The pandemic and paediatric extractions: Where are we now?

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Key points

- Assessment of pre-pandemic concerns
- Consider whether there are any areas of progress and improvement
- Discuss future challenges on the horizon

Introduction

In the autumn of 2020, I was fortunate enough to chair a webinar with three leading voices in the community dental service. The focus of the webinar was to assess how the CDS could recover, problems patients were facing, possible solutions, and finally what the future of the service may look like.

Given these are quite meaty topics to dig into, not only did we end up slightly overrunning, but there was limited scope for an open Q&A. Yet, I vividly remember that, had we had time for one, only two issues – unfortunately inextricably linked – would have been discussed: GA and paediatric extractions.

Attendees were concerned about the redeployment of staff who ordinarily would have been on hand to assist, not to mention the number of patients who could – and were happy to – be seen. We were very much in the midst of a COVID-19 wave, so who could blame parents for not wanting to take their child somewhere they considered was unsafe?

As things stand

Approaching a full two years later, a picture is forming of how these pandemic-affected years have diverted the direction of travel when it comes to children's oral health. Figures released by NHS Digital reveal that 5.6m children were seen in the 12 months up to June 2022, an increase of 42.1% compared to the 12 months up to June 2021, when 3.9m children were seen. When compared against the 12 months up to June 2019, the report showed a decrease of 20.2%, with 7.0m children seen.[1] It also pointed to fluoride varnish treatments accounting for 53.8% of clinical treatments for children in 2021/22.

The latter of these interests me. In August 2022, research in the *Journal of the American Dental Association* compared several measures of children's oral health and oral health care use early during the pandemic in 2020 with 2019. That research discovered children in 2020 were 16% less likely to have excellent dental health as perceived by parents and 75% more likely to have poor dental health than in 2019. In addition, children in 2020 had higher risk of bleeding gingivae.

The likelihood of having a dental visit in the past 12 months was 27% lower in 2020, including lower likelihood for preventive visits. Significantly, the differences between 2020 and 2019 were observed across demographic and socioeconomic subgroups.[2]

While there are still relatively limited data available on the pandemic's impact on oral health behaviours in the UK, research published in the *British Dental Journal* identified some patterns that may point to habits. Stennett and Tsakos wrote:

> 'Whatever the answer, it's important to assess where paediatric dentistry found itself before the pandemic hit to see what impact data like these may reveal'

'*Prior to the COVID-19 pandemic, few people met dietary recommendations and although those from higher income groups were nearer to achieving some recommendations, diets did not meet recommendations across all income groups. Compared to the corresponding weeks in 2019, there were increases in the reported purchase of confectionery, biscuits and sweet home cooking (all foods 'rich' in free sugars) among adults in the weeks before the initial lockdown (March 2020) and also later in June/July 2020. High intakes of sugars are a major risk factor for dental caries and can also lead to excess calorie consumption, thereby increasing the risk of becoming overweight or obese. Both of these are more prevalent in deprived groups*.'[3]

If – or indeed when – these data presented in *JADA* are available in England, Wales, Scotland and Northern Ireland, it will be fascinating to see whether this purchasing pattern runs alongside poorer levels of children's oral health, and whether this causality implies causation. Whatever the answer, it's important to assess where paediatric dentistry found itself before the pandemic hit to see what impact data like these may reveal. Charlotte Waite, Chair of the BDA England Community Dental Services Committee, pointed to one area of high need that was problematic.

'One key issue is the inequity of access to specialists in paediatric dentistry', Charlotte said. 'The current distribution of paediatric dental specialists is not equitable, leading to inequity of access to specialist led services. Training posts are also not evenly distributed with many being clustered around dental hospitals.

