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Dentists' perceptions of their professional roles regarding referrals within primary dental care in England: a qualitative study

Zoe Allen, Janet Richardson, Mona Nasser and David Moles

Faculty of Health: Medicine, Dentistry & Human Sciences, University of Plymouth

Objective: To describe dentists' perceptions of their professional roles, including the reasons why they make, accept or decline patient referrals within primary dental care in England. ***Basic research design***: Qualitative semi-structured interviews, conducted via Skype, telephone or face-to-face. Transcripts were analysed using thematic analysis and typologies were developed. ***Participants***: Ten general dental practitioners (GDPs) and 12 community dentists working in England. ***Results***: Five main themes were identified: professional independence, the nature of dental care, the business of dentistry, obscure rules and 'no man's land'. This final theme described a notional gap between GDPs' and community dentists' responsibilities towards vulnerable people, who were perceived by participants to include frail older people, anxious and socially marginalised adults and children with high levels of disease. Three typologies of dentists were generated. 'Entrepreneurs' felt no allegiance to the National Health Service and no obligation to treat vulnerable patients. 'Altruistic carers' were committed to caring for exceptionally deserving patients. 'Pragmatic carers' tried to provide relational dental care (time and emotional support) for vulnerable patients but encountered discouraging systemic barriers. ***Conclusion***: Dentists' perceptions of their roles may influence whether and how they provide access to primary dental care for vulnerable people through referral systems. Access issues may exacerbate the oral health inequalities experienced by vulnerable groups. Based upon the findings, approaches are proposed that may encourage and enable the dental workforce to support vulnerable people actively to receive primary dental care.

Keywords: *Dentistry, Qualitative methods, England, Primary care, Professional identity*

Introduction

Most primary dental care in England is provided by general dental practitioners (GDPs) (NHS England, 2015a). GDPs work in independent or corporate-owned dental practices (Steele, 2009, NHS England, 2014). They may provide private dentistry as well as holding General Dental Services (GDS) contracts to provide dentistry under National Health Service (NHS) regulations (Boyle, 2011). There is significant variation in the distribution and availability of GDPs providing NHS dentistry across England (Boyle, 2011).

Community Dental Services (CDSs) also provide primary dental care (NHS Primary Care Commissioning, 2010, NHS Commissioning Board, 2013) and accept referrals from GDPs for various types of dental care, including treatment under conscious sedation or general anaesthesia (Boyle, 2011, NHS Primary Care Commissioning, 2010). There is local variation in the range of services provided by CDSs (NHS Primary Care Commissioning, 2010). Historically, CDSs also had a safety-net role, providing routine dental care for people who were unable to access primary dental care from GDPs (NHS Commissioning Board, 2013). Recently, CDS commissioning has focused upon specialist services, notably Paediatric and Special Care Dentistry (NHS England, 2015b, NHS England, 2018).

GDPs can refer patients to other generalist or specialist dentists when they consider patients' care to be beyond their 'competence' (p.58, General Dental Council, 2013). Thus, GDPs act as gatekeepers to many referral services within primary and secondary dental care in England (General Dental Council, 2013) and their decisions about whether, and where, to refer a patient, could lead to variations in the care that those patients are able to receive. Similarly, the capacity of CDSs and secondary care organisations and the willingness of community dentists and specialists to accept those referrals will also influence their availability to patients.

A systematic literature review of referral pathways in primary dental care indicated that dentists exercise considerable autonomy to influence the referral process, when making and receiving referrals within primary dental care (Allen, 2018). Dentists' decisions appeared to be influenced by non-clinical factors, including their perceptions of their own roles and those of other dentists. Dentists' perceptions of their professional roles in relation to referral decisions have not been explored in depth previously. Therefore, the aim of this study was to describe dentists' perceptions of their professional roles within primary dental care in England, with particular reference to making and receiving referrals. The research objectives were to consider what it means to be a GDP or a community dentist and how these meanings, perceptions and expectations relate to the experience of making and receiving referrals, within primary dental care.

Correspondence to: Zoe Allen, Faculty of Health: Medicine, Dentistry & Human Sciences, University of Plymouth.
Email: zoe.allen@plymouth.ac.uk

Method

This qualitative study was designed to understand the meanings which participants constructed to explain their actions and decisions, rather than to test a hypothesis. This design facilitates a deeper understanding of participants' individual perspectives and patterns of socially constructed meanings, generating concepts which could be tested on a larger scale using other research methods. Semi-structured interviews (Legard *et al*., 2003) were used to derive a rich, descriptive interpretation of participants' social worlds through their own words (Snape and Spencer, 2003). The study population included dentists working as GDPs and community dentists in England only, due to distinct differences in primary dental care provision between the devolved nations and England (NHS Scotland, 2006, Boyle, 2011, Donaldson, 2014, Knowledge and Analytical Services, 2015). The Research Ethics Committee of the Faculty of Health and Human Sciences, University of Plymouth, approved the study.

