Listening to older adults: community consultation on a new dental service

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Background: Increased life expectancy, retention of a natural dentition often heavily restored, and increasing risks of oral disease mean that older people have particular dental needs and yet uptake of care is low. A new health and wellbeing centre in south London offering student-delivered care has been built to serve the local community. Community views could informed the planning of acceptable care for older people. **Objective:** To explore the views and expectations of older adults towards dental services and ascertain how a new dental centre may best provide dental care. **Research design:** This qualitative study used in-depth and triad interviews to explore the views of older people. Purposive sampling of local centres/groups for older adults was undertaken and all willing clients interviewed. Interviews were audio recorded, transcribed and analysed using Framework Methodology with emerging themes categorised according to Maxwell's six descriptors of quality. **Results:** Nine sessions (five triad and four in-depth interviews) involving 17 older adults were conducted in local day centres. Barriers to dental care were largely related to fear, cost, transport, lack of perceived need and the attitude of clinicians. Outcomes related to acceptability featured highly in a dental service for older adults; the overarching principles of 'delivering mutual benefit' for students and older people, 'experiencing warm humanity' and 'restoring dignity and worth' were central to their views of quality care. The importance of clinicians, whether student or staff, delivering person centred care with warm humanity was dominant: comprising 'welcoming', 'valuing', 'listening' 'communicating' and 'caring' for older adults to enhance relationships and contributing to 'restoring dignity and worth'. **Conclusion:** Community engagement identified a willingness amongst older adults to utilise dental services where mutual benefit was perceived and, importantly, there were low barriers to care and a warm humanity was exhibited.

Key words: *dental, older adults, access, quality, community consultation, England*

Introduction

Older adults now have improving life expectancy and increasingly retain more teeth albeit heavily restored and requiring complex dental care with under 1% having excellent oral health (HSCIC, 2009). In spite of often having heavily restored dentitions and increased risk of conditions, such as dry mouths, uptake of care is poor (Al-Haboubi *et al.*, 2013; Gallagher *et al.*, 2009). Low uptake amongst these older adults has been linked to such factors as a lack of perceived need, cost, fear, perceived lack of availability of services, characteristics of the dental practitioner, inconvenient appointment times and a lack of trust (Borreani *et al.*, 2008; 2010). Additionally, patients report a mismatch between primary care services and their expectations (Borreani *et al.*, 2010; WHO, 2008).

The National Health Service (NHS) promotes equity through the services it provides and reflects the needs and preferences of patients through partnerships with local communities (Department of Health, 2013). Increasing orientation of health services to an evidence-based preventive approach and the use of the skill mix of the wider dental team are influencing NHS dental contract reform and the quality of dental care. Maxwell (1992) emphasised that 'quality NHS services need to have a genuinely patient-centred approach designed around individual needs; instead of patients being expected to fit around services, services must start fitting around patients' and proposed a quality framework with six dimensions: acceptability, access, equity, relevance, effectiveness and efficiency.

Community engagement is the process of getting communities involved in decisions that affect them. A community here is "*a group of people united by at least one ... common characteristic, including geography, ethnicity, shared interests, values, experience or traditions*" (O'Mara-Eves *et al.*, 2013). Engagement here may be defined as "*a continuum of approaches to engaging communities in activities to improve population health and/or reduce health inequalities*"; these range from more limited amounts of engagement ('information' and 'consultation') towards 'development', 'participation' and 'empowerment' (O'Mara-Eves *et al.*, 2013). Engagement can aid the planning, development and management of services, as well as activities which aim to improve health or reduce health inequalities (Popay, 2010) and may improve the appropriateness, accessibility and uptake of services as well as impact on people's health literacy (NICE, 2008). However, these claims are not yet supported by a strong evidence base (O'Mara-Eves *et al*., 2013).

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Lambeth, an inner London borough, is one of the most densely populated and ethnically diverse boroughs in England, with large areas of socioeconomic deprivation juxtaposed with pockets of affluence. West Norwood Health and Leisure Centre has been jointly re-developed by Lambeth Council (2014) and NHS, in consultation with local residents and informed by needs assessment. It will offer a range of holistic services, e.g. GP and leisure facilities, among which is an outreach primary dental care centre with services offered by supervised dental students from King's College London Dental Institute. The new centre presented an opportunity to shape services differently informed by community engagement. West Norwood and its surrounding wards, have a higher proportion of older adults living in deprivation than is typical in England. Uptake of dental care among older adults is particularly low (Al-Haboubi *et al.*, 2013; Gallagher *et al.*, 2009).

