The Dental Team – PCDs. Where are we now?

JANET CLARKE

Abstract: **Professionals Complementary to Dentistry (PCDs) have varying roles within the dental team, from chairside assisting to the actual provision of clinical treatment. These tasks are closely proscribed at present, but this may change in the future. The modernization of dentistry, the introduction of registration for PCDs, the introduction of workforce development confederations responsible for funding and commissioning training of dentists and PCDs, and a workforce review looking at the whole dental team will all impact upon the working lives of dentists and their teams. These current changes represent an opportunity to improve the functioning and composition of the dental team, which should not be missed.**

Dent Update 2002; 29: 110–113

Clinical Relevance: **Day-to-day dentistry is performed by a dental team. Appreciation of the role and potential of all team members is essential for effective teamworking. After reading this article, the reader should have a clear understanding of the role and responsibilities of members of the dental team and how this may change in the future.**

The provision of dental care is very much a team exercise, with various members of the team involved as the patient undergoes the journey from possible non-attendance through to a successfully completed and maintained course of treatment. The quality of each patient's experience depends as much upon the care and expertise of the team around the dentist as the treatment provided by the dentist.

In a world of acronyms, yet another has recently appeared – the PCD. This stands for 'professional complementary to dentistry', replaces the outdated term dental auxiliary and has been recognized by the General Dental Council (GDC) in *Maintaining Standards – Guidance to Dentists on Personal and Professional Conduct*,[1] following the Dental Auxiliary Review Group report[2] in 1998. The term properly acknowledges the positive role of the team member in complementing that of the dentist, rather than simply passively assisting.

***Janet Clarke**, BDS, MCDH, DDPH RCS, Diploma in Health Service Management, Clinical Director, Birmingham Personal Dental Service, Birmingham Specialist Community Health NHS Trust.*

Dentistry is being modernized and the important role of the dental team is highlighted in the document *Modernising NHS Dentistry – Implementing the NHS Plan*.[3] It seems appropriate therefore to review the role and responsibilities of PCDs and consider how they could be developed in the future.

WHO ARE THE PCDS?

The GDC has determined that, with the dentist as team leader and responsible for diagnosis, treatment planning, quality control and audit and the patient's overall long-term care, the PCD may perform procedures for which they have appropriate qualification and experience, under written prescription of the dentist.

The Dental Nurse

Dental nurses provide close chairside and surgery support to the operating dentist. They have a pivotal role in ensuring appropriate standards of cross-infection control and other health and safety or risk management issues (such as implementation of COSHH (Control of Substances Hazardous to Health) regulations).

Dentists are encouraged by the GDC to employ 'suitably trained' staff and should usually be assisted by a dental nurse. Dental nurses can obtain the National Certificate of Proficiency awarded by the National Examining Board for Dental Nurses (NEBDN). This is being supplemented by new NVQ-based (National Vocational) Qualifications in oral healthcare awarded jointly by City and Guilds and NEBDN. The NVQs include a significant workplace assessment, in which candidates will have to demonstrate practical competence in the various activities that make up dental nursing. There are two levels of NVQ:

- level 2 covers very basic health and safety skills, but is fairly generic;
- level 3 covers the chairside role of the dental nurse.

A level 3 NVQ will be required for entry to the GDC register once this is established.

One advantage of the NVQ approach is that some elements are transferable to other qualifications, which may encourage school leavers to use dental nursing as an entry into other healthcare careers.

Another advantage is that there are relatively few entry requirements, so school leavers without many formal qualifications may be encouraged to enter a career with an NVQ qualification.

Dental nurses are encouraged to join the Voluntary National Register if they have the National Certificate of Proficiency or experience which equates to the certificate. This experience is assessed and determined in individual cases by the committee of the Dental Nurses Standards and Training Advisory Board. Membership of this register will allow acceptance onto the GDC register (once it is established). For 2 years after establishment of the register there will be transitional ‘grandparenting’ arrangements for other dental nurses, who will need to demonstrate that they have worked satisfactorily as a dental nurse for at least 4 years full-time (or equivalent period part-time) within the previous 8 years.

