feel more confident to smile as my teeth are a much better colour. I can't wait to have the rest of them done. It will take up to a year. I think it will improve my employment prospects by looking better and having less pain."*

Tamzin was keen to get a job working outside and was interested in working in the railway industry. She has now completed a Railway Engineering course and Construction Skills Certification Scheme to help her employment prospects.

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Carol's story

Carol is looking for part-time work in customer service, ideally in a library or café, and feels her appearance is holding her back. Her Key Worker had noticed Carol seemed embarrassed of her dental appearance she avoided would not open her mouth properly when talking and kept covering her mouth. As a result, her Key Worker explained to her about the WW RtD scheme.

Carol explained that she had been unable to find an NHS dentist for years despite trying. She had been several missing teeth, including her front teeth on her top jaw, several teeth that required extraction or fillings, and intermittent dental pain. This caused sleep problems and had made it difficult to eat a balanced diet due to difficulties chewing, and made it difficult to drink cold and hot drinks.

She was initially anxious about being treated in an open plan area with lots of people. However, she overcame this when she experienced how welcoming the students were. She has two further appointments left to complete the course of treatment and feels that when the treatment is completed she will be less self-conscious of her appearance. Carol explained the impact of the support from WW RtD:

> *"This is a massive thing for me …. I just couldn't find a dentist and if I had the cost would have been too much … I think it does affect my chances of working because in a café – who wants to see a person working there with bad teeth?"*

Her Key Worker has noticed the excitement in Carol when she talks about the treatment. When Carol thought she might have the treatment completed by the end of 2024 she said: "this is the best Christmas present ever." Her Key Worker feels that this confidence boost is just what Carol needs as she is always doing everything for other people and not for herself.

Impact on UDHM

Early student feedback has been positive. UDHM students are now benefitting from engaging with patients who need a wide range of treatments, including more complex treatments, and come from a greater diversity of backgrounds. Staff considered the experience they were gaining beneficial both for their technical skills and their softer skills.

Student feedback will continue to be monitored by UDHM. Patient behaviour is also monitored to understand how the cohort are responding to the treatment.

WW RtD also aligns well with the new requirement from the General Dental Council to factor social responsibility into teaching and assessment.

Future plans for WW RtD

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Re-opening WW RtD

Opening WW RtD for referrals

The re-opening of WW RtD is currently under consideration with a suggested capacity of 200-300 participants per year. This could entail:

- Opening WW RtD back up to referrals from WWWHP
- Opening WW RtD up to referrals from other WW programmes

Alternative referral routes

Other options that were suggested for consideration include the following – although there may be good reasons not to pursue either option:

- Key Workers – who would then better understand the scheme
- Participants' family and friends – spreading the benefits

The final slides reflect on key learning to factor into the re-opening WW RtD and the possible expansion to new programmes.

Evolving WW RtD and translating WW RtD model to other health needs

Evolving WW RtD offer

WW RtD may evolve further, with an option under consideration being that a patient will be attached to a specific student who will follow them through from initial assessment to completion of treatment. This would be a novel approach that is anticipated to be very beneficial to the development of softer skills. Students would need to be sufficiently experienced so this approach is being considered for 4th year students.

Translating WW RtD

The WW RtD model of collaborating with universities for a mutually beneficial and social responsibility focused scheme is being considered for other health needs, including:

- Physiotherapists (13% of participants report problems with their arms/back/hands/feet/neck)
- Clinical psychologists (30% of participants report a mental health condition)

Much of the learning around WW RtD set out in the final slides could apply to these schemes.

Scale of demand for re-opening WW RtD

If expanding WW RtD or developing new schemes the scale of demand against supply will be important. We recommend exploring the potential scale of demand across WWWHP and the four other WW programmes based on current caseloads and expected on-flows.

Potential demand for WWWHP and Pioneers
For WWWHP and WW Pioneer we estimate a potential pool of 721 referrals amongst new joiners based on:

- 5,839 starts profiled between Sep-23 (when WW RtD closed for referrals) and Sep-24 (when WWWHP/Pioneers close for referrals)
- Proportion reporting an oral health issue amongst starters since Jan-23 (which has been 14% and 10% respectively)

However, of these, an unknown proportion won't have severe issues, would decline a referral and/or might disengage – so the true scale of demand would likely be less. There may be additional participants who joined before Sep-23 who need support though.

Expanding to other WW programmes would further increase demand. Of the 184 participants started to date on WWIPSPC 17% reported a dental issue and 20% said they would like to see a dentist. Equivalent figures for other WW programmes are not known.

Embedding referrals
Referrals to WW RtD could be generated going forwards by building the referral in as a potential action based on responses to the dental question in initial assessment

Criteria for appropriate referrals
KWs should have clear criteria to ensure referrals are appropriate (and to help prioritise places?)