The aim of this study was to explore the views and expectations of older adults in West Norwood, south London, on how a new primary care dental centre may best provide appropriate dental service to adults aged 65 and over, living in and using day centres in that community.

Method

Older adults' day groups and centres in the area were identified via the internet, Age UK and Lambeth Council then contacted by letter, email and telephone for permission to put up posters and to run sessions with their attendees at the centres. Preliminary information about the research was provided in advance to centres in the form of posters and information sheets. All adults aged 65 years and over were invited to participate in the study. Research approval was granted by King's College London, Research Ethics Committee [BDM/12/13-77].

Adults expressing an interest in participating received an explanation of its purpose and were invited to join a triad discussion or, if preferred, an individual in-depth interview in the centre to explore the issues pertaining to dental care in the centre. Each participant received written information and was asked to sign an informed consent form. Participants were advised they could withdraw at any point during the discussion/interview; however, once contributions had been made to the discussions, its relevance to the whole meant their views could not be removed. Assurances were given as to confidentiality and anonymity.

A qualitative approach was used for collecting the data; the triad interviews, conducted by author KC, each consisted of two to four participants per session and ran for under an hour while in-depth interviews lasted up to thirty minutes. The topic guide was informed by the literature and explored dimensions of contemporary care including perceptions of care quality and the new centre being developed. Specific issues included communication, skill mix of the dental team, the role of prevention, engagement, patterns of dental attendance, barriers to care and patterns of oral health behaviour (Maxwell, 1992; The King's Fund, 2012; Watt *et al.*, 2013). The topic guide was piloted with older adults at King's College Hospital outpatient clinic.

Discussions were audio-recorded between April and June 2013, with contemporaneous field notes made if noise levels impeded clarity of recording. The recordings were transcribed verbatim. Dual analysis and coding of the transcripts was undertaken by authors KC and JG with differences resolved by discussion.

Data analysis was undertaken using 'Framework' (Ritchie and Lewis, 2003), a widely used thematic approach method to analyse qualitative data (Borreani *et al.*, 2008; 2010). The thematic framework for this study was based on Maxwell's (1992) dimensions of quality, supported by analysis of the transcripts. Familiarisation with the data at the start of analysis identified recurring themes. The data were then indexed and sorted according to these themes, grouping together material of similar content. The penultimate stage involved summarising the data in a coherent manner to enable results to be clearly described. The analysis then moved to abstraction and interpretation where more analytic concepts and themes were created, and interrogated for patterns of meaning.

Results

Four local centres agreed to facilitate the study with non-participation being associated with time constraints of the research, capacity and interest. Five triads and four in-depth interviews were conducted encompassing 17 participants. Most, 11, were female. Of the 17, 64% were aged 65-74, 6% 75-84 and 30% were 85 years or older. A range of ethnicities was represented: White British (n=2), Afro-Caribbean (n=6) and Asian (n=9).

The findings are presented according to the dimensions of Maxwell's quality framework and finally in relation to the patient journey. Older interviewees placed most emphasis on accessibility and acceptability. Interestingly many interviewees de-personalised their comments and therefore whilst there were personal stories, there was a tendency to relate some of the issues to 'other people' and respond as advocates for older people in general. The results of the interviews and focus groups are described in the following sections. Selected quotes illustrate the findings and are labelled by gender (M/F) and then interview (A, B, D, etc.)

Accessibility

Barriers to dental attendance were reported to be related to the cost of treatment, and fear, particularly in light of previous experiences through to lack of perceived need. The triggers of fear ranged from the discomfort of 'thinking of dental needles' and the 'drill' to 'trauma' experienced during dental treatment in the past through to a lack of time because of other responsibilities.

> *"The dental service privately is very expensive ... the elderly people; I know some of them they don't go to the dentist because they cannot afford it."* (M,B)
> "*I have to say, long before you were born, school dentists were, like,* dreadful...*So many of my teeth were filled and it was, like, brutal.*" (F,D)
> *"Me personally – I hate the noise of the drill and that is one of the things that keeps me away...."* (F,W)

Further challenges included provision of transport to the centre and the preferred times to travel to the appointments.

