

## RESEARCH INSIGHTS

## Paediatric dental GA – a time for change?

Variations in provision of dental general anaesthetic for children in England. *Br Dent J* 2022; <https://doi.org/10.1038/s41415-022-4455-8>

The topic of dental general anaesthetic (DGA) has for a long time commanded large amounts of media press attention. This was heightened by the COVID-19 pandemic, which has seen waiting lists for both routine and urgent paediatric dental care soar.

With the ever-increasing pressure on the current system, it begs the question: is it time for change, and in what form could this come?

This paper by Alkhoury *et al.* aimed to describe the provision of DGA in England on the basis of: who is providing the care, what type of list this involves, and the speciality and grade of clinician planning and delivering the DGA.

In doing so, data were extracted from the Hospital Episode Statistics (HES) database for NHS trusts and internet-based search engines for community dental service providers. Overall, 73.5% of providers contacted were found in the HES, and the lack of a sole storage database was emphasised. Furthermore, 18% of providers contacted did not reply, meaning not all data in this area were available and the different databases led to variations in how data were recorded by providers.

Overall, the results of this research showed stark variability in the provision of this care in different regions of England. I found the diagrammatic representation of data in the form of bar charts alongside pie charts allowed the reader to see this difference, which made the results easier to understand.

The authors highlighted how the data regarding DGA care from all providers are not accumulated and stored centrally, meaning an overview of care cannot be captured to undergo comprehensive analysis for implementing future change.

The authors also highlighted the variability of the grade and specific type of practitioner planning and carrying out care. Most treatment



lists were planned by specialists, with 39% in oral surgery, 32% in paediatrics and 29% by non-specialists. Furthermore, over one-third of providers delivered exodontia-only lists and these providers were found to be in regions of limited access to paediatric speciality dentists. The difference in regional care was highlighted by the lack of continuity in comprehensive care provision in all regions, which the authors argued potentially leads to a postcode lottery for treatment.

With changes to the HES, data could be collected from all providers, allowing for planning for standardised treatment provision based on patient needs, which could reduce variability and ensure the workforce is ready for changes in treatment needs of the population.

By Matthew Maguire  
DFT, Newcastle upon Tyne, UK

## Author Q&amp;A: Nabih Alkhoury

University College London Hospital, Royal National ENT and Eastman Dental Hospital, London, UK



## Why did you decide to undertake this study?

Data from a pilot study (Sanders and Ashley, 2019) highlighted the variability of paediatric dental general anaesthetic (DGA) provision across the areas surveyed. The methods used, however, meant only limited data could be collected. A more holistic approach was developed in this study to better capture this information.

## Did any of the results surprise you?

Yes and no. We expected there to be variability, but the extent surprised us. There was no consistent pathway across England and this study highlighted significant inequalities across regions. Access to DGA is a postcode lottery at present. We also faced significant challenges in

accessing the data and needed to resort to Freedom of Information requests in a large proportion of cases. This was largely due to issues with the HES database, which at present does not capture this activity – 25% of providers did not even appear on it. Other limitations of HES (which were also mentioned in the latest GIRFT report) include missing the modality of treatment (sedation versus DGA) and not always including non-hospital-based providers.

## What do you think the next steps should be considering your findings?

A new central national database, where every activity (including type/responsible provider) is recorded, must be developed. NHS Digital should take notice of these results, improve their data collection methods and move towards consistent coding. This has also been outlined in the commissioning standards for paediatric dentistry in England. Commissioners' decisions would then be better informed, and the NHS can formulate better plans to improve quality and ensure equality across regions. Lack of specialists in paediatric dentistry remains a national challenge. More resources should be invested in training and retaining staff to be able to deliver on those standards. ■