An impetus for change?

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Key points

- Fundamental change is required to ensure the UK has sufficient numbers of specialists in paediatric dentistry to meet population needs.
- The continuing decline in non-consultant specialists in paediatric dentistry is undermining the ability to provide local services and must be reversed.
- An appropriately trained and equitably distributed specialist-led workforce is critical for optimum care delivery.

Abstract

For years, the British Society of Paediatric Dentistry has been highlighting the shortage of specialists in paediatric dentistry in the UK and the consequent inadequacy of provision of, and inequality of access to, specialist care. This is a problem which must be addressed nationally. The aim of this article is to understand the obstacles to change and the impact of this continuing shortage, with a particular focus on the decline in the numbers of non-consultant specialists. I will examine the challenges and possible solutions, taking into account the impact of COVID-19 on service delivery.

In the animal kingdom, species in decline are put on an endangered list; attempts are made to halt the decline and, at best, drive up numbers. If there were a human equivalent of the endangered species list, I would be on it. I am a community-based specialist in paediatric dentistry and there are not enough of us to meet demand.

Can I stress, at the outset, this is not about me; I, like the majority of the current specialist paediatric workforce, will not be working for too many more years. I have a clear idea of how we are declining in numbers thanks to my colleague Robin Mills. Using a profiling system that he designed in order to analyse General Dental Council registrants, he ascertained that 40% of current paediatric specialists will be 60 years or older in ten years time.[1]

Layered onto this impending decline in the total numbers of specialists is the apparent trend for non-consultant specialists to be leaving the workforce more rapidly than consultants. By my own calculations, while there has been a much-needed increase in consultants in the last ten years, there has been a proportionate 25% decrease in non-consultant specialists. The net result is that overall numbers on the specialist register (specialists plus consultants) has remained static for nearly two decades.

The shortage issue is both generic and particular. Robin Mills was additionally able to identify[1] that 54 (44%) of the 124 postal areas in the UK have no specialist in paediatric dentistry. The greatest numbers of specialists in paediatric dentistry are in areas where there are dental schools. One would expect this to be the case. Dental schools tend to be sited in large centres of population and it is well recognised that professionals, including dentists, tend to prefer working near to their university of qualification. If jobs are readily available near to their dental school, it can be very difficult to attract dentists to other parts of the country.

Over the last decade, there have been countless documents which have raised concerns around the shortage of specialists in paediatric dentistry:

1. Ten years ago, a research team in Cardiff highlighted that the feminisation of the UK paediatric dentistry workforce, with attendant career breaks or part-time working, would contribute to a shortfall of specialists.[2] As stated in the conclusion, 'workforce planners must be cognisant of the need to increase the number of specialists in training to take account of service lost through part-time working and career breaks'
2. The 2015 landmark report[3] *The state of children's oral health in England* by the Faculty of Dental Surgery of the Royal College of Surgeons of England (RCS FDS) identified the need to address the shortage of specialists in its key recommendations: 'The relative shortage (and in some areas absence) of specialist dentistry services in some parts of the country must be addressed to ensure all children with advanced tooth decay have timely access to specialists with appropriate skills and facilities' (the report highlights the paucity of specialists in the South West of England, where I work)
3. The British Society of Paediatric Dentistry (BSPD) drew attention to the issue in its submission to the House of Commons inquiry into 'Children's oral health' in 2015;[4] the BSPD's past president and RCS FDS board member Stephen Fayle was in the House of Commons and raised his concerns with MPs
4. Several speakers at a BSPD stakeholders meeting in 2016 highlighted the decline in specialists[5] – identifying that, despite societal concerns about children's oral health, new treatment centres were being built to meet demand for access from which children were excluded
5. In a submission[6] to the Health and Social Care Committee last year, the BSPD further underlined concerns around workforce issues.

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Since then, the report[7] from phase 1 of the *Advancing dental care: education and training review* has been published. On the topic of speciality training, it highlights, among several other concerns, that 45% of speciality training posts are in London where only 16% of the population is based.

The review identified possible steps which might ameliorate these challenges. These included:

- The need for accurate workforce planning
- The need to employ the skill sets of the whole workforce – that is, dental care professionals (DCPs), too
- The commissioning of taskforce reviews – including why training is more attractive in some areas and not in others
- A strategy for the dental specialties with consideration as to how more training can be delivered in primary care.