"I think transport, to some people, is always a problem wherever they've got to get to." (F,D)

There was a general concern about the difficulty of obtaining appointments, particularly emergency services when the need arose.

The concept of having a centre where free treatment was on offer to pensioners was greatly welcomed and perceived as a good motivator for encouraging dental attendance. The importance of facilitating easier access to care was emphasised:

"because obviously… the opening of Norwood Road, that is extra facilities and maybe quicker you can go and see them. Because sometimes dentists… they give you a couple of weeks or sometimes they're busy." (M,B)

Information on dental services and the care available were considered an important resource for older people. In promoting the future service to older adults within the community, there was most emphasis on having written information in traditional formats, recognising, in the words of one participant that...

"…the written word is better than the lost memory." (M,A)

Physical advertising suggestions involved having 'external signs' on the building, internal signs within the health and leisure centre and, information at other key locations such as GP surgeries, libraries and day centres. Leaflets and adverts in newspapers were considered important, with only a minority seeking electronic information. However, important as all of this was considered, 'word of mouth' was particularly viewed as a powerful means of signposting others to the service – or away from services if they did not serve needs adequately. In essence, satisfied patients would be one of the best advertisements for the centre.

"… so much is done by word of mouth, so if you get some people and you're good, you'll get other people come" (F,D)
"I would say doctor's surgery; shopping centre, and also, gymnasium… people go." (M,A)

Having leisure or well-being facilities and health services in one establishment was perceived to be convenient and also a good advertisement strategy:

"These centres they advertise and if they combine [...] another service available, like a dentist as and it would be easier to go [attend]" (M,B)

Acceptability
Older adults presented distinct views of what constituted acceptable services across four themes including the importance of the clinician's attitude and manner; receiving care under supervision when it is delivered by students; quality being more important than skill mix and the importance of surgery settings.

Participants were of the view that the clinicians' approach and manner towards them was of paramount importance and considered it to be just as important as the treatment they were offering. They expressed the need to experience being treated with 'warm humanity' which would 'restore respect and dignity'. Good rapport was regarded as making the difference between a good and a bad dental experience.

"...We used to have a dentist in too called Dr X... He wouldn't talk to you. He's a very good dentist, very good … in dentistry…" (F,L)

Talking with patients was considered a very important aspect in facilitating the delivery of care. So important was rapport that in some cases where it was lacking, older adults reported that it led patients to disclose less information about their conditions. There were concerns regarding being rushed during appointments and the importance of careful explanation and discussion; but equally there were examples of good practice.

"... I've been going to a dentist for a few years, and then I got a dentist lady [female dentist] and she was excellent – we had good rapport and I looked forward to going. And then she retired, and I went again and it wasn't her, it wasn't the same service as I had with her. It was a pleasure going to her – she would explain everything, talk with me, even let me feel a bit more at ease when she drilled my teeth. And the next one wasn't like that – it was all tense... and again, it depends on the person." (F,W)
"Maybe they can listen to the patient a little bit more but I think they are pushed for time. They have a lot of patients ...I think you would like the dentist to talk to you for a while and put your mind at rest so you can relax a little bit rather than just get it later … When you go there, you feel by their action that you are getting rushed, you are taking too much time so you just keep quiet sometimes and forget to tell them what you wanted to tell them, if there's anything. That sometimes happens." (F,L)

There was also the view expressed in relation to 'others' that as people get older they may require more time and reassurance.

"I think as people get older, they do require more reassurance" (F,D)

Generally the idea of being treated by different dental care professionals was well received, provided that the treatment was of good quality and their approach and manner accommodated their needs.

"I don't think there is a problem of different people, as long as the treatment is done properly..." (M,B)

In addition to the manner of the clinician, the setting was also important. Waiting rooms were perceived as places which with a positive ambience can be used to distract thoughts associated with dental fear/anxiety. Playing soft music in the background and having nice pictures on the walls and sufficient chairs were suggested to alleviate anxiety. A short wait was preferable as was allowing sufficient time to move from the waiting room to the surgery.

"Not encouraging at all when you're worrying about the drill! So you need something to take your mind off of that, just a bit of music, or something. Because, wherever you go, it's going to be painful, whether it's in this new centre, or if it's in a dungeon, the pain is going to be the same, but it's the surroundings that you have to encounter that is important." (F,A) *"I expect that they'll have facilities so that when older people come in and they have difficulties walking, getting to seats and say when they start digging into their teeth, their sort of comfort and their disabilities are taken into account."*(F,D)

Equity

There was a strong sense of older people having a right to dental care at this stage in their lives, particularly having contributed to society. And that receiving dental care was 'restorative'; there was some evidence that accessing dental care was part of restoring dignity and confidence'.

