Where are all the specialists?

Key points

- Shortage of specialists needed to tackle preventive problems
- UK seemingly overloaded in 'university' regions
- Are specialists following the money or a trend?

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Introduction

As consumers, I am sure we all get frustrated when something we want is unavailable in our area. Leaving the bustling city for the quiet retreats of West Cumbria has many, many advantages, but 4G and superfast broadband – in an era of connectivity – are not on that list.

And, as consumers, we expect things to come to us. Online shopping deliveries, for example. Gone are the days when 3-5 working days was acceptable – next day delivery or we go somewhere that does offer it. We have the choice.

Those rules of consumerism do not apply to NHS dental patients. The ongoing recruitment crisis and paucity of the NHS dental contract means fewer and fewer are turning to the profession as a viable career. And, on top of that, more and more are leaving the service before their careers take off. The effect is profound at service delivery level – patient access remains an issue – but the long-term effects are just as dangerous to the longevity of NHS dentistry.

Forward planning

In Phase II of the Advancing Dental Care (ADC) Project, Malcolm Smith, Chair of the ADC, highlights that there is a 10% reduction in dental school places, while an inequality in workforce distribution adds to the notion certain areas of the country enjoy better access to NHS dentistry than others.[1] Which begs the question, if there are fewer dental students being granted places, and more of them want to leave the service, take on portfolio careers and seek ways to increase their income without necessarily moving up the career ladder, who exactly will take on the mantle of training for longer than a decade to become a specialist?

Take oral medicine, for example. To achieve a Certificate of Completion of Specialist Training in Oral Medicine requires a training programme of five years' duration. This is reduced to three years' duration for those who apply with a medical and dental degree. That's already up to a minimum of eight years.

The basic entry requirement is two years of postgraduate foundation training in dentistry, including experience in primary and secondary care settings. A DCT/clinical teaching post in the specialty allows valuable experience/publications prior to applying for a specialty registrar position. Training involves significant time spent in oral medicine outpatient clinics, seeing new and review patients and specialist medical clinics under the supervision of a consultant.

For oral microbiology, training is five years full time programme (previously joint with medical microbiology) and passing the Fellowship examination of the Royal College of Pathologists in Medical Microbiology. Oral and maxillofacial pathology is the same length of time.

This in itself is a long old time, and that's before you factor in the environment in which dentists are operating. Across the dental workforce, women now constitute more than 50% of the NHS general dental practice workforce in England and represent about 65% of new dental graduates. Dental student intake stands at 63:37 female to male ratio. This significant change in the demographics of the profession must be factored into proper workforce planning. Females outweigh their male counterparts in approximately half of the specialties recognised by the GDC. Taking into account workforce projections, it is not a stretch of the imagination to think this will only increase – both in number of specialties and within the specialties themselves.

Are those women coming through the education system prepared to sacrifice their careers to consider family commitments? If they already have a family, is returning to education for that length of time something they would be willing to do? There is every chance that these factors – alongside a growing tendency to indulge in a portfolio career – will create a situation where dentists simply aren't engaging with long-term training because they see no future in the service.

Recruitment

Besides the composition of the workforce, there is the ongoing crisis in dental recruitment. Previous BDA analysis revealed almost 58% of the UK's NHS dentists were planning on turning away from NHS dentistry in the next five years and over half (53%) of young and newly qualified NHS dentists (aged under 35) intend on leaving the NHS in the same period. Furthermore, nearly 10% of these young NHS dentists state they intend to leave dentistry entirely, with similar numbers stating they intended to move to work overseas and 42% planning to refocus on private dentistry.[2]

Within the community dental service, there has been an ongoing trend of a noticeable number of posts being unfilled. BDA evidence submitted to the DDRB as far back as 2018 showed an issue in recruitment to the more senior grades within the CDS, with only a fraction of Band C and B vacancies filled.[3] This clearly will have an impact on the ability of services to deliver the complex care many CDS patients require. Furthermore, the almost impossibility of filling Band C Specialist posts places services at a clear risk of being unable to meet commissioning requirements for services to be Specialist led. Resultantly staff are now being asked to cover the gaps in service left by these unfilled posts either through general increased working or as direct cover.