Post-qualification training can lead to further certification; for example, in sedation nursing or dental radiography. Possession of a post-qualification certificate may be necessary to undertake some tasks such as taking radiographs under the supervision of a dentist.

The Dental Hygienist

Dental hygienists are able to undertake scaling and polishing of teeth and application of prophylactic materials such as fissure sealants and topical fluoride. They must work under the direction of a dentist and may administer infiltration local anaesthetic only under direct supervision of a dentist, and providing they qualified since 1992 or have undertaken further training.

To practise, a dental hygienist must hold a Diploma in Dental Hygiene and must be on the Roll of Dental Auxiliaries of the GDC. They may work in any branch of the profession.

The Dental Therapist

Fewer than 400 dental therapists currently work in the UK. They are able to undertake simple dental fillings, extract deciduous teeth, scale and polish teeth and apply prophylactic materials to teeth. They must work under written prescription of the dentist and are allowed to administer infiltration local anaesthesia only.

Dental therapists are not allowed to work in the GDS unless they are working in a Personal Dental Service (PDS) pilot authorized under the NHS (Primary Care) Act 1997.

Both dental hygienists and dental therapists may place temporary dressings in teeth, under direction of a dentist, if a filling becomes dislodged during treatment. They may prescribe and expose radiographs if they have had suitable training. They are not allowed to work on sedated patients.

The Dental Technician

The dental technician is often the hidden member of the dental team, working at a site remote from the practice. Dental technicians manufacture crowns, bridges, dentures and orthodontic or other appliances to the prescription of the dentist. Whilst there is no need at the moment for dental technicians to be registered, the Dental Technicians Education and Training Advisory Board (DTETAB) would define a dental technician as someone who has undergone training approved by DTETAB which is equivalent to a BTEC national diploma, and who is registered with an appropriate body.

Maxillofacial Prosthetists and Technologists

These are PCDs who are trained to an advanced level and who undertake prosthetic rehabilitation of patients referred to them by surgical consultants, for example maxillofacial surgeons. They usually work in a hospital environment as part of a quite different dental or surgical team.

NON-PCDS

The following members of the dental team are not recognized by the GDC as PCDs at the moment, but are nevertheless valuable people within the team and as such fall within the scope of these discussions.

The Dental Receptionist

The dental receptionist is a pivotal member of the dental team. He or she is often the first person patients (or potential patients) come into contact with at the surgery and often the last one they see as they leave. A positive encounter with the receptionist can ensure that the dental visit goes well – although the reverse is also true. As more practices are using computerized appointment, charging and clinical record systems, the role of the receptionist is crucial in ensuring these systems work effectively. Requirements to undertake point of treatment checks and ethnic monitoring also usually fall upon the receptionist.

There is no formal qualification, although many receptionists have training in computer skills (often in word processing and use of spreadsheets) and NVQs.

The Practice Manager

This is another member of the dental team who may not fall within the PCD definition. The practice manager is often responsible for the day-to-day operational management of the practice, including staff and budgetary management. Dentists are highly trained clinicians, but the undergraduate course includes little management training, so it is beneficial to employ an appropriately experienced manager to allow the dentist to concentrate on clinical work.

Specific qualifications for dental practice managers include a Certificate and Diploma in Dental Practice Management, but many have other management or business qualifications.

The Oral Health Promoter

Oral health promotion can be delivered to individuals, groups or communities and is increasingly becoming part of the general health promotion arena. The skills required are quite different from clinical skills and include negotiating skills, teaching skills and the ability to network effectively. Many oral health promoters were

originally dental nurses, therapists or hygienists. Many have obtained further qualifications, for example the Certificate in Oral Health Education or teaching certificates.

REVIEWS AND RECOMMENDATIONS

The training and role of PCDs was comprehensively reviewed in 1993 by the Nuffield Foundation.[4] This report followed the Inquiry into Dental Education (1980), which considered that dentistry would become more team based. It recommended that diagnosis, prescription and quality control should remain the preserve of the dentist as team leader, but that dentists should delegate some preventive and treatment work to other members of the dental team. The second report, in 1993,[4] looked into education and training of PCDs, which it termed 'Personnel Auxiliary to Dentistry' to mirror the 'Personnel Auxiliary to Medicine'.