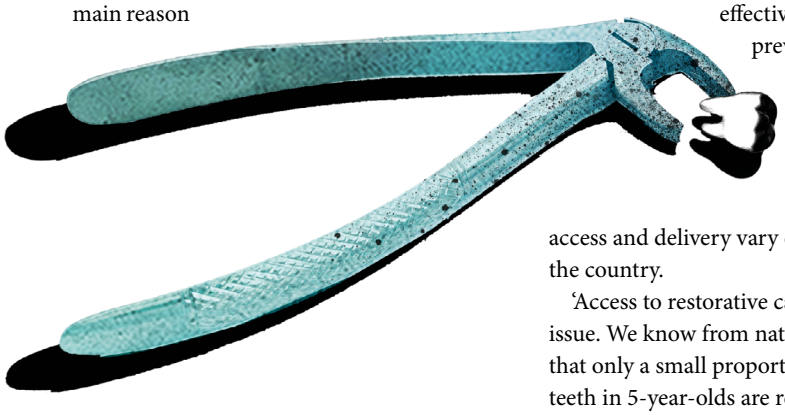
'Some work was being undertaken to address this. The direction of travel in relation to paediatric dentistry, before the pandemic was being shaped significantly by 'Commissioning Standard for Dental Specialties – Paediatric Dentistry' published in 2018. It heralded the 'NHS Five Year Forward View' which set out a shared view of the challenges ahead across health care and promised to bring a greater preventative focus into the planning and delivery of health services.

'We also saw the publication of 'The NHS Long Term Plan' in 2019, which promised a plan for the next ten years. It had a number of actions which specifically related to children's health. In the years leading up to the pandemic we also saw the establishment of Managed Clinical Networks in paediatric dentistry. All of these were designed to increase and enhance paediatric dental services in England.'

Professor Sondos Albadri, President of the British Society of Paediatric Dentistry, pointed to bigger picture improvements, with work still to be done in some areas.

'Overall, children's oral health has improved during the last 20 years – however, there is still much work to do. The British Society of Paediatric Dentistry (BSPD) believes that every child and young person should have a 'dental home'. But we recognise that the current provision doesn't work for children and the pandemic has shone a spotlight on some long-standing issues.

'It is unfortunate that even though dental caries in children is almost always a preventable disease, dental decay was the main reason for children to be admitted to hospital for treatment under general anaesthesia in recent years prior to the COVID-19 pandemic. As paediatric dentists, we usually consider dental extractions under general anaesthetic (GA) as one of the last resorts. However, due to the large number of children presenting with advanced disease and symptoms, many children end up having dental extractions in hospital.



> 'In some regions teams are working at 180% of pre-pandemic capacity as the profession strives to reduce the currently unacceptable waiting times for procedures under general anaesthesia.'

'Access to specialist services and the 'postcode lottery' have been significant issues for a long time. Children undergoing dental treatment under general anaesthesia should ideally have a specialist-led treatment plan but unfortunately, this is variable across the country as demonstrated by recent research in the *BDJ*. This paper also demonstrates that access to GA services is currently inequitable with variable waiting lists across the country.

'Our members, many of whom were redeployed to support the nation-wide COVID-19 response, are working hard to recover children's dental services equitably and fairly but this will take time. In some regions teams are working at 180% of pre-pandemic capacity as the profession strives to reduce the currently unacceptable waiting times for procedures under general anaesthesia.'

Paul Ashley, Professor at the UCL Eastman Dental Institute, echoed the problems highlighted by Charlotte and Sondos.

'I completely agree with Charlotte and Sondos' assessment of the problems faced. I would also point to access to effective, evidence-based preventive schemes. They exist – fluoride varnish and water fluoridation, for example – but access and delivery vary enormously across the country.

'Access to restorative care is also a huge issue. We know from national surveys that only a small proportion of decayed teeth in 5-year-olds are restored. There are lots of reasons for this including training, capacity and remuneration, which have been mentioned. The same applies to timely and uniform access to specialist hospital care. Sometimes the only management plan is to provide care under GA. Access to this and then the subsequent wait varied enormously dependent on where you lived throughout the pandemic – and beforehand, too.