"We have contributed, you know, to the society already, more of your life... More of your working life. When it comes to 65 and over you should get some consideration in the price of the dentist, you know." (M,B)
"To address the situation concerning an elderly person, the first thing is to restore their dignity, restore their confidence and stature. Make them feel wanted and it goes across in all walks of life, everybody feels wanted; need, everybody's hungry for that." (M,B)

A further issue related to managing diversity. For some older people there were concerns about language. The lack of interpreters for non-English speakers and not responding to other cultural and religious expectations were deemed discriminatory to those groups.

"...in fact, they were discriminated against, even now also you go for insurance they say," Oh you're old, oh yeah, yeah, anything yes, oh yes, he's an old man, yes." *So that feeling is there that their 'sell by date' is over, I mean that's my expression sorry, but that is a fact, really. Same thing even with GPs also, even the GPs also tend to treat elderly people with a bit of scepticism, they think oh yeah, he's a bundle of problems only this man."* (M,B)

Relevance

As contemporary dental care places greater emphasis on prevention of disease, this was specifically explored in relation to its relevance. Preventive advice was accepted as vital to care and very relevant to the group,

particularly 'others'. So too was the need for denture services amongst older people who may have lost their natural dentition.

"Your personal hygiene is quite important, they should deal with things that are will protect the ... help protect the teeth." (M,A)
"And also, teach them the proper way to brush teeth, I know I don't do it properly, but there is a right way and a wrong way ..." (F,A)*"...I would like to see that they could do dentures there too.*" (F,A)

Effectiveness

On the whole, older adults were willing to receive treatment from students and it could be perceived as 'delivering mutual benefit'; however, the importance of supervision by a mature person was fundamental and a marker of quality. Reservations towards treatment by students were linked to scars from previous dental experiences. The concerns centred on students' lack of experience, immaturity and most importantly about things going wrong during execution of treatment. On balance there was an acceptance of being seen by students, and therefore a turnover of clinicians, provided they were working under supervision and with an appreciation of the importance of learning so that the experience was effective for everyone concerned as shown below.

"Yes I would be comfortable (being treated) by the students. I would be comfortable because I think that's the way they would learn and that's the way they would know. I think I would be comfortable with that." (F,A)
"I don't know, provided they're supervised by someone who's more qualified" (M,A)

Generally, the informants were of the view that guidance by a supervisor was fundamental to provision of effective treatment by the dental students. There was a sense that the King's label was a quality marker and the system could include referral on to main hospital campus where required, providing extra confidence.

" They are learning, you have to summon the supervisor, who's in charge of them, and they, in turn, will advise them, and keep a check that they're doing ..." (M,A)
"Yeah, I think adults could be treated by students, providing there is a head higher one just so see what they are doing. I think they should be treated by students, because that's the way students would learn." (F,A)

Efficiency

The process of delivering care to older people attending the centre was explored. Participants were concerned about the preparedness of the centre to accept large volumes of people for dental treatment and manage them smoothly without undue waiting and do so in comfort.

"I'm wondering, will you be able to manage, because you'll be surprised to know when people think 'OK, there's an alternative, I don't have to go here'..." (F,W)

For the service to be efficient in carrying out its appointment system for established patients it was considered crucial to find out what the best way would be to contact older adults. Telephone calls were thought to be the best way to send appointment reminders.

"Not such a good idea, because they send ... send email. Not all older people know how to use the computer. 'Cause it's very important to read the email as well and I know." (F,A)

Patient pathway and quality care for older people

Themes outlined above covered the patient pathway from 'promoting' the service to 'welcoming', 'valuing', 'listening' and 'caring' for older adults to enhance relationships, dignity and worth, treating them in appropriate facilities and 'reminding' them of appointments. The overarching principles of 'delivering mutual benefit' for students and older people', 'experiencing warm humanity' and 'restoring dignity and worth' were central to older adult views of quality care in an outreach teaching centre embedded in a south London community. Older people would then act as advocates for the service if care was deemed to have been successful.