Learning and recommendations

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WW RtD's successes

The WW RtD pilot has been successful in that:

- It achieved its target referrals and most of those referred attended their initial appointment, with subsequently high levels of attendance.
- Participants are receiving dental treatment they might otherwise struggle to get. WWWHP monitoring data shows that most participants with oral health issues did not experience an improvement during their time on the programme. WW RtD is helping to meet this need.
- Improved oral health is anticipated to have a positive effect on their quality of life and employment prospects. Emerging findings support this.
- Meanwhile, it appears to have benefitted UDHM students who are now treating a greater diversity of patients to develop both their technical skills and soft skills.
- It has generated learning for a re-opening or expansion of WW RtD, and for the possible translation of the model to support health issues.

This success is down to individuals in UDHM, GMCA, WWWHP providers and NHS GM who have made the scheme happen and driven its delivery.

WW RtD's issues for reflection

Key issues for reflection for the pilot have been around:

- The need to minimise the requirements on all staff involved as far as possible. In particular the management and monitoring of referrals and attendance needs to be done in an efficient and streamlined way. The pilot involved a lot of resource to deliver across all partners disproportionate to a relatively small scheme (albeit one that there is now scope to roll out more widely to more participants, more programmes, more health areas and possibly elsewhere in the country). Reducing resource to sustaining the programme. requirements as services become more routine will be key
- How to maintain and further improve the initial attendance rate. If prioritising monitoring resource, this should be the main focus of any monitoring in a future roll-out given initial non-attendance was quite high and subsequent non-attendance very low.
- Information governance, which was partly responsible for the issues above. Resolving these issues has been a key focus throughout the pilot's delivery.

These issues and others are considered in the final slides along with recommendations for any future delivery of WW RtD or similar schemes.

Issue: Resourcing, monitoring, oversight and information sharing

Recommendations:

- Develop project plan and SLA/MoU for next phase setting out details including roles, responsibilities and frequency of update meetings.
- Agree extent of referral/attendance monitoring and:
  - Establish corresponding DPIA between UDHM and WW programmes (in progress)
  - Identify resource within UDHM/WWWHP for monitoring and sharing updates
  - Streamline updates to / requests from WW programmes – especially if for multiple WW programmes
  - Prioritise initial attendance over subsequent attendance if unable to automate/resource/streamline sufficiently
- Assist communication between partners by:
  - Share WW organogram featuring key organisations, contacts and roles within GMCA and each WW programme, with an explanation of each's role, to help understanding of UDHM and other partners.
  - Identify alternative contacts within WWWHP/UDHM to reduce likelihood of delays/bottlenecks.

Issue: Reducing/maintaining non-attendance rates

Recommendations:

Focus on likely reasons for non-attendance: knowledge of appointment date, anxiety, travel, and buy-in.

Anxiety:
- Consider how 'handholding' by KW is offered to participants
- Consider video of first appointment from participant perspective

Travel:
- Agree extent of travel support available e.g. are taxis permissible for 12 months of support?
- WWWHP to consider alternative approaches for participants to travel (e.g. minibus for multiple participants from WWWHP offices)
- UDHM to consider feasibility of outreach approaches/locations

Knowledge of appointment:
- Share with KWs in streamlined manner and ideally in real time
- UDHM to consider use of an identifiable phone number when calling participants

Buy-in:
- Focus on referral appropriateness/willingness rather than referral numbers

Issue: WW staff turnover = risk of awareness/knowledge of WW RtD being lost

Recommendations:

- Build WW RtD into new KW training
- Considering regular webinars by UDHM staff to provide reminders and reduce risk of errors e.g. once every six months
- Capture and circulate good news stories to staff.

Issue: Achieving smooth roll-out for: (1) WW RtD to other WW programmes and (2) WW RtD model to other areas

Recommendations:

- Pilot use of the referral tracker before a full roll-out
- Wait until referral process is in place to train WW staff and start identifying participants
- Access to good news stories from WWWHP to sell programme to staff
- Schedule regular meetings around launch
- Manage expectations and plan to re-calibrate during early stages.

Issue: Future evaluation

Recommendations:

For process/implementation evaluation, prioritise:

- UDHM to monitor number of referrals and attendance (is there scope to monitor 'quality' too?)
- UDHM final questionnaire to capture whether participants expect to 'register' for dentist

For impact we suggest:

- Use UDHM baseline and exit questionnaires to evidence direct and anticipated indirect dental impacts (which can be anticipated to contribute to wider impacts) and improve this evidence base by:
  - Increasing completion of baseline questionnaires
  - Achieving high completion rate of exit questionnaires
  - Exploring ability to link baseline/exit questionnaires in future roll-out

- A focus on qualitative evidence to tell the story of WW RtD's impact on wider outcomes:
  - Capture qualitative evidence on wider impacts at exit via questionnaire in final UDHM appointment
  - WW provider case studies to tell the stories of participants supported WW RtD and its contribution to outcomes relative to other factors

Research, analysis and advice on economic and social development

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