In 2014, the Centre for Workforce Intelligence commissioned by Health Education England to study the DCP workforce estimated that, by 2025, dental therapists and dental hygienists would carry out 18% of patient care (they obviously did not foresee that the 2006 contract would still be in place in 2021!) The BSPD's Specialists' Branch supports our DCP colleagues fully working within their scope of practice – but this is only part of the workforce solution. Consultants and specialists in paediatric dentistry must be part of the workforce, not only to plan and deliver care for children with the most complex needs, but also to provide leadership for specialist teams and training for others in the workforce (level two care providers, general dentists, foundation dentists, undergraduates and DCPs).

It is frustrating, given the repeated calls for urgent change, that progress has been so slow and we now await the delivery of phase 2 of this review. We are also waiting on the delivery of a new general dental services contract, which we hope will remove what is widely agreed to be a significant barrier to transformation.

I take heart that Nicholas Taylor, the Chair of phase 1 of Advancing Dental Care (ADC), said that the second phase of ADC should 'identify, share and upscale current good practice'. My undergraduate training experience in Manchester some 30 years ago is an excellent example of good practice, based on the 'hub and spoke' model. It involved training sessions at the hospital – the hub – but also practical experience in the community service and in general dental practice – the spokes – so that, as undergraduates, we understood all aspects of care. Nearby to us in central Manchester was an internationally-renowned research centre with which we were closely associated.

Despite the shortages of suitably trained staff, the model lives on in Manchester, although decision-making around the management of dental services is of course very different today. A series of NHS commissioning standards for dental specialities[8] has been developed, setting out the role and responsibilities of each dental speciality. These documents were created to provide commissioners with an understanding of dental provision and they assign responsibility for service planning to managed clinical networks (MCNs).

The *Commissioning standard for dental specialties – paediatric dentistry*[9] sets out three treatment complexity levels. Level 1 care should be provided by a general dental practitioner (GDP), while those providing level 2 care require some additional training and development. The Eastman Dental Institute has had the vision to provide such training and continued support to committed local dental practitioners who have an interest in paediatric dentistry. However, sustainable countrywide mechanisms for commissioning and contracting out such services to the salaried dental services have yet to be clarified. Level 3a procedures should be provided under the care of a specialist, who will have undertaken three additional years of training, and level 3b by a consultant who has undertaken a further two years of development beyond specialist level. Consultants and specialists work symbiotically in paediatric dentistry, ensuring that specialists are supported to deliver care locally as far as possible.

It is up to commissioners and MCNs to assess current pathways and care provision against complexity levels and to demonstrate whether service transformation is required. Clearly, transformation is needed in many areas but, year after year, insufficient specialist training places are allocated to paediatric dentistry! Clinicians may have influence via the MCN, but they do not have a budget or the ability to create training places.

Referring once again to the *Commissioning standard for dental specialties – paediatric dentistry*,[9] the document states that children should 'receive the care they need provided by an appropriately qualified and trained member of the dental team. This care should be delivered as local [sic] to the child as is possible'.

Despite this recommendation, the shortage in specialist numbers means there are still many community dental services across the UK without a specialist to offer care, treatment planning or guidance and support to other staff. As a consequence, many children and young people face long waits for specialist care, often suffering repeated pain and infection while waiting, and travelling for many miles to have effective specialist interventions. When it is well recognised that dental caries (which is only one of the conditions that frequently require specialist care) is among the childhood diseases most commonly leading directly to hospital care and treatment under general anaesthesia, why is specialist paediatric dental care provided in so few centres? Is it right to expect families, many of whom are deprived and economically challenged, to travel such distances to a hospital to access care? If the specialist skills needed to treat these children were normally available close to their community, then surely this would be far better in so many ways?

