If this then that

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There's an app on my phone that if X happens, Y follows suit. For example, if I post to Instagram, it appears on my Twitter feed. It's terrific – and rather clever. It's nothing new by all accounts, but it does harness one of life's great predicaments; consequences.

It's like a dangerous game of dominos. One thing happens, and a multitude of other things follow. Yes you can skimp on materials, but the final product may be of lesser standard, and the patient might complain, which might mean a trip to Upper Wimpole Street, which will mean stress. Get the picture?

The same applies to where children – and adults for that matter – are accessing dental care. If they head to A&E, there's a chance they won't get seen by someone with the right tools to fix them, which means they will be discharged with painkillers or antibiotics, which further increases anti-microbial resistance, which also means they haven't seen the right person, which also means additional pressure on the NHS. I could go on.

The fundamental principle is this: adults and children alike aren't visiting the right places for the right care, and issues will follow.

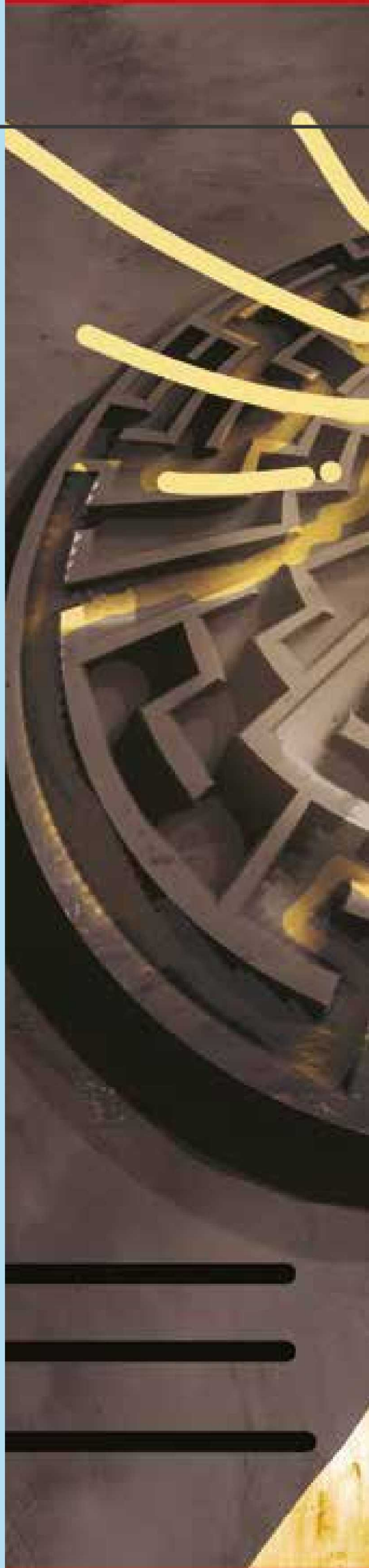
The reality of the situation is that a significant number of children still attend A&E services for non-traumatic dental problems, placing great pressure on an already overburdened NHS.