Discussion

The study demonstrates how undertaking community consultation to consider and represent the views of the local community and prospective patients may contribute to healthcare planning. The research was conducted during the building phase of the health and leisure centre project, the overall scheme having been the subject of wide community engagement in south Lambeth (Lambeth, 2014), and informed by a dental needs assessment. Patient values, expectations and perceptions are therefore informing detailed service provision as the dental centre opens for patient care. However, community engagement should go well beyond consultation and the evidence would suggest that co-production, delegated power and providing community control are important levers for change and the more challenging aspects of community participation (NICE, 2008); this remains an ongoing challenge for this new service.

Reaching out to the community through older peoples' centres allowed the research to connect with the local older population in their familiar environment away from their homes and its success could be used to advocate that the method used in this study provide a template for others to replicate to identify the views of older adults in their local area. Participants welcomed the opportunity to share their views on features of a quality dental service during interviews. Overall, they welcomed the centre's development and there was a sense of willingness to try the new service, particularly as it offered free dental care and it may be that those who are more receptive to using dental services participated in the discussion. However, the nature of the discourse suggested that participants considered themselves as advocates for older people as opposed to merely expressing their own views, and they were not all regular dental service users. Diversity of the community groups meant participants were mixed

socially and ethnically, reducing previously reported risk that those service users who involve themselves in consultation may be those who are more educated and articulate (Church *et al.*, 2002). Some of the challenges of achieving participation in this type of research were that only more engaged centre managers facilitated the study and time restraints restricted the breadth of centres for older people that were approached; however, many of the general findings support past research (Borreani *et al.*, 2008; 2010) and provide insight to service providers regarding older people in the community.

Participants reported numerous practical barriers to accessing dental care. These supported traditionally reported themes such as fear, cost, lack of perceived need, and perceptions of the dentist (Borreani *et al.*, 2008, 2010; Slack-Smith *et al.*, 2010). In addition, transport to and from the clinic, obtaining appointments and emergency care were shared concerns supporting reporting that frail older adults may have direct disablers to accessing care such as diminished mobility and dependence on others (Niesten *et al.*, 2013).

Maxwell's (1992) criteria were used as a framework for features of quality – the broad features of care relating well to the six domains; however outcomes concentrated more on accessibility and acceptability than efficiency, i.e. those features which relate to gaining access to care and an acceptable experience. The development of positive relationships with clinicians and clinicians' attitudes, were expressed as central to older people's experience 'demonstrating warm humanity'. This aligns with evidence from previous surveys that good relationships between the dental team and the older patient are essential to achieve improved oral health (Borreani *et al.,* 2008; 2010). McCormack (2003) introduces the idea that respect for a person is central to the notion of patient-centeredness and stresses the importance of having a clear vision of what the patient values about their life – an approach which requires active listening and engagement. Mills *et al.* (2013) highlight concerns that 'patient-centred care' is widely used but poorly understood and indeed there is little research in dentistry of this nature. Our study contributes to an understanding of what 'patient-centred' quality means to the older patient in relation to the delivery of dental care and should be replicated in other contexts to examine this important issue. The findings highlight the responsibility on clinicians to take the necessary time to deliver quality dental care, an issue which requires further research and policy consideration. The focus on 'efficacy' by policy makers as exhibiting 'value for money', in neo-liberalistic health policy is clearly in contradiction with that of older people and requires serious consideration in the funding mechanisms for future primary care. Older people should have more time, given the complexity of their medical, dental and social histories and the need for careful explanation and discussion, as core elements of clinical care. Having access to quality care was seen as a right for older people and supports the findings of Borreani *et al.* (2010), who highlight the importance of citizenship and their right to health. These findings suggest that receipt of such care was perceived as part of the societal response in 'restoring dignity and worth'.

Two features of contemporary care were specifically explored with informants: teamworking and prevention. It was encouraging to note that participants did not consider being treated by different members of the dental team as a barrier to dental care. As people live longer, and retain their natural teeth, there is likely to be a progressive change in the volume and type of dental care required in older adults, and demand for care will necessitate using the widening of the skill-mix in the dental team, to build capacity and meet the oral health needs of an ever increasing population. Participants all reported that they were 'happy' to receive preventive advice although they were divided on the mode of delivery for this preventive advice, with some opting for one-on-one advice and others preferring delivery through group sessions. This could be an area for further action involving older people themselves in co-production and control (NICE, 2008), with research to examine the feasibility and cost effectiveness of multiple person sessions held in community settings as opposed to one-to-one delivery in clinical settings.