Purposive sampling (Ritchie *et al*., 2003, Braun and Clarke, 2013) was achieved by contacting participants via local and national professional bodies, creating a heterogeneous sample of dentists at all stages in their careers, working throughout England. An invitational message about the study was distributed by email, leaflets and brief oral presentations at professional events. Invitations provided a link to the study webpage, giving access to participant information and consent forms. Participants and other professional contacts also shared information about the study with their own professional contacts, in a snowballing approach (Ritchie *et al*., 2003). Recruitment ceased when all of the known professional bodies had been approached to cascade the invitation to members, by which point data saturation was also apparent.

In order to conduct the research with participants across a large geography, interviews were conducted via telephone (14 interviews), Skype (five interviews) or in person (three interviews) (Seitz, 2015). Valid consent was obtained in writing before arranging interviews and confirmed verbally at the start of each interview. One researcher (ZA) conducted all interviews using open questions from a topic guide based on a preliminary systematic literature review (Braun and Clarke, 2013; Allen, 2018). Interviews ranged in duration from 33 to 88 minutes and were audio-recorded, transcribed by ZA and managed using NVivo 11 software.

Data were analysed using thematic analysis (Braun and Clarke, 2006), a commonly used qualitative method that enables the researcher to record and interpret patterns (themes) in a data set. Analysis was carried out primarily by one researcher (ZA), concurrently with data collection. Early transcripts were coded separately by several researchers (JR, MN, DM) in order to check consistency of coding. Initial codes and themes were discussed with a second researcher (JR) at each iteration. 'Typologies' (p.214, Spencer *et al*., 2003), representing groups of people who share social characteristics, were also developed.

Results

Characteristics of participants

Twenty-two dentists were interviewed between January and May 2016. Twelve worked primarily in CDSs (of whom, six were specialists) and ten worked in general dental practice (of whom, six were principal dentists). Two participants were foundation dentists and four had experience of working in corporate dental practices. Participants worked in rural, suburban and urban areas located throughout England (Table 1).

Table 1. Characteristics of Participants

Role	*Gender*	*Years since qualifying*			*Combined total*
		Up to 10 years	*11-30 years*	*31+ years*	
GDP	Male	1	4	3	8
	Female	1	1	0	2
Community dentist	Male	0	2	1	3
	Female	2	4	3	9
Combined total		4	11	7	22

Key themes

Five key themes were generated:

- Professional independence;
- The nature of care;
- The business of dentistry;
- Obscure rules;
- 'No man's land'.

Aspects of each theme were identified across many participant interviews. The quotations provided in this section have been selected as concise illustrations of the themes, including conflicting viewpoints.

Professional independence

Participants emphasised their desire for clinical autonomy but also illustrated how professional independence contributed to disconnections between dentists, impeding communication and patient care. Some participants appeared to prefer working in relative isolation, whilst others felt a strong allegiance to colleagues, communities or the NHS.

Many participants expressed a strong need to exercise clinical autonomy in their roles, which they associated with independence and control.

'I've always worked in a small friendly practice that allows you to be your own boss…' (GDP2)

Curtailment of participants' clinical autonomy was associated with frustration and disillusionment.

'…not a lot of autonomy, so you just do what you've been told to do, you can't do anything more.' (CDS10)

Some GDPs sought wider professional autonomy, criticising 'far too much interference' (GDP9) from the Care Quality Commission. They were unwilling to engage with the NHS:

'…would I advise anyone to go into the NHS? No, don't join the NHS… I think as soon as you can get out of it, the better you are…' (GDP4)

Most participants indicated that communication between dentists working in different primary dental care settings was very limited. GDPs perceived CDSs to be impersonal, rarely knowing the names or faces of dentists in their local service.