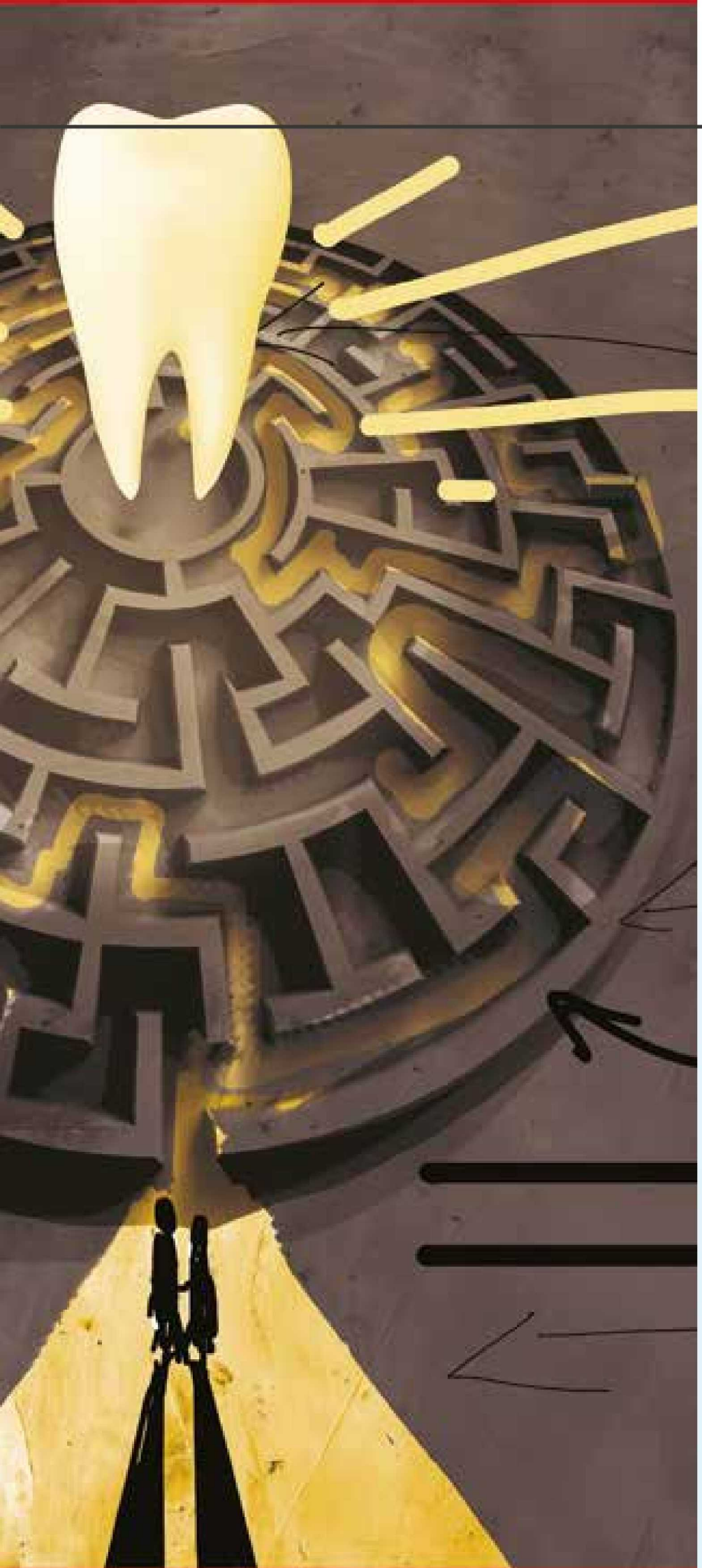
Tooth decay is an entirely preventable condition, but is the leading cause of child hospital admissions. The condition can be effectively managed in primary care – minimising distress to patients and the costs to the health service. Figures from the Local Government Association reveal 160 children and teenagers are undergoing tooth extractions under general anaesthesia in hospitals in England every day.

Latest annual data on NHS spending in 2015/16 reveals there were 40,800 extractions of multiple teeth in under 18s in England at a cost of more than £35.6 million. For GDPs in England 179,000 teeth were removed from children aged nine and under – costing £14 million.

The BDA has long raised concerns about the persistent oral health inequalities that are borne largely by the most disadvantaged communities in England, while independent studies show that oral health problems can have a lasting impact on children's school readiness, impair their nutrition, development, and ability to socialise with other children.

Treating dental disease costs the NHS £3.4 billion a year in primary and secondary dental care (2014). Over 26,000 children aged between five and nine were admitted to hospital in 2014/15 for dental reasons.





Many of the children's tooth extractions carried out in the NHS under general anaesthesia are performed by dentists in the Community Dental Service (CDS). CDS dentists treat vulnerable adults and children and in recent years have faced major problems with low morale, recruitment issues, shrinking services and ever increasing demands. The Community dental services are under attack at the moment with services being tendered out with the resulting loss of jobs and increased pressure on dentists that remain. As the BDA's evidence to the Review Body on Doctors' and Dentists' Remuneration revealed, many community dentists are nearing retirement age and many will look to retire as soon as they can in the face of low morale, increasing stress and increasing pension and GDC costs. Children with the most acute treatment needs can ill afford to lose their expertise.

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Children who are referred to hospital for general anaesthesia are screened and only children who really require this level of intervention undergo it. Nevertheless there are long waiting lists in many areas and children have to endure ongoing pain, repeat courses of antibiotics and continuing interruptions to schooling and family life.

Treatment in hospital, by its very nature is going to be more expensive than treatment in a primary care setting. What is needed is a national programme of prevention, focussing on children from deprived areas that will reduce the need for dental general anaesthesia. We are expecting an announcement from NHS England that will focus on the areas that have the worst and not improving oral health for under five year olds and provide a practice based intervention that will reach out to local communities.