As a young graduate, why would you want to subject yourself to a decade of training just to be hugely over-worked? Special Care Dentistry, for example, requires a holistic approach to the provision of care in order to meet the complex requirements of the individual. Longer patient appointments, unique approaches and often complex treatment plans – not to mention the ad-hoc nature of their attendance – do not lend themselves to covering gaps in the service or working as direct cover. Add in that there are roughly 20 trainee posts based across community and hospital settings, and you begin to see the recruitment crisis runs deeper than high street dentistry.

This is shown in Tables 1 and 2, which show stagnation and slight decreases across nearly all areas of specialty in a two-year time frame. Previous research has alluded to the fact that consultant posts are often permanent, and that 92% of BDA consultant members also reported that they were appointed on a permanent contract, there is a greater degree of 'ongoing commitment' to the hospital dental service.[4] In essence, once you're in the service, you're committed to it – retention isn't the issue.

Home comforts

It's only natural that when you settle somewhere, you're reluctant to move. That's even more prevalent when you're young. Dental students try – where possible – to stay close to their roots. It's not always easy – there are many stories of DFT placements being many a mile away from what they're used to. However, there is one pattern

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that shows many former students end up returning to familiar surroundings.

Work undertaken by the BDA shows that where dental hospitals are situated, there's a significant concentration in that and the immediately surrounding area of specialists, as shown in Figure 1.

At present, speciality training is mostly delivered in teaching hospitals within urban areas, which is understandable and logical. As the map shows, there are vast swathes of the UK with little to no access to specialists, rendering services to patients as no more than a postcode lottery – treatment is therefore provided by availability, not need.

Take children's oral health, for example. As far back as 2014, former BSPD President Robin Mills had highlighted a chronic shortage of paediatric specialists across the country. In 2015, Stephen Fayle, a Paediatric Dental Consultant and member of the British Society of Paediatric Dentistry, was one of a panel of five giving evidence to the inquiry into the oral health of children in England by the House of Commons Health Select Committee. Even then Fayle highlighted a crisis in the decline in specialist paediatric dentistry services within primary care in some regions. This was contributing to dental decay being the most common reason for a child between the ages of 5-9 to be admitted to hospital in England.

Five years later, decay is still the number one reason children are admitted to hospital, and paediatric dentistry remains as stretched as it ever has been – 239 paediatric dentistry specialists is nowhere near the level needed to cover the UK, particularly when hospital admissions for extraction under general anaesthetic topped 26,000 in 2017/18.[5] In submitting written evidence to the inquiry into dental services, the BSPD stated:

'Workforce shortages within Paediatric Dentistry are leading to acute access problems in some areas, with long waiting lists for children to be seen by a paediatric dentist. The rise in the need for specialist and consultant-led paediatric dentistry services means need more Specialists and more Consultants.

'Consultants and Specialists not only provide care for the most complex cases, but are also needed to train, support and develop other practitioners with so they can manage more common conditions which are nonetheless beyond the scope and skill-set of a family dentist (GDS). They are also needed to train future specialists and consultants.

Table 1 Registrants by Specialty as of January 2018

Speciality Description	Male	Female	Gender unknown	Total
Dental and Maxillofacial Radiology	14	13	0	27
Dental Nurse	0	7	0	7
Dental Public Health	45	57	0	102
Endodontics	208	75	0	283
Oral and Maxillofacial Pathology	19	16	0	35
Oral Medicine	42	28	0	70
Oral Microbiology	3	5	0	8
Oral Surgery	498	216	0	714
Orthodontics	693	670	0	1363
Paediatric Dentistry	54	180	0	234
Periodontics	248	125	0	373
Prosthodontics	339	98	0	437
Restorative Dentistry	218	77	0	295
Special Care Dentistry	89	211	0	300