'As a result – and having spent most of my career working in the hospital service – sadly I would have to say paediatric extractions were our 'bread and butter'. A proportion of children with significant dental disease just can't be managed in the chair and end up needing teeth out, usually under GA, in a dental hospital.'

Falling on deaf ears

With words and phrases like access, lack of specialists, recruitment and postcode lottery used by all three, you might just be forgiven for wondering how much of priority addressing these problems really is. They're not new – they pre-date my appointment as editor in 2016 – but rather like many other areas of dentistry, waiting for change is akin to watching a sloth and snail Olympic race.

Sondos' highlighting of the paper by Alkhouri, Sanders, Waite, Marshman and Ashley – in which they concluded children's access to paediatric speciality-led dental general anaesthetic (DGA) in England was variable, with children in certain regions being advantaged[4] – only serves to further highlight the need for those responsible for improving the services to heed the warnings sounded for some years. Sondos added: 'There has been progress in many areas including the establishment of managed clinical networks in England, upskilling of dentists to Tier 2 level and initiatives like child-focused practices in many areas in England. Utilising the dental teams is another area seeing progress.

'On the other hand, we still have an insufficient number of specialists and inadequate distribution especially in those areas with high need. As a society we have been calling for the need to increase the number of specialist trainees especially in the community dental services and areas of high need, but unfortunately there has been limited progress.

'In November 2020, national guidelines were issued on 'Surgical Prioritisation for Children and Young People Requiring Paediatric Dental Treatment Under General Anaesthetic'. This guide gives clear

categorisation of urgent and less urgent oral health conditions to support paediatric dentists on how to assess and prioritise children and young people. The guidance supports the dental team to prioritise children and young people on the basis of clinical need, and not just waiting time. This means that as capacity becomes available, we are treating those that need us most. This aligns us with the process that our paediatric medical colleagues have been using for some time. We are confident that this approach will guide our profession to an equitable recovery, in line with other paediatric surgical services.

'Another significant step was taken more recently with the introduction of 'Welfare Check for Children and Young People Awaiting Dental Care Under General Anaesthesia'. Whilst patients wait for treatment, it is imperative that welfare checks are in place so that those most urgently requiring care are identified and prioritised. The checks will identify the longest waiting patients and work backwards until every patient waiting longer than six months has received a welfare check.'

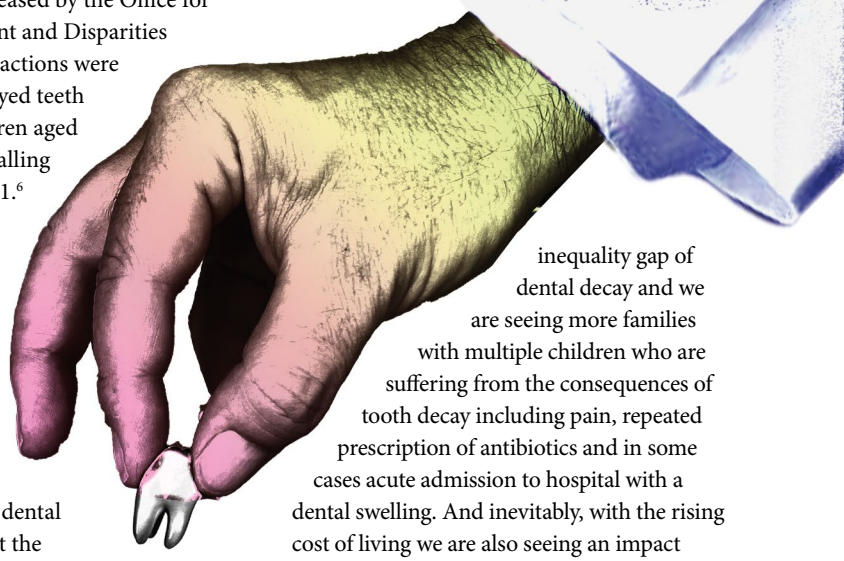
I also asked Paul if he thought any progress was being made. He said: 'Honestly, it's difficult to say. In some respect things moved backwards – the move of dental public health budgets to Local Authorities put them under additional threat so I can't say there was improvement there.