'*I think the referral process is horrendous… Now there's a triage system, you've no idea… who they're seeing, it could be anybody.*' (GDP4)

Many GDPs felt that they were 'just left in the dark all the time' (GDP9) and put the onus on the CDS to provide them with clear information about what the CDS could offer their patients. Some generalist community dentists were unclear about how GDPs could access information about their services' referral processes, stating 'I don't know how they know' (CDS8). They did not engage with GDPs beyond rejecting referrals or discharging patients, usually in writing. Several senior community dentists had struggled to engage with younger GDPs and those new to their area, who did not use conventional professional networks:

'…[GDPs] should be involved within the Managed Clinical Network. The difficulty is getting them to the meetings.' (CDS2)

Notably, neither independent GDPs, nor community dentists, felt that they had any significant connections with dentists working in corporate dental practices:

'*What you don't get [at professional meetings] is the associates working in the corporates, and it's the corporates that are the ones sending in the silly referrals.*' (CDS12)

All participants considered themselves to have a professional responsibility for individual patients' oral health. However, some described feeling a broader social responsibility for people's general wellbeing or for a local community.

'…we very much try to embed ourselves within the community; we get involved with lots of fundraising things…' (GDP8)

Community dentists' career choices were often underpinned by a social motivating factor, such as 'trying to help people' (CDS1). Many highlighted their multidisciplinary work within the NHS. Several GDPs also felt an allegiance to the NHS:

'*…I fundamentally believe in the NHS, and that the general public should be able to access NHS dentistry.*' (GDP6)

The nature of care

Almost all participants declared that providing high quality care was important to them. Quality and time were intrinsically linked for many participants:

'*…being totally private… I have been able to take the time and effort it takes to get certain treatments done.*' (GDP5)

Some participants felt unable to achieve high quality care for all, due to the perception of time constraints that were attributed to the GDS contract.

'*…a more time-consuming patient costs the practice more money because of the time spent per appointment, and it's a shame that… you're not possibly remunerated to allow you to do that.*' (GDP2)

However, participants differed in their interpretation of the nature of the care they aimed to deliver. Some participants placed more emphasis upon using exemplary technical skills to treat dental disease. In contrast, others prioritised a 'holistic' (CDS2), patient-centred approach to care.

The business of dentistry

Participants consistently described the collective purpose of general dental practices, and the role of GDPs themselves, in terms of providing most dental care for most of the population. For all the participating associates and principal dentists, the financial bottom line was fundamental:

'…what you get paid will also move you in a certain direction in how you treat patients. It's inevitable… at the end of the day, the practice has to make a profit and you have to make a living...' (GDP4)

For some GDPs, 'buying and… selling [dental] practices' (GDP7) was 'great fun' (GDP7), adding interest to their careers, whilst for others, 'it was the obvious thing to do' (GDP9).

When achieving quality care and running a business were perceived to be mutually incompatible under the GDS contract, some participants moved into private dentistry. For some GDPs, this had been a pro-active plan to deal with having 'too many patients' (GDP9). For others, the 'difficult decision' (GDP6) to convert to private practice was taken reluctantly and generated a feeling of 'guilt' (GDP8); however, all felt the process had been successful and none planned to return to NHS practice.

GDPs perceived that some 'demanding patients' (GDP5) could not be treated cost-effectively within the GDS contract, because they needed more time or support during a course of treatment. Although a few GDPs indicated that they were prepared to absorb costs occasionally, in order to provide uneconomic care for patients, they emphasised that this was becoming 'financially untenable' (GDP8):

'*You couldn't have a day list of patients like that but the odd patient… I treat within practice, yeah.*' (GDP2)

Obscure rules

Participants' perceptions of the purpose of the CDS and the roles of community dentists were inconsistent, even between community dentists themselves. Some depicted specialist-led services for adults and children with complex additional needs, which rejected referrals for more straightforward situations. Others described working as generalist community dentists, providing routine care for socially marginalised people but unable to provide care that was more complex:

'…unfortunately our service doesn't have [intravenous sedation], and no general anaesthetic services, we refer out to other hospitals for general anaesthetic.' (CDS3)

In particular, the role of the CDS in delivering domiciliary care for frail older people, sedation for anxious people and routine treatment for people with extensive dental disease, appeared to be contested.

'*…it doesn't need specialist care… going to somebody's house to replace a set of dentures for them [when] they've lost them in hospital doesn't really need the community dental service to do that…*' (CDS5)

Some senior community dentists described what they felt were successful organisations, providing 'seamless'

(CDS2) patient care. However, most GDPs, and some community dentists, claimed that their local CDS was chronically under-resourced, or failing to provide the quality and range of services that they expected for patients.

'*It got quite mixed up and complicated because there was a merger in the services… sometimes we do accept [patients] but then we can't do any treatment, we then have to refer them to another service*.' (CDS4)

Participants reported acceptance criteria and service provision that appeared to vary between or within services, for unclear reasons that were thought to relate to commissioning decisions.