What's out there already?

In the Emergency Department at North Manchester General Hospital, a significant number of children were attending with non-traumatic dental problems such as toothache, abscesses and swellings. In reality these patients are the ones adding pressure to the NHS and

overcrowded A&E wards. Given that doctors don't have too much training in the way of dentistry, many of these patients were referred to the max fax team, often un-necessarily. These referrals meant that children were in the department for longer – which isn't great for the children or the (often very busy) department.

Dr Rachel Isba, a Consultant in Paediatric Public Health Medicine working in the Emergency Department at North Manchester General Hospital audited the attendances and discovered that of all the children who came to the department, only 1 in 8 ended up actually being admitted to the ward. 'The vast majority of children were sent home from the department and told to see the dentist, with no formal follow-up', Dr Isba explained. 'Additionally, the discharge letter from the hospital automatically gets sent to the GP, so even for the children who had a dentist – and we know that some of our local families don't access primary dental care for a variety of reasons – they wouldn't necessarily know that the child had been to hospital. We realised something needed to be done to join up our secondary medical care with existing primary dental care services and to improve the management and referral of these children in the department.'

In a nutshell, the programme enables children who access emergency care to get the right treatment, both in the emergency department and in the community. Dr Isba brought together staff from the emergency department, max fax consultants, community dentists and local commissioners to develop a system that didn't just send children back out of the medical system into the community without being signposted to the correct dental services.

Dr Isba explained: 'One of the important developments in the programme was to develop a clinical pathway for use in the emergency department that would help support the correct management and appropriate referral of children within the hospital as well as identifying those suitable for referral to services.

'If a child is identified using the clinical pathway as needing urgent dental care (but not in the hospital setting), a 'referral' is made by giving the parent or carer a 'golden ticket' voucher (we have two community services involved and parents are given the choice of which one is easiest for them to get to). The parent can then call the number on the voucher, speak to someone in the Urgent Dental Care centre, and make an appointment. These children are prioritised and are given the first available appointment. Vouchers are numbered so that we can track the scheme's success. We also developed an advice sheet for the parents and carers of children who attend the emergency department, giving them advice on how to prevent oral health problems from developing and how to access emergency dental services, should they need them in the future.

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'Everything is designed to provide the most appropriate care to the children but also to try and release the growing pressure on A&E services – the theory being that if children access dental services for their toothache now, this may prevent them from re-presenting to the emergency department in the future with an abscess. This scheme will also hopefully increase the number of children receiving routine primary dental care.'

Dr Richard Valle-Jones, Director for Dentistry at the Pennine Care NHS Foundation Trust, heard about the work Dr Isba was doing, and made it a priority to find out more. He said: 'A colleague of mine mentioned that a doctor at a local hospital was doing some audit work into children attending A&E with dental pain. So I hunted Rachel down, as I thought there might be some potential to collaborate to provide better care in the right setting for these children, initially utilising the unscheduled dental care services provided by Pennine Care NHS Foundation Trust and the Community Dental Service from Central Manchester NHS Foundation Trust.

'It's well-documented that barriers exist for enabling children to access primary dental care, so this particular project was of great interest to me.

'Collaborating and co-designing pathways is a new way of working, but here in Greater Manchester, devolution is enabling this to start to happen. New relationships and networks are being established. From a health economics stance, this work will help to free up significant amounts of money spent on unnecessary attendance at hospital. It takes a number of like-minded individuals including patients to get in a room and begin to understand the complexities involved and use their skills to map out pathways.

'I can't understate the importance of seeking ways in which we can deflect children – and adults for that matter – away from A&E services and into primary dental care services. This not only reduces the strain on hospitals but also provides optimal care for patients. Too many children discharged from hospital don't get the right follow-up care they need. Our team is happy to accept them because we know we are in the best position to give them the right care in the right place and at the right time. Furthermore we can direct them to a general dental practitioner after the episode of care.'

It's worth noting that the programme Dr Isba has created is actually nothing new here. There's no re-inventing the wheel. There's no 'new' service. It simply joins up two pre-existing services. Richard added: 'It's actually a classic example of putting the mouth back in the body. Many of the barriers faced are relating to attitude, understanding, time and cost. Working with non-dental partners really helps share and spread the importance of oral health.