Table 2 Registrants by Specialty as of January 2020

Speciality Description	Male	Female	Gender unknown	Total
Dental and Maxillofacial Radiology	13	15	0	28
Dental Public Health	42	54	0	96
Endodontics	226	77	0	303
Oral and Maxillofacial Pathology	18	15	0	33
Oral Medicine	40	29	0	69
Oral Microbiology	2	5	0	7
Oral Surgery	490	234	0	724
Orthodontics	673	688	0	1361
Paediatric Dentistry	51	188	0	239
Periodontics	250	125	0	375
Prosthodontics	336	102	0	438
Restorative Dentistry	212	79	0	291
Special Care Dentistry	79	210	0	289

'Unfortunately, in spite of growing demand and waiting lists, there has been a long-standing failure to prioritise the training of specialists in Paediatric Dentistry, leading to a critical shortage. In 2000, when the specialist list for paediatric dentistry was established, there were initially about 200 specialists registered in the whole of the UK. In 2008 there were 234 and the number today remains almost unchanged at 239, which is made even worse by uneven distribution around the country. In comparison, there are now around 1,400 registered Specialists

Figure 1 Map of the UK showing hotspots of specialists and NHS dentistry access problems

in Orthodontics, the vast majority of whom only provide orthodontic tooth straightening.'[6]

More than anything, the evidence only highlights the stagnation rife throughout the profession. The Commissioning Guide for Dental Specialties – Paediatric Dentistry, published in 2018, focus on 10 priorities highlighted in the guide.[7] While some of those priorities are making their way into the thought conscious, others remain a work in progress.

For the people

What is striking about the BSPD's submission is the comparison between paediatric specialists and their orthodontic counterparts. Is there such a thing as too many orthodontist specialists? Does the profession really need that many? Are they simply reacting to patient demand or is there a move towards work that has more of a financial gain?

In excess of 200,000 children and teenagers in England and Wales have treatment within the NHS every year, with growing numbers of adults and young people seeking treatment on a private basis. One would have to question – from a holistic stance – whether training for three years and not being prepared to complete an additional two years and heading off to the private sector in search of more money is the right thing to do. The NHS website states that 'because of high demand, there can be a waiting list'. Following a similar pattern to the provision of paediatric specialists, there is a density around dental hospitals. Yet unlike paediatrics, there are almost six times as many of them. How can in excess of 1,400 specialists result in waiting lists?

According to LaingBuisson, in the autumn of 2017, 35.2% of practices described themselves as a 'specialist practice' or 'specialist cosmetic practice'.[8] Many of these will of course be private – little wonder when the same report values the sector at around £3.6bn and growing.

There is a lot to be said for evolving to meet patient demand – it's the hallmark of any good businessperson, and we must not forget that dentistry, as well as a service, is also a business. With dentists coming into the profession wanting to earn as much as they can as fast as they can while balancing work/life commitments before leaving the service, the huge growth in orthodontic specialists is perhaps of little surprise. The smartphone era means patients want to look good as well as being healthy. It's on-trend and shows no sign of slowing down. Could NHS orthodontic services be under pressure due to the demand of under 18s wanting to look better? It's not out of the realms of possibility, but I am sure few reading this will suggest those specialists would not be better off in paediatric dentistry helping to prevent the very problems their orthodontic colleagues rectify.

Future?

So if retention isn't the issue, recruitment into most specialties are showing signs of slowing down and more patients are moving to private, is there a future for some on the specialty list?

In January of last year, The GDC launched a consultation on the fundamental principles governing its approach to the system of specialist listing. The consultation encouraged views on proposals to change the way the regulator approached three key areas, all with the aim of improving understanding for professionals and the public in relation to the dental specialties. Of particular interest in the consultation was question one in Section 2, which read: 'What types of evidence should be considered, or required, before adding or removing a dental speciality?'[9]

A foray into the world of workforce planning – not within the GDC's remit – or a move designed to provide additional clarity for patients? As ever that is open to interpretation, and in responding, the BDA made it clear that changes to specialist listings would not be particularly welcomed (Box 1).

