Robin Mills introduces the BSPD

What have been the most substantial initiatives promoted by your Scientific Society to date?

One of our biggest successes over the last few years has been our work on safeguarding. As well as developing a new training course (see below) we now have regular representation at NSPCC (National Society for the Prevention of Cruelty to Children) Health Liaison Committee meetings and have invited membership of NHS England Task Group on Dental Care for Vulnerable People, Children and Young People work stream. We have a number of members

Some key dates

1952 The London Study Group is formed – the UK’s first association of paediatric dentists

1968 The British Paedodontic Society (BPS) is created and amalgamates the different groups of dentists established around the UK – it later becomes BSPD

1969 A handbook is published of a BPS meeting, a precursor to the Journal of Paediatric Dentistry

1971 BPS representatives are invited to the Department of Health and Social Security to discuss concerns about the poor standards of child dental health in the UK

BPS representatives are invited as observers to the Specialist Advisory Committee (SAC)

1991 The Journal of Paediatric Dentistry is merged with the International Journal of Paediatric Dentistry which to this day is a key BSPD member benefit

1998 The General Dental Council establishes a specialist list in Paediatric Dentistry

in orthodontics which is later renamed the SAC in orthodontics and children’s dentistry

2013 BSPD acquires an official home in the administrative offices of the Royal College of Surgeons in Lincoln’s Inn Fields

2014 BSPD calls for a meeting with the Chief Dental Officer to discuss ways of improving children’s dental health and a new relationship is established

BSPD - BRITISH SOCIETY OF PAEDIATRIC DENTISTRY

THE BRITISH SOCIETY OF PAEDIATRIC DENTISTRY (BSPD)

History of the Society

The British Society of Paediatric Dentistry (BSPD) has an established place in the dental profession thanks to the dedication of dentists stretching back over 60 years. Throughout its history, BSPD has campaigned for improving standards in child dental health. Today BSPD is a thriving Society with a membership of Consultants, Specialists, GDP’s and Dental care professionals. Our Executive committee provides strategic direction in line with our mission statement and 3 year plan and oversees our engagement with other special interest groups and political decision makers. BSPD is now in a strong position to campaign for and implement improvements in children’s oral health in the UK.

General information concerning the Scientific Society

Country: The United Kingdom.

Established in: 1968 (in its current nationwide form) as The British Paedodontic Society (BPS). The BPS grew from the London Study Group for Paediatric Dentists which was founded in 1952. The term of office of elected members of the Executive committee is one year, honorary members hold office up to five years (confirmed annually at AGM); the media officer is a permanent position, reviewed annually. The BSPD holds an annual Scientific Conference. The location varies year to year.

Admission procedure: Member-ship is open to qualified dentists, dental care professionals, undergraduate and post-graduate student dentists and dental care professionals with an interest in paediatric dentistry.

Executive committee

President: Robin Mills

Past President: Janice Fearne

Vice President: Rosemary Bryan

Vice President Designate: Claire Stevens

Honorary Secretary: Clare Ledingham

Honorary Treasurer: Urshla Devalia

Honorary Membership Secretary: Anne Maguire

BSPD Editor of the IJPD: Sondos Albadri

Media Officer: Claire Stevens

Main office: c/o the Faculty of Dental Surgery - The Royal College of Surgeons of England 35-43 Lincoln’s Inn Fields - London  

e-mail address: administrator@bspd.co.uk; media@bspd.co.uk

www.bspd.co.uk

Robin Mills introduces the BSPD

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who are considered leaders in their field and who lecture internationally. The BSPD Policy document on dental neglect in children has been widely praised and disseminated.

A year ago we took the decision to develop a media team to ensure that the messages concerning children’s oral health in the media are clear and consistent. This has been a hugely successful venture with our members appearing on national and local tv and radio as well as giving interviews for features in national papers and the dental press. Never has children’s oral health been more topical and we are now seen as a voice of authority in this field.

We have also worked with RCSEng and other senior dentists to successfully call for a change to the GDC’s position on tooth whitening in the under 18’s.

We led the way by being the first Specialist Society to devise a specialist map of the UK and hope that other specialities might do the same so that the profession and the public know how specialists are distributed throughout the UK. This will hopefully promote less inequality of access. We also produced a graph of the demographics which demonstrated that significant numbers of specialist paediatric dentists were heading for retirement with implications for future training within the specialty.