'The NHS has to deal with a high turnover of staff, this can be a positive as it allows the staff to pass on what they know to colleagues and peers, when they move into new roles, which can only be a good thing.'

Care in the community?

Following the publication of new NICE guidance on oral health promotion in the community earlier this year, it's fair to assume local authorities should improve their oral health services and the signposting of available dental services to local community dental services.

The new guidance outlines how local authorities can identify the oral health needs of people in local communities and also put in place steps they can take to address oral health inequalities in those communities.

As a result, the charity is calling on local authorities, working in collaboration with the NHS and dental profession, to do more to identify the needs of their communities and offer them advice and guidance towards dental services which many people are currently missing out on.

Dr Ben Atkins, Clinical Director of Revive Dental Care and a Trustee of the Oral Health Foundation thinks collaboration could go a long way to improving oral health in local

areas.

Dr Atkins said: 'We have to let people who are in need of help know that help is available for them.

'One of the first steps towards this is for local authorities to ensure they understand the needs of their communities when it comes to oral health and put in place the necessary interventions to address any problems.

'Some local authorities already run excellent and effective oral health services. Work done in areas such as Tower Hamlets and the London borough of Hammersmith and Fulham should be held up as a benchmark of what authorities can achieve if they put more focus on oral health.

'There are still some regions in the UK where oral health promotion is not treated with the priority that it deserves and as a result many people feel disillusioned with the help they can get.

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'The NICE guidance includes some very common sense information for local authorities which can help change this. Including carrying out oral health needs assessments in their communities to identify groups at high risk of poor oral health as part of joint strategic needs assessments.'

As well as carrying out oral health assessments of communities, the NICE guidance also advises local authorities to ensure that health and social care services include oral health in care plans of people who are receiving health or social care support and are at high risk of poor oral health. They also recommend that local authorities provide oral health improvement programmes in early years services and schools in areas where children and young people are at high risk of poor oral health.

Dr Atkins continued: 'These are two of the most 'at risk' groups which we are currently seeing, by addressing these areas local authorities can really make a statement about how serious they are taking oral health in their communities.'

But does the money exist in order to carry out oral health assessments of communities in the current financial climate? Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, thinks some areas benefit more than most.

'The pattern seems to be very mixed across the country in terms of local authority involvement with oral health and oral care', Dr Carter said. 'Unfortunately, we are seeing areas with previously excellent oral health programmes such as toothbrushing in schools lose 100% of their budget and other areas where all of the oral health promotion team have lost their positions. Against this background and with across-the-board cuts in Public Health budgets, it will be difficult for local authorities to justify the necessary spend to meet their obligations in oral health whilst cutting other vital services such as tobacco cessation and sexual health.'

Show me the money

Although Dr Atkins cited Hammersmith and Fulham and Tower Hamlets as benchmarks of what can be achieved, areas in Yorkshire, for example, suffer from a chronic lack of funding, a situation made clear when Dentaid provided emergency care in Halifax. Besides financial assistance, I asked Dr Carter what he thought could be done in order to improve care pathways for children accessing secondary, let alone primary dental services.

'The one trend in common across the country is a chronic lack of funding for local authorities to take on, what for them, is a new area and look seriously at the oral health of their population using the recently issues series of NICE guidelines.

'For mainstream dental practice we do need much better provision of up-to-date data so that patients can determine, without marathon effort, what practices in their area have openings. This is a historic challenge existing over many years and not the fault of the local authorities. Obviously the dental practitioner acts as the gatekeeper for secondary care for those patients attending. There is a real issue with the number of patients either attending their medical GP or turning up at A&E with dental problems. Not only is this not the most appropriate route to receive care but in the lack of appropriate training very often the advice or treatment given is not entirely appropriate.

'For an unregistered child with dental problems this may well be the best way of accessing secondary care. The local authority's role here needs to be less on manging the care pathway and more on preventing the need for treatment in the first place. The huge majority of child admissions to hospital for general anaesthetics are entirely preventable as we all know and the local authority role needs to major on ensuring that these preventive messages are received. Integration of oral health into all policies is also important. The mouth does not exist in isolation and dental caries is the most common non-communicable disease worldwide but shares common risk factors with obesity and diabetes and here local authorities can help with an integrated approach.'