Conclusion

The findings of community engagement suggest a willingness amongst older adults to engage with new dental services where mutual benefit was perceived and barriers to care reduced. The importance of patient-centred quality care was stressed with the findings emphasising the significance of the attitude of the clinician and their relationship with the older person demonstrated through warm humanity and delivered in appropriate premises. They also suggest that access to dental care at the centre would be enhanced by reducing practical barriers such as transport and cost, together with improving communication. Community engagement has offered an opportunity to develop a relationship with potential service users as well as a deeper understanding of their needs and expectations in relation to access to health care which should inform service planning.

Acknowledgements

References

Al-Haboubi, M., Klass, C., Jones, K., Bernabe, E. and Gallagher, J.E. (2013): Inequalities in the use of dental services among adults in inner South East London. *European Journal of Oral Sciences* **121**, 176-181.

Borreani, E., Jones, K., Scambler, S. and Gallagher, J.E. (2010): Informing the debate on oral healthcare for older people: a qualitative study of older people's views on oral health and oral healthcare. *Gerodontology* **7**, 1-8.

Borreani, E., Wright, D., Scrambler, S. and Gallagher, J.E. (2008): Minimising the barriers to dental care in older people. *BMC Oral Health* **8**, 7.

Church, J., Saunders, D., Wanke, M., Pong, R., Spooner, C. and Dorgan, M. (2002): Citizen Participation in health decision-making: past experience and future prospects. *Journal of Public Health Policy* **23**, 12-32.

Department of Health (2013): *The handbook to the NHS Constitution for England*: London: Department of Health.

Gallagher, J.E., Cooper, D.J. and Wright, D. (2009): Deprivation and access to dental care in a socially diverse metropolitan area. *Community Dental Health* **26**, 92-98.

Health & Social Care Information Centre (2009): *Adult Dental Health Survey*. Leeds: HSCIC.

Lambeth Council (2014): *West Norwood Health and Leisure Centre*. www.lambeth.gov.uk/places/west-norwood-health-and-leisure-centre

Maxwell, R. (1992): Dimensions of Quality revisited: from thought to action. *Quality in Health Care* **1**, 171-177.

McCormack, B. (2003): A conceptual framework for patient-centred practice with older people. *International Journal of Nursing Practice* **9**, 202-209.

Mills, I., Frost, J., Moles, D.R. and Kay, E. (2013): Patient-centred care in general dental practice: sound sense or soundbite? *British Dental Journal* **215**, 81-85.

National Institute for Clinical Excellence, NICE (2008): Community engagement to improve health. *Public Health Guidance* 9.www.nice.org.uk/Guidance/PH9

Niesten, D., Van Mourik, K. and van der Sanden, W. (2013): The impact of frailty on oral care behaviour of older people: a qualitative study. *BMC Oral Health* **13**, 61.

O'Mara-Eves, A., Brunton, G., McDaid, D., Oliver, S., Kavanagh, J., Jamal, F., Matosevic, T., Harden, A. and Thomas, J. (2013): Community engagement to reduce inequalities in health: a systematic review, meta-analysis and economic analysis. *Public Health Research* **1**.

Popay, J. (2010): Community empowerment and health improvement: the English experience, 2006. In: *Health assets in a global context: theory, methods, action.* Eds Morgan, A., Davies, M. and Ziglio, E. New York: Springer; p183–195.

Ritchie, J. and Lewis J. (2003): *Qualitative research practice: a guide for social science students and researchers*. London: Sage.

Slack-Smith, L., Lange, A., Paley, G., O'Grady, M., French, D. and Short, L. (2010): Oral health and access to dental care: a qualitative investigation among older people in the community. *Gerodontology* **27**, 104-113.

The King's Fund (2012): *General Practice in London: supporting Improvements in Quality*. London: King's Fund. www.kingsfund.org.uk/publications/articles/general-practice-london-supporting-improvements-quality

Watt, R.G., Steele, J.G., Treasure, E.T., White, D.A., Pitts, N.B. and Murray, J.J. (2013): Adult Dental Health Survey 2009: implications of findings for clinical practice and oral health policy. *British Dental Journal* **214**, 71-75.

World Health Organization (2008): *Primary Health Care: Now more than ever*. Geneva: WHO. www.who.int/whr/2008/en