'Schemes were put in place to try and drive more delivery of care in the primary sector, Dental Check by One, the BSPD initiative to push for every child to see a dentist before their first birthday, for example. There were early results showing a positive impact, but the pandemic hit before they could be fully felt. There is now a renewed drive to push this forward.'

The renewed drive mentioned by Paul is brought into focus by an editorial in the *BMJ* which suggested '*children and young people in the UK, including a group of infants who would have been eligible for their first dental visit (365 000, i.e., half of the birth cohort in the previous year)*' missed out on routine dental care.[5] The same article also highlighted Paul's concern about COVID-19 jeopardising children's oral health initiatives, both in the short and long term.

Needs must

Another of the questions that yet remains unanswered is whether the pandemic resulted in a change in the need of treating paediatric patients. The need remained, but the service did not. Figures released by the Office for Health Improvement and Disparities showed 35,190 extractions were performed on decayed teeth in 2019/20 in children aged 0-19 in 2019/20 – falling to 14,615 in 2020/21.[6]



While Paul believes the underlying structural problems still exist – and therefore the need does, I asked Sondos about the shape of paediatric dental services throughout the pandemic, and whether she feels the need of these patients had changed.

> 'Essentially for many months we were only able to see those children who are suffering from constant pain and infection. This led to many children waiting longer than necessary, disease progressing and some requiring more extractions.'

'Our members continued to work hard throughout the pandemic and the recovery period', she added. 'Innovation was embraced by members from virtual consultations to introducing new treatments like silver diamine fluoride. Many colleagues were redeployed into other areas and some continued to see children with urgent needs. But essentially for many months we were only able to see those children who are suffering from constant pain and infection. This led to many children waiting longer than necessary, disease progressing and some requiring more extractions. Many children also struggled to access their family dentists due to the pressures and restrictions there, this meant that we were supporting more patients and managing issues usually handled by GDPs.

'The very nature of the situation means the need has increased. We recently surveyed our members and most of them reported that they are experiencing more pressure on their services, with an increased need and longer waiting times. The pandemic has widened the inequality gap of dental decay and we are seeing more families with multiple children who are suffering from the consequences of tooth decay including pain, repeated prescription of antibiotics and in some cases acute admission to hospital with a dental swelling. And inevitably, with the rising cost of living we are also seeing an impact within paediatric dentistry with many families not prioritising oral health. We need to target prevention and implement an evidence-based approach like water fluoridation and targeted supervised tooth brushing programmes. We must invest in our children's health and well-being to secure them a better future.'

Charlotte also pointed to the backlog that was created, along with the discussion raised by Stennett and Tsakos about diet, and the need for better evidence upon which to base future decisions.

'Urgent Care Hubs provided care for children with urgent dental issues, often by remote consultation or were limited to antimicrobial prescription and analgesic advice during the early stages of the pandemic. Access to theatre lists for extractions under general anaesthetic was very limited during this early stage of the pandemic.

'As elective care under general anaesthetic resumed, infection prevention control, requirements for patients and carers to isolate and test for COVID-19 pre-operatively, led to a significant reduction in the capacity on these dental operating lists.

'The dental needs of the patients remained but managing, prioritising, and triaging the backlog of waiting patients was a significant challenge. This took frontline dentists away from direct patient care and so further exacerbated the backlogs.

'Anecdotally, many colleagues are reporting patients experiencing what they believe to be higher rates of caries in the past few years. Perhaps being attributed to so called 'lockdown diets', loss of routine in relation to toothbrushing and exacerbation by the current access issues to NHS dentistry in the GDS.

'In order to determine if this is the case, we will need to look at the emerging evidence in the years to come; NHS BSA submission data, Hospital episode statistics and the data collected by the National Dental Epidemiology Programme. By piecing together this evidence we can assess the true extent of any increase in dental diseases and gain a better understanding of the associated dental needs of this population.'