'*…we used to take a mobile dental unit into homeless projects… since we've been taken over that no longer happens…*' (CDS11)

Several GDPs felt they had encountered obscure and confusing rules whilst attempting to navigate referral processes on behalf of their patients.

'*…it is often frustrating when some referrals come back to me with refusals, saying that it is not… justified… and, I think, also causes some frustration for the patient, because they have to wait even further.*' (GDP3)

'No man's land'

A notional gap seemed to exist between the types of patients for whom GDPs considered themselves responsible, and those for whom the community dentists expected to provide care:

'*...there are lots of patients that it isn't so clear where they should go, and they sometimes get bounced around and fall in between the spaces and the gaps…*' (GDP8)

In this 'no man's land' (CDS1), participants positioned several groups of vulnerable people, including some young children, anxious and socially marginalised adults and frail elderly people. They were described as having more dental disease and more chaotic or dependent lives than other patients attending general dental practices.

'*…I always knew the kind of person… they just dropped off or disappeared sometimes… there was a lot of people that we felt like we couldn't help, for various reasons…*' (GDP5)

Some GDPs felt that dentists required special skills, beyond those of a GDP, to manage vulnerable patients:

'*He works in community… he is amazing… he treats patients that most people can't even treat … those kind of skills are not being taught, not at the level that he can do it at.*' (GDP4)

However, some community dentists felt that GDPs could, and should, provide more support and time for 'slightly challenging' (CDS5) patients in general dental practice. Consequently, they were not perceived to be sufficiently 'deserving' (GDP2) of access to CDSs.

'*…they'll send them in saying… 'multiple caries and child is uncooperative'… and the child turns out to be not in the least bit frightened… they didn't want to have to see a child with six carious teeth.*' (CDS12)

Several participants explained how they had 'bent the rules' (CDS10), in general dental practice or a CDS, to accommodate vulnerable patients. However, opinion was divided as to whether, in principle, responsibility for these groups should lie with community dentists, GDPs or both.

Dentist typologies

Participating dentists clustered into three typologies in terms of their role perceptions: entrepreneurs, pragmatic carers and altruistic carers. Entrepreneurs were highly motivated to own and run dental practices as businesses, offering their technical dental skills to patients who were willing to pay for them privately. These GDPs valued their independence exceptionally highly.

Pragmatic carers, whether working as GDPs or generalist community dentists, aimed to balance providing dental care for a whole community with earning a reliable salary or activity-based income. They described bending rules to do their best for patients, providing domiciliary care or sedation for patients in need. Some GDPs were willing to accept the financial burden of treatment decisions on an occasional basis; some had struggled with the decision to convert from NHS to private practice. They expressed frustration and disillusionment with the GDS contract and chronic under-resourcing and organisational change in CDSs.

Altruistic carers were dedicated to helping people whom they perceived to be the most deserving in society; some described this as their vocation. They were usually specialists in Paediatric or Special Care Dentistry, committed to a career working entirely within the NHS, in which the cost of providing patient care was not reflected in their salary. They were devoted to the concept of holistic care, often collaborating across healthcare organisations to deliver patient-centred treatment plans for people with complex medical conditions and impairments.

Discussion

This study illustrates how primary care dentists perceive their roles in patient care and the personal priorities and structural factors that influence how they carry out those roles.

Dentists who felt it was within their professional role to provide care for the whole community, including vulnerable people, expressed feelings of disillusionment, demoralisation and powerlessness. Unable to overcome the structural barriers of NHS contracting and organisational transition towards specialisation, these pragmatic carers appeared to be experiencing role conflict (Kahn *et al*., 1964). Reluctantly referring vulnerable people from general dental practices, or reluctantly rejecting them from CDSs, they felt they were not adequately meeting the needs of the vulnerable people in 'no man's land'. Conversely, the same structural factors appeared to support and sustain the professional role perceptions of entrepreneurs and altruistic carers, who described feeling fulfilled and autonomous. This spectrum of role perceptions is consistent with patients' perceptions of dental practices, which range from 'public service' to 'consumer-orientated' (Dyer *et al*., 2013).