Barriers

According to Dr Carter, last year's 5% rise in patient charges against a background of very low inflation really amounted to an additional tax on dentistry. In successive surveys over many decades patients have cited dental charges as one of the major barriers to attendance. Against a background where the rest of the health service is free at the point of delivery (with the exception of prescriptions – where effectively the patient has no option but to pay) even those who attend have always resented dental charges. 'It will certainly send poor signals of the government support for dentistry if charges rise ahead of inflation again this year', Dr Carter added.

Of course the trickle down (or, trickle up. It depends where along the river you are) effect impacts on community dental services. It's a service that's underfunded and overstretched across the board, and Charlotte Waite, Vice Chair England Community Dental Service Committee, thinks community dental services would benefit from a different approach.

'In many ways it's frustrating because the skills within community dental services are there to deal with a lot of the burden, but we're not attached to training hospitals and not part of national recruitment', Dr Waite said.

'A lack of paediatric specialists is a significant problem. There are calls for CDS to be specialist-led, and I feel this would be a huge stride forward. The scope for 'top-up' training and bringing in specialists through a different route would reduce the burden greatly. NHS England's Guide for Commissioning Dental Specialities set out the case for change with the 'getting serious about prevention' mantra in mind. A commissioning guide for paediatric services is the next step in that process and a crucial one at that.

'The issue with that is CDS is very much a reactive service. Patient needs assessments need to be robust. They need to be taking care to the right people in the right places. Local authorities must be pressed to budget for the appropriate services.

'This can only feasibly be achieved if we

have the right workforce in place to deliver care. CDS is a female-dominated environment, which does need to be taken into account. Flexible working hours and career breaks are just two areas that do need to be factored in. The workforce is a highly-skilled one, but without the development afforded by training posts in dental hospitals, we will always be playing catch up.'

Although the shortage of specialists isn't extending waiting times for GA, British Society of Paediatric Dentistry spokesperson Claire Stevens thinks more can – and should be – done locally.

'The shortage of specialists in paediatric dentistry means more children are being referred out of primary care and into secondary care because their care is not being managed locally', Claire told *BDJ In Practice*.

'For example, we know that Hall crowns work and are very easy to place, yet few GDPs have the confidence and experience to do so. BSPD would like to see more specialists working in the community as part of managed clinical networks and a more even distribution around the country. Every area should have a specialist in paediatric dentistry as a resource and to help raise the standard of care of children in that locality. In February 2015, there were 167 Specialists in Paediatric Dentistry registered in England, with a total of 228 in the whole UK.

'Where there is a specialist working in the community, at a community clinic, local GDPs can refer to him or her for an opinion. The dentist may need advice on the management of the child or refer to the specialists who will provide care. Ideally, the advice or treatment from a specialist will mean that the child's dental health issues are managed, preventive advice given and the child does not end up needing a GA for multiple extractions.

'Specialists working in the community are likely to influence and input into clinical standards in that area Support GDPs, input in the provision of care, provide appropriate clinical intervention to obviate a referral for a GA Identify children, families or communities and for those who are at high risk prescribe fluoride varnish, offer preventive advice and implement shortened recall intervals. These skills are necessary for the often challenging nature of the patients seen.

'More specialists in paediatric dentistry should reduce the number of children needing GA. It's better to have diagnosis and treatment planning undertaken by a specialist. There is evidence that a child whose GA is treatment planned by a specialist is less likely to fail the treatment plans and require a repeat operation.'

Allied to Dr Waite's comments, those most at risk of poor oral health are those statistically least likely to have touchpoints with CDS and oral health promotion teams. Taking the care to them is one thing, but engagement is another.

'This really is the value of programmes that take dentistry and oral health promotion out into the community at large', Dr Carter said. 'For many years all children had to have an annual examination by the school dentist but this was actually found to increase inequalities since patients in the system tended to receive more treatment and those not attending would not follow through with suggested treatment. This whole issue demonstrates the huge value of oral health promotion and taking the message out into the community

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where all can access the information in a non-threatening way.

'With oral health promotion teams being disbanded it may be down to the profession using vehicles such as National Smile Month to reach out to the community by taking the message of good oral health out to schools, universities, employers and shopping malls. Being creative on shoestring budgets is something we see all the time.'

Until there comes a time when dentistry marries barriers to care, nothing will change. A&E departments will get more crowded with children (and adults) seeking care for financial reasons. CDS will continue to operate on their outer limits until money is invested – both in recruitment and resources. Primary care services will suffer from a lack of signposting to the right care. If one thing happens, another will follow. And that needs to happen sooner rather than later. ◆