The 1993 report recommended an increase in the number of PCDs, who would enable improvement in oral health by undertaking much of the 'routine' work needed. As in the 1980 report, the dentist should diagnose and plan treatment, but then delegate to PCDs. The 1993 report did not prescribe exact roles and duties, but preferred a flexible approach whereby PCDs could carry out any procedure for which they had been fully trained and were able to perform competently. Two types of clinical PCD were proposed: the oral health therapist and the clinical dental technician. PCDs could work in any branch of the profession, but all must be registered and should re-register at intervals, providing evidence of continuing training.

The report generated considerable debate amongst dentists and PCDs. The GDC responded by producing a consultation document on the regulation of dentistry and then establishing the Dental Auxiliaries Review Group in 1996 to look at the future registration and working practices of existing and potential new groups of PCDs. The Review Group produced a consultation paper in 1998.[2]

This consultation paper also recommended that all PCDs should either be appropriately qualified or training for a recognized qualification, and must be registered with the GDC. It outlined specific changes to the roles of different groups of PCDs.

- Dental nurses should be able to remove packs and sutures and take diagnostic impressions, under written prescription of the dentist, who must also be on the premises at the time.
- Hygienists and therapists should be able to administer inferior dental nerve blocks, take impressions and re-cement crowns with temporary cement.
- Dental therapists should be able to work in the GDS.
- Dental technicians should be able to take shades and take impressions, under prescription of a dentist; they would be titled Registered Dental Technicians. Dentists would be directed to use only the services of such registered technicians, through the GDC's ethical guidance.

Two new groups of PCD were proposed:

- The first group would assist during orthodontic treatment, under direct personal supervision of the dentist.
- More controversially, Clinical Dental Technicians would be qualified and registered dental technicians with additional approved training. These PCDs would be able to work to the written prescription of a dentist, but at a remote site, to construct and fit removable complete dentures (including taking impressions) and give advice relating to the treatment they had provided. They would also be able to accept payment directly from patients. If he or she is carrying out part of the treatment plan, as delegated by the dentist, then they could be involved in provision of partial dentures, although without receiving payment directly from the patient. This new class of PCD was intended to address the issue of illegal practice of 'denturism', although transitional arrangements which might encompass such individuals and allow them to practice legally were not proposed.

Many of these recommendations, in particular the statutory registration of all groups of PCD and the introduction of new classes of PCD, would require change to the Dentists Act 1984. This is still awaited, but can be achieved by using a series of draft Orders in Council. The first draft order has now been published and subsequent ones are planned to make registration of the dental team possible. The additional duties proposed for dental therapists and hygienists have been approved by the GDC and await approval by Order in Council. The extension of the work of therapists into all branches of dentistry (in particular the GDS) will be approved by Privy Council.

Careful preparation will be needed, particularly for registration of dental nurses, where transition arrangements which take into account the large number of experienced but unqualified dental nurses working at the moment. In addition, extension of duties and introduction of new classes of PCD will require development of approved training (and syllabus) and establishment of new qualifications and training providers. The requirement for mandatory continuing professional development for all PCDs will take resources and planning at a time when the profession is also coping with recertification requirements for dentists. This could be a valuable opportunity for some training as a dental team.

THE CURRENT CONTEXT

The document *Modernising NHS Dentistry – Implementing the NHS Plan* was published in September 2000.[3] It concentrates on improving access to NHS dentistry, so that anyone will be able to find a dentist by phoning NHS Direct. It also considers modernization of the GDS and salaried dental services, improving the quality of care available and improving oral health. The document states that 'there is now the potential to develop skills and opportunities for the PCDs if:

- Training is made more widely available and is matched to the

extended duties;
- The professions are properly regulated;
- Dentists' overall accountability for the performance of their teams remains clear'.

This is in line with the recommendations of earlier reports and represents a substantial opportunity to enhance the role of PCDs in the dental team.