In some appropriately equipped and staffed community settings, specialists like myself are already providing a full range of care, including inhalation sedation and exodontia, and full-mouth dental care under general anaesthesia is delivered at local hospitals. This keeps children in settings they are familiar with and reduces referrals into secondary/tertiary care hospitals. If there were more paediatric dentists, we would be able to cater to more children and young people closer to their homes and in familiar surroundings. For young children with less advanced early childhood caries, minimally invasive, evidence-based oral healthcare, such as the placement of preformed crowns using the Hall technique, and enhanced prevention with novel interventions such as silver diamine fluoride application can provide effective stabilisation. Local specialist-led clinics could also be training centres for DCPs, foundation dentists or local GDPs wanting to build their skills in managing caries in the primary and young permanent dentition, or to accredit as level 2 practitioners.

I work peripatetically in the West Country, visiting community clinics where the majority of children I treat have severe learning difficulties, medical comorbidities or complex oro-dental problems. All non-consultant specialists should have the benefit of working, albeit remotely, within a managed paediatric dentistry network led by a paediatric dentist. Regrettably, this is not the case in some parts of

the UK, such as mine. In these circumstances, there is little or no peer network support, continuing specialist development involves travelling long distances, and the clinical demands upon us severely restrict our ability to provide training for local GDPs and DCPs. Many community-based specialists in paediatric dentistry work in relative isolation.

My postgraduate training and first years of paediatric experience in Manchester showed me how collaborative care benefited not only the patients but also the staff. All undergraduate paediatric clinical training was by community-based senior dental officers, and we provided training and audit jointly with the consultant team who led on research. This was a clinical network before MCNs were invented!

Is it possible that the calls to address the shortage of specialists have been ignored because those responsible for workforce planning believe that, once the tide of children requiring general anaesthetics has subsided, there will be no more need of us? If that is true, then the full extent of our specialist remit as detailed in our specialist training curriculum[10] is poorly understood and should be recommended reading! While the huge prevalence of dental caries always grabs the headlines, paediatric dentistry encompasses the management of pre-cooperative children and those with significant disability, comorbidity, anxiety, behavioural and communication disorders, developmental disorders of the teeth and dentition (including molar incisor hypomineralisation, which affects one in eight of the population), and the management of more complex traumatic dental injuries.

What are the solutions to our current predicament?

I would like to see:

- Paediatric dentistry-led MCNs being established and fully operational across the UK, as suggested by the NHS commissioning standards, ensuring equitable access to specialist care pathways supported by an appropriately commissioned specialist paediatric dentistry workforce
- Mentoring and buddying systems – which could be delivered virtually – to address the relative isolation of some consultants and community-based specialists, who can then in turn support the development of others in the dental team
- More posts allocated to the training of specialists in paediatric dentistry to address the multilevel under-provision of specialist children's dental services
- A national commitment to ensuring that specialist posts in the community dental services are remunerated at band C, as was originally intended, in recognition of their additional responsibilities and training
- Trusts working together to share employment of specialists on a consultancy basis, for training, audit, policy guidance and, most importantly, supporting the local workforce to deliver high-quality care for a wider range of children
- Collaboration with other specialties; for instance, with colleagues in special care dentistry to agree local priorities (joint trainees across hospital and community can only benefit the future provision of care for the most vulnerable of children).

We need solutions to all these problems, but instead, paediatric dentists are dragged down by the problems we face simply struggling to meet the needs of our patients, as so well expressed in *BDJ In Practice*[11] last year.

Winston Churchill is credited with saying: 'An optimist sees the opportunity in every difficulty'. I am an optimist at a time of enormous difficulty for the dental profession and its patients. COVID-19 has made us think outside of the box and it has been liberating. Microsoft Teams and Zoom meetings have been used to share resources, rapidly produce new guidelines, and support consultants and specialists. Many paediatric dentistry units have remained very busy throughout the pandemic and, to support this within the BSPD, we have worked together more closely than ever.

Has this shown us the way forward? Has this showcased a potential model of support for non-consultant specialists working outwith hospitals? The answer is a resounding yes!

We need change now. It's not just the shortage of specialists which must be addressed, but geographical distribution and balancing of specialist grades. Without addressing both, the opportunities for more efficient and effective management of child dental problems by an appropriately trained and supported multi-professional team (as has been achieved in orthodontics) will not come to fruition. It is my contention that children have waited long enough. We know the obstacles and we know what needs to be done. All that is required is the leadership, opportunity and the impetus before it's too late.

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