I decided to take early retirement from NHS dentistry a year or so ago but before I did so I asked the NHS pensions agency how much my pension would be worth. The figure they produced did not quite tally with my estimate and so I asked from where all my pension contributions had originated. Being somewhat compulsive I had kept payslips from all my hospital work several years ago. Whilst I acknowledge that is slightly sad, it did mean I had full records of pension deductions taken from my pay in those early years.

When the NHS pensions agency eventually sent me my full breakdown, I discovered that to my surprise two of the major hospital trusts had taken contributions from me, but in the main, had not credited them to my NI number (pension account) at all. A third large hospital trust had taken the money but on several seemingly random occasions had credited the wrong National Insurance number. For what it's worth, there were no errors in credits from the Dental Practice Board so that is at least reassuring for those who have only ever worked in general practice. Over several months it took thorough searching of old microfiche payroll records (and payroll staff were very helpful) followed by threats of legal action against the two major culprits before they agreed to settle the amount they owed by upgrading my pension. One hospital trust even suggested (wrongly) that as they had now merged with another trust they could not be held liable for their former errors.

This took a lot of time and leg work on my part especially as it is somewhat worrying that we put our trust in NHS payroll to get it right. Eventually, I am happy I am receiving the correct NHS pension but I wonder how many others are receiving the incorrect pension because they just assumed deducted pension contributions would be correctly credited to their pension account? I appreciate the NHS pensions agency could now be snowed under with enquiries, or that few NHS workers still have their payslips as proof of actual deductions taken *vs.* benefits received but it is worth noting these errors do happen. If you are starting your career, I urge you to keep all records of amounts deducted for the lifetime of your career to ensure you receive your correct pension when you retire.

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AN EXCELLENT RESOURCE

Sir, I would like to draw your readers' attention to the *Oral health and nutrition guidance for professionals*, a publication by NHS Health Scotland. Released in June 2012, this guidance provides an excellent resource to support the dental team in delivering the nutritional outcomes of oral health improvement strategies.

The need for this document grew from the problem of confusing and sometimes conflicting oral health education messages being provided by different healthcare professionals. This guidance focuses on improving the modifiable risk of diet, specifically in relation to the areas of conflict between oral health and nutrition messages. By adopting the common risk factor approach,[1,2] oral health can be improved and diet-related diseases of the population tackled. The potential benefits of such an approach are far greater than isolated interventions. This approach is advocated in the World Health Organisation strategy in oral disease prevention at a global level.[3]

This guidance covers advice on: diet and nutrition, oral health, between-meals food and drink and recommendations for specific groups, such as the under-fives and nutritionally vulnerable older people. It aims to provide agreed, consistent, evidence-based guidance for improving both oral health and general nutrition for the whole population. There is also a particular focus for the under-fives as intervention in the earliest years is vital for improved outcomes in the short and long term and will positively impact across the life course.

While the guidance takes a population approach, it is not clinical guidance. It does not address any medical conditions or individual nutritional and dental needs of particular groups, therefore these issues should be referred to the appropriate professional. Although the guidance is a Scottish publication, it is also available electronically at www.healthscotland.com/documents/5885.aspx.

C. A. Yeung, Bothwell

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2. Watt R G, Sheiham A. Integrating the common risk factor approach into a social determinants framework. *Community Dental Oral Epidemiol* 2012; **40:** 289–296.
3. World Health Organisation. *Strategies and approaches in oral disease prevention and health promotion.* www.who.int/oral_health/strategies/cont/en (accessed 16 August 2012).

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AT YOUR OWN ASTERISK

Sir, I read with interest the paper in the most recent issue of the *BDJ* entitled *Oral diagnosis and treatment planning: Part 3. Periodontal disease and assessment of risk* (*BDJ* 2013; **213:** 111–121).

However, I noticed that the Basic Periodontal Examination (BPE) scoring system mentioned in this paper differs from the most recent guidelines published by the British Society of Periodontology (BSP). In October 2011 the BSP published updated guidelines.

The main changes were that the use of the asterisk symbol (*) should now be used to denote only the presence of a furcation, and that both the BPE code and the * should be recorded for each sextant where furcation involvement is found.

This means that a * should not be scored without a number to indicate pocket depth and hence in theory, a 3* or 4* score can be awarded in a sextant.

I feel that this update is key in removing any ambiguity as to what clinical finding * represents on a BPE chart. However, in order that the BPE should be used as a universal standardised tool for screening for periodontal disease, it is imperative that ALL dental practitioners follow the same guidelines.

The updated guidelines can be found at www.bsperio.org.uk. I would urge all dental practitioners to review these as a reminder of how to score a BPE and for guidance on interpretation of these scores.

S. Marshall
By email

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