INTERVIEW

Rakhee Patel: 'We need to develop a skilled workforce in gerodontology'

Interview by Kate Quinlan

Rakhee Patel, NIHR Doctoral Research Fellow and Consultant in Dental Public Health, King's College London and Public Health England, is the first author of *Crisis in care homes: the dentists don't come*,[1] published in *BDJ Open* on 8 June (https://go.nature.com/3vI23vu).

Rakhee spoke to **Kate Quinlan** about her research interests and why the issues outlined in this paper have been hugely exacerbated by the COVID-19 pandemic.

Can you outline your career background and interests up to the publication of *Crisis in care homes: the dentists don't come*?

After graduating from Cardiff University, I spent the next few years across general practice, hospital and teaching. As an SHO I did some dental public health and really enjoyed the different perspective it offered. Taking a step back and seeing the system from a population perspective was interesting and the opportunity to impact at a wider level appealed to me.

So, once the year ended, I decided to do my Masters. At the same time, I worked as a clinical lecturer and as a domiciliary dentist on a general dental practice contract. I was shocked at how poor dental access was for care home residents and how little was done to prevent disease. I found it devastating that on clinic I was teaching undergraduates about *Delivering better oral health* and the preventative agenda; in surgery I was delivering risk-based prevention to my patients; and yet for those residing in care homes, I was seeing vast amounts of dental disease and there was no routine care and little prevention. This is what led me to apply for a National Institute of Health Research (NIHR) doctoral research fellowship looking at dental prevention in care homes, which is what this paper is based on.

Can you describe the wider focus of your fellowship?

Delivering evidence-based prevention is vital. There is a wealth of evidence on the dose dependent relationship between dental caries and fluoride delivery.

However, having worked in care homes for years, the feasibility of delivering these interventions, be they varnish programmes or high fluoride toothpaste programmes, is challenging. Social care is a complex environment and before advocating for these programmes, we need to explore how feasible it is to actually deliver them in the 'real world'. This is the focus of my fellowship.

> 'I was shocked at how poor dental access was for care home residents'

The Fluoride Interventions in Care Homes (FInCH) study is a three arm clinical trial exploring the feasibility of delivering fluoride varnish and 2,800 ppm fluoride toothpaste compared to control (standard toothpaste). We are looking at delivery not only from a clinical perspective, but from the care home managers' and residents' perspectives for acceptability.

Why is this newly published paper in *BDJ Open* important?

Access to dental care has been a long standing challenge for care home residents. This paper speaks to the experiences that care home managers and staff have had in navigating the dental care system and demonstrates the complexities around accessing and retaining care. The pandemic has been devastating for the social care sector, but has also highlighted the difficulties long faced by care homes. Dental care has always been neglected and with the CQC 'Smiling Matters' report (2019),[2] NICE guidance and focus on integrated care models for care homes, there is a unique opportunity to develop an urgent and routine dental access system that takes into account the voices of care staff such as those in this paper. ▸▸

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When do you think the oral health crisis in care homes began and what factors had an impact?

Care home residents not being offered the same access to care as their community-dwelling peers is not a new issue; the problem has been entrenched for many years in our society. There are factors that have precipitated the issues: the changes in the 2006 dental contract resulting in domiciliary care being limited, social care reform meaning residents are going into care later and with more complex needs, and of course an ageing population. We need to start thinking about healthy ageing and what this means for keeping people dentally functional and pain free as they move towards dependency. For this we need a trained and expert workforce, which currently resides in our community dental services, but with an ageing population and pressures on the community services, we need to develop a skilled workforce in gerodontology across all parts of the dental system, so that complex care home residents can be seen in the right place, by an appropriately skilled clinician, in a timely manner.

How has the COVID-19 pandemic affected the oral health crisis in care homes?

We have all seen the devastating effect that COVID-19 has had on care homes, residents and their family members. The FInCH study continued throughout the pandemic and I saw first-hand how difficult the time was for the care home teams in the study. I sadly lost a significant number of my residents in the study over the pandemic which was awful.

As with most agendas, COVID-19 highlighted the challenges that already existed in the system. Care homes already had poor access to dental care, and during the pandemic this ceased altogether as entry into care homes was restricted. Even now that care homes are keen to resume healthcare access, one of the consequent challenges is that most domiciliary resource is in the community dental services, which have a huge backlog of patients and long waiting times.

We need to start thinking of other, innovative ways to engage with care homes. Many oral health promotion teams have been offering virtual training to care staff, and the opportunities for virtual tele-health models should be considered.

Has the pandemic also restricted the progress of your studies?

We had to defer the six-month examinations, but all other data collection we were able to do virtually. The homes were keen to maintain contact during the pandemic for advice and support for those with needs, which we continued with. I was able to go in as soon as the lockdown eased, to undertake the clinical examinations, so we had to extend the data collection period by three months. Given all that has happened in the last year, it was remarkable that we were able to continue the programme. The willingness and support from care homes emphasises that oral health can be a priority for homes if they have access to advice and support navigating the care pathway.

What urgent action is required to meet the oral health needs of the growing care home population?

We need a collaborative approach with health and social care. Designing a care model with and for social care to meet the needs of the system is crucial if it is to embed and integrate into existing care systems.

> 'As with most agendas, COVID-19 highlighted the challenges that already existed in the system'

Access is only one part of this extensive care system; it should be part of a larger model. A model which includes training of care teams, preventative interventions, integration with wider healthcare and communication between different parts of the dental system. This should all be underpinned by a trained and skilled dental workforce. To make real, long-term, sustainable and scalable progress supporting our vulnerable older people in care, we need to develop a dental care system that is joined up, embedded and embraces innovation.

What are you focusing on now/next in your work?

My immediate focus is to complete my fellowship and write up my PhD. It's been a seven-year labour and I want to highlight what I have learnt to influence meaningful impactful change.

There is limited research in care homes and very few clinical trials involving older people that lack capacity due to the complexities of the social care landscape, ethical considerations and trial governance processes.

As well as highlighting the dental trial elements of FInCH, I think it's really important to show that research can be undertaken with older people in care and that it is really important and valuable to involve them throughout the research process, from conception to design and delivery.

Following this, my area of interest is healthy ageing. I would hope to continue to undertake translational 'real world' research on how we can support our population to maintain function, stay pain free and keep smiling into later life.

Do you think more dental graduates should consider an academic career route?

For me, the clinical academic route has been an excellent career choice. I went from an Academic Clinical Fellow to a Doctoral Research Fellow and hope to continue through the NIHR pathway. The opportunity to do translational research with real world implications and impact has been rewarding and enlightening and I would want to continue in this. I find the clinical and academic components of my posts complement and inform each other, and I would say to any dental graduate that a clinical academic career can be hugely fulfilling and will challenge you to learn new things and think in different ways which will add value to your career and enhance your skills. ■

References

1. Patel R, Mian M, Roberston C, Pitts N B, Gallagher J E. Crisis in care homes: the dentists don't come. *BDJ Open* 2021; **7:** 20. doi: 10.1038/s41405-021-00075-4.
2. Care Quality Commission. Smiling matters: oral health care in care homes. 25 June 2019. Available at: https://www.cqc.org.uk/publications/major-report/smiling-matters-oral-health-care-care-homes (accessed 22 June 2021).

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