In their original Final Report published in April 2018, ADC suggested there was an argument for providing more specialty dentistry within an NHS primary care setting, subject to cost implications. The review stated it had 'widespread support' for introducing a 'Specialty of General Dental Practice' as a more formal training pathway for the dental practitioner. This could up-skill the workforce, provide leaders of the profession and provide a route to gain Tier 2 complexity skills. It could also produce a dental practitioner better able to lead an NHS multi-skilled dental team.

The argument set about causing a bit of a furore, with authors across the publishing landscape shining a dim light on the idea. In the *British Dental Journal*, Len D'Cruz wrote:

'This is a brave move and perhaps a laudable attempt to resolve an issue of increased referrals to secondary care of particular treatments and also to inject some equity back into how those referrals are dealt with by the recipients of those referrals from primary care.

'Endodontics is notoriously complex and achieving high quality results in a general practice environment is not easy. Attempting to raise standards is certainly a worthwhile endeavour though in a cash limited NHS system it is questionable to what extent this can be sustainably delivered using Tier 2 practitioners who cost more per case than GDPs.

'Some might argue that the increased referrals have arisen out of the unintended consequences of the 2006 contract. The payment system, based on UDAs, has clearly influenced the behaviour of dentists as this study suggests along with other qualitative reviews. Opinion leaders have talked about the 'ridiculous expectations attached to UDAs by way of limitless amounts of treatment for the same fee' and the manipulation of the NHS dental contract having 'corrupting effects on the behaviours of some members of the dental profession.'[11]

In the most recent corporate strategy, the GDC stated it will be pressing on with implementing a process for mediated entry to the specialist lists by Q4 of 2020. For some the phrase 'if it isn't broke don't fix it' comes to mind, which makes you wonder exactly why the regulatory body is looking at specialists.

Rather inevitably the question surrounding the lack of specialists comes back to the introduction of the 2006 dental contract. Why would a GDP provide the treatment when a Level 2 accredited practitioner is getting paid more to do the very same treatment? There is a long-held suspicion that the referral pathway – as tight as it may be – is open to manipulation. It doesn't make good business sense to be doing 'duplicate' work. Community dental services have long told us they are overstretched and underfunded, both of which have the 2006 contract at the heart. Contract reform, we are told, is inching ever closer. The BDA has expressed cautious optimism from those involved in the prototypes. But it will take a huge effort to repair the damage done by 14 years and counting of the 2006 contract. Current practitioners will need to believe there is more to dentistry than meeting targets and private practice. Set against a backdrop in the changes of society – flexible working patterns, career breaks – the ADC project faces a tough task to develop pathways appealing to those who wish to train to be a specialist. Only time will tell whether this is a success or not. And in the meantime, the advice is clear and simple: if you want specialist treatment, find yourself a dental hospital, or forever be waiting in the wilderness. ◆

Box 1 BDA response to Section 2 Question 1[10]

The GDC must be clear and transparent in the level of proof it requires to de-list a specialty. We believe that both dental public health and independent academic evidence should be provided as a basic minimum.

Without the need for such evidence there is the possibility that the NHS may seek to defund certain treatments deliberately and subsequently use this as evidence that said treatment was no longer current and hence appropriate for de-listing of a specialty, without agreement from those actually providing the care, and to the detriment of patients in need. Nothing would subsequently stop the NHS from providing said treatments again albeit no longer by 'specialists'.

If the GDC believes that specialist listing exists to 'support the provision of specialist care for patients as part of effective patient pathways', then workforce planning – that is, the NHS-funded provision of specialist care, and related training pathways – must not be a factor in considerations for de-listing or amalgamating lists.

Such a development would also have a great deal of jeopardy for those with job descriptions that require a specialist status as an essential criterion. Without an existing specialty to underpin such posts, it is difficult to envisage what would happen, for instance, to a hospital dental consultant in that specialty – would they be expected to renounce the title 'specialist' or expected to train for additional years in a different area to return to the use of the title in a similar discipline? Professionals would be unlikely to support such changes, and the systems that underpin care provision would also be destabilised, as many referral pathways rely on the existence of specialist care.

A better approach to any de-listing in such cases would be a closing of the specialty to new entrants, so that change is not sudden, but takes place over longer time periods.'

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