**What is the level of collaboration between dentists and paediatricians?**

BSPD has a strong working relationship with The Royal College of Paediatrics and Child Health.
(RCPCH) with cross-representation on a number of working groups. We have a successful “Safeguarding Children: Recognition and Response in Child Protection (CPRR) course”, run jointly by the RCPCH, Advanced Life Support Group (ALSG), BSPD and the NSPCC which integrates dental safeguarding training with that of our medical colleagues (http://www.rcpch.ac.uk/news/paediatric-dentists-work-side-side-doctors-protect-vulnerable-children). This working relationship is reflective of the collaborative working which exists between dentists and paediatricians, especially those working in a children’s hospital environment. We do, however, recognise that more can be done and that there is regional variation. Our current challenge is to ensure that oral health is integrated into general health, for example in public health advice concerning sugar and obesity. The current president of the BSPD served on local safeguarding children boards. This is an excellent way of forging links with local paediatricians. We are campaigning to make having a dental surgeon on a local safeguarding board a mandatory requirement.

What would be necessary to improve children’s oral health?
Scotland has a fantastic initiative called “Childsmile”. Childsmile is a national programme of prevention designed to improve the oral health of children in Scotland and reduce inequalities both in dental health and access to dental services. (www.child-smile.org.uk/). A national programme of prevention, akin to Childsmile, for the rest of the UK would be top of our list of priorities. Furthermore, proper planning of treatment under GA by paediatric dental specialists leads to less repeat treatment under GA, which in turn leads to less expense for the health service and better long term oral health for the child. BSPD is campaigning for the role of Specialists to be fully valued and supported.

What are the association’s future projects?
We strive to work ever more closely with government to help ensure best use of valuable resources. BSPD is currently contributing to the design of a Commissioning Guide for Paediatric Dental Services in England. This vital piece of work will shape the way that Specialist services are commissioned and we are optimistic that it has the potential to improve children’s oral health in England. We aim to continue to engage at the highest levels to ensure we have a voice in the future restructuring and commissioning of children’s dental services. Next year we will be holding a ‘Stakeholder day’ as part of our drive to increase our public engagement. We are also producing Patient Information Leaflets and developing a media strategy (to include the use of social media), to ensure we are in a position to engage with and deliver a co-ordinated response to media enquiries. We continue to develop, endorse and disseminate best evidence, guidelines and clinical protocols to the public and healthcare professionals through the BSPD Policy and Clinical Effectiveness Committee and supporting the production of high-quality systematic reviews through the Cochrane Oral Health Group Professional Global Alliance, ensuring that child-friendly versions of these documents are published.

Pierluigi Altea

View BSPD full mission statement and three-year strategy at: bspd.co.uk/About-BSPD/Mission-Statement

THE KEY FACTS FROM BSPD’S RECENT CHILD DENTAL HEALTH SURVEY (2013)

In 2013, nearly a half (46 per cent) of 15 year olds and a third (34 per cent) of 12 year olds had “obvious decay experience” in their permanent teeth. This was a reduction from the last survey in 2003, when the comparable figures were 56 per cent and 43 per cent respectively. The proportions of children with some untreated decay into dentine in permanent teeth have also reduced, from 32 per cent to 21 per cent of 15 year olds and from 29 per cent to 19 per cent of 12 year olds. In 2013, nearly a third (31 per cent) of 5 year olds and nearly a half (46 per cent) of 8 year olds had obvious decay experience in their primary teeth. Untreated decay into dentine in primary teeth was found in 28 per cent of 5 year olds and 39 per cent of 8 year olds. Children who were from lower income families (eligible for free school meals) are more likely to have oral disease than other children of the same age. A fifth (21 per cent) of the 5 year olds who were eligible for free school meals had severe or extensive tooth decay, compared to 11 per cent of 5 year olds who were not eligible for free school meals. A quarter (26 per cent) of the 15 year olds who were eligible for free school meals had severe or extensive tooth decay, compared to 12 per cent of 15 year olds who were not eligible for free school meals. A fifth of 12 and 15 year olds (22 per cent and 19 per cent respectively) reported experiencing difficulty eating in the past three months. More than a third (35 per cent) of the parents of 15 year olds reported that their daily life had been affected by problems with their teeth and mouth in the past three months. More than a third (35 per cent) of the parents of 15 year olds reported that their child’s oral health had impacted on family life in the last six months; 23 per cent of the parents of 15 year olds took time off work because of their child’s oral health in that period.