Challenges ahead

As previously mentioned, recruitment is an issue that affects vast swathes of dentistry. According to Charlotte, in the BDA's Evidence to the Review Body on Doctors' and Dentists' Remuneration for 2022-23, data suggest that there are fewer community dentists working in England year on year.[7] The CDS workforce is also an ageing one, urgently highlighting the need for workforce and succession planning for this group of dentists.

Sondos added: 'We are also seeing this trend. In our BSPD survey, members told us that they find colleagues retiring early and that they are finding it extremely difficult to recruit specialists into the community dental services.

'However, the problem in hospitals is more complex as we have difficulties recruiting specialists and consultants because we simply don't have the workforce due to the chronic lack of investment. However, when it comes to training positions, we have large demands but not enough training positions. That means many excellent candidates are giving up on training due to lack of opportunities.

'To be fair, there are areas of improvement – I mentioned the upskilling of the workforce with many positive schemes e.g., Tier 2 training in Yorkshire and the Humber and children-focused practices first piloted in Greater Manchester – and now commencing in many other areas across the country. Adopting more minimally invasive techniques to stop children requiring extractions under general anaesthesia, is another area of progress. And, most importantly, the prospect of water fluoridation is a big step forward, as this can make a significant difference to the long-term oral health of society.

'However, there are many colleagues who are feeling the struggle and that their working life has been affected negatively by the pandemic. I am afraid the backlog, waiting listing and access to primary care is currently putting us in a worse position than the situation in 2019.'

Paul's answer was slightly blunter.

'My own belief is that the underlying structural issues are still there, so I think we're heading back to where we were pre-pandemic', he said. 'What we need is policy change to meet the current stresses on the system.'

One also wonders whether the deluge of stories about lack of access to an NHS dentist may prompt more parents to assess their and their child's oral health habits. While Paul emphatically said this is not the case, Charlotte added: 'One observation is that discharging back to high street GDPs following the completion of the child's treatment is more of a challenge. Parents and carers often report that they can't access care with their GDP anymore.

> 'Almost two years after the webinar, the conversation has changed, but the concerns remain, and it should be a great source of angst – and shame – that this is the situation children requiring extractions find themselves in.'

'This means that there is a bottleneck of patients in the CDS who we could and should discharge, but if we did, they would lose access to dental care. It is proving challenging for many children to access dental care in the high street. Until this access issue is resolved, patient flow through the system will be affected.'

'This is a good question but a difficult one to answer', Sondos explained. 'Those children who have dental decay are usually the poorest in the society and visiting the dentist is lower on their priority lists. The cost-of-living crisis is making things much harder for parents – as well as the lack of access to NHS dental services. I saw a family recently, where children are sharing toothbrushes and living mainly on food bank supplies, which means they have limited say on food choices, making healthy diet options more difficult. It is important we keep this in mind when discussing children's oral health as its usually the most vulnerable who end up suffering the most.

'Whilst the pandemic has had a detrimental impact on children accessing a dentist, there is now a renewed focus and urgency for us to get the message out there focusing on prevention and the importance of infants seeing a dentist before their first birthday.'

Sondos' poignant comment about the cost of living crisis once again brings into focus just how much of a priority oral health is going to be. Yes, children are seen free of charge, but petrol and transport costs are not. Can parents afford to take time off work to take their child to the dentist? Will they replace electric toothbrush heads, which for families suffering financially, may be seen as a luxury. Relying on messages of prevention when access is such a problem is like being informed working out is good for me, only to find my nearest gym is a 40-minute train journey from home and then choosing fast food for dinner – it's well-intended, but will have little to no impact.

Almost two years after the webinar, the conversation has changed, but the concerns remain, and it should be a great source of angst – and shame – that this is the situation children requiring extractions find themselves in. Something must change, because without it, patients and profession alike will bear the burden for years to come.

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