Participants recognised that providing dental care for vulnerable people requires dentists to forge empathic dentist-patient relationships with patients whose lives, expectations and priorities differ markedly from dentists' own. It calls for dentists to provide time and emotional support to enable patients to cope with routine dental procedures. Scambler et al. (2015) established that

people living with disabilities felt that spending time, showing patience and being able 'to see the human being underneath' (p.111) was critical to dental teams gaining their trust and delivering their dental care. Dyer et al. (2013) found that time also enhanced patients' trust in dental teams when their dental care was delegated to dental therapists. This type of relational work (Fletcher, 2001) can be described as relational dental care. Motivation to provide relational dental care is consistent with the strong sense of obligation which community dentists have expressed towards vulnerable patients in the past (Mander, 1993). In this study, a sense of obligation was also evident in some GDPs. It contrasts with the tangible, technical work which has traditionally underpinned the ethos of dentistry, especially general dental practice (Taylor-Gooby *et al*., 2000), and which is valued in units of dental activity for GDS contracts (Steele, 2009).

Mills et al. (2015) found that patients identified five 'relational aspects of care: connection, attitude, communication, empowerment and feeling valued' (p.409). In this study, dentists themselves were conscious of patients' need for relational dental care but appeared to vary in their willingness to provide it for vulnerable people, who are generally unable to pay privately for GDPs' time and support but do not necessarily meet increasingly stringent eligibility criteria to access additional time and support from CDSs. Participants' descriptions indicated that people with hidden disabilities (such as some mental health problems and learning disabilities) and socially marginalised people were deemed to be vulnerable. Such people have reported 'feeling stigmatised' and considered an inconvenience in general dental practices (p.111, Scambler *et al*., 2015). Some reported feeling their referral was made for convenience by GDPs, only to find themselves 'caught between' providers as they were 'not sufficiently disabled' to meet CDS eligibility criteria (p.111, Scambler *et al*., 2015). This study concurs that professional responsibility for vulnerable people is contested, leaving some vulnerable people without reliable, consistent access to primary dental care. Furthermore, as GDPs have a gatekeeper role, access to other specialist dental services via referral may also be disproportionately impeded. National epidemiological data shows that vulnerable people are most likely to experience the greatest burden of oral disease (Nuttall *et al*., 2011, Steele *et al*., 2015). Consequently, this gap in access may exacerbate the oral health inequalities experienced by vulnerable people, including those with hidden disabilities.

Based upon these findings, approaches to improving access to primary dental care for vulnerable people may include developments, summarised below, in dental contracts, commissioning, workforce opportunities, training and recruitment.

The current GDS contract does not overtly value the relational dental care that some patients need their dentists to provide. This creates a barrier to providing NHS care for vulnerable patients in dental practices. This could be reduced by weighting dentists' payments according to patient characteristics which relate to their vulnerability, but which are not subjectively determined by GDPs (Grytten, 2017). Additionally, commissioners could fund dentists on a salaried basis to support vulnerable patients when dental care may not be financially viable in a business context. Options include acknowledging hidden disabilities and social aspects of vulnerability in CDS eligibility criteria. Creating salaried posts in general dental practices could enable more GDPs to focus on relational dental care for vulnerable patients, as adopted in Scotland to manage rural access issues (NHS Scotland, 2006).

Many participants indicated that their career decisions were influenced by clinical experiences during their undergraduate training. Ensuring all dental students spend time working with vulnerable people and enthusiastic clinical educators through outreach placements may normalise relational dental care. In addition to adopting values-based recruitment of dental students (Kay *et al*., 2010), dental schools and professional bodies could actively promote alternatives to working in general dental practice as a career. Furthermore, dental schools could encourage people who want to work with vulnerable people to do so through a dental career.

Strengths and limitations

This study provides insight into primary care dentists' perceptions of their professional roles regarding referrals within primary dental care. GDPs' perceptions of their professional roles have not been explored in depth since the 2006 GDS contract was introduced (Nettleton, 1992, Taylor-Gooby *et al*., 2000). Community dentists' perceived professional roles have not been considered since the early 1990s (Mander, 1993) and have not included in-depth interviews about receiving referrals. It was relatively difficult to recruit recently qualified dentists and dentists working in corporate dental practices; additional recruitment via online professional networks may have widened participation.

Conclusions

Dentists' perceptions of their professional roles influence their decisions to make, accept or decline referrals within primary dental care in England. These decisions can negatively affect access to primary dental care for vulnerable people, exacerbating oral health inequalities. Dentists' perceptions are influenced by their willingness to provide relational dental care for vulnerable people and by structural factors such as GDS contracts and reduction of the CDS safety-net function. We have suggested several approaches to encourage and enable the dental workforce to actively support vulnerable people to receive dental care.

Declaration of conflicting interests

The authors declare no conflicts of interest.

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