The issue of the cost-effectiveness of PCDs is regularly raised and the general conclusion appears to be that more work is needed to establish whether or not PCDs are as cost-effective as dentists. However, it would be more appropriate to consider the added value given to the 'dental experience' by the use of PCDs, in the widest sense, rather than considering treatments per hour by different types of clinician. The size of the dental practice and the patient mix is also important.

However, there is also a shortage of qualified dentists working in the NHS and a corresponding shortage of PCDs. The House of Commons Select Committee report into access to dentistry[5] recommended a dental workforce review. This review will take into account the whole dental team, including its composition and size. In addition, as dentistry is now incorporated into National Workforce Planning structures, this means that workforce needs will be regularly reviewed, rather than being looked at infrequently and in isolation from the rest of the NHS.

Primary care itself is being reorganized, with the advent of primary care trusts, which commission and provide care, and the imminent demise of health authorities, which currently administer the GDS. General medical practitioners figure largely in primary care trusts and are used to working proactively with auxiliary personnel. This culture may spill over into dentistry. NHS Direct is playing a larger part as a gatekeeper or triage system for medical care. It will act similarly for dentistry, using clinical decision support software to assess the urgency of callers' dental problems and the most appropriate way to direct them through the system, whether to a GDP in 24 hours or to an accident and emergency department immediately. Nurses are already involved as call handlers in NHS Direct, and it is possible to envisage a similar role for dental nurses as the dental roll out intensifies.

Clinical governance is now required in all NHS dental services to ensure and assure the quality of care received by the patient. It involves participation in appraisal and development, clinical audit, risk management and evidence-based care. It involves everybody who is engaged in caring for patients from dentist to practice cleaner, so once again PCDs will be involved and able to contribute. Effective delegation should ensure a role for everybody in the team, without overloading any one individual.

So, currently there is demand and a growing role for PCDs in dentistry. There are proposals to expand the tasks which PCDs can undertake, with suitable training, and to enable therapists to work in the GDS. There is also a shortage of suitably qualified PCDs who wish to work in the NHS, and often of trainees.

WHAT CAN WE DO NOW?

The operation of the dental team will be enhanced if potential members train together before and after they qualify. Dental schools and teaching hospitals play a valuable role, but expansion of training placements into the primary care sector (general, community or personal dental services) would create more training places and involve more qualified personnel as trainers. This in turn might enhance jobs and improve retention.

Recruitment strategies targeting very local populations, initially aiming for NVQs at levels 2 and 3, might engage people who would not have considered a career in the dental team. Qualification as a dental nurse could then lead to an enhanced role or further training in another branch of dentistry. This is also starting to address involvement of service users in actual provision of care.

The new confederations, which are replacing educational consortia, will be responsible for funding and commissioning post-qualification training for all NHS staff, including dentists and PCDs. This represents an opportunity to address the problems of MADEL (Medical And Dental Education Levy: Section 63) funding, which could be spent only on dentists' training, thus (theoretically at least) excluding PCDs from MADEL courses of great value to them. It should also encourage provision of courses aimed at the dental team, enabling everyone to gain new skills.

The PCD workforce has always been largely female; a gender shift that is now happening within the dental profession and is leading to increasingly family-friendly policies and working patterns. Add to this the increasing demand for extended opening hours and there is potential to create jobs outside the normal '9-5' scenario, which may attract new PCDs, increase retention or attract qualified PCDs back to work, at least on a part-time basis.

Career development opportunities are improving for members of the dental team as more practices invest in practice managers, and the potential for oral health promotion (in the broadest sense) is recognized. Careers outside dentistry should also be promoted, to enable skilled and talented PCDs to move onwards and upwards. PCDs may well be able to become operational managers, health and safety specialists, customer care managers, trainers, information managers and so on.

Finally, competition for scarce workers means that the dental profession must make working within the dental team an attractive proposition. We face competition from many, possibly superficially, more attractive careers, which pay more and offer better working conditions. The Dental Strategy has given us the opportunity to enhance the role of the PCD – and we must seize it.

References

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