Letters to the Editor

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BOUNTIFUL DATA

Sir, we write to express support for the views of Dr Larah in his letter (*BDJ* 2012; **213:** 49). He states that, as part of the consent process, he would like to be able to quote accurate success rates for the various restorative dental procedures that general dental practitioners carry out daily and suggested that prior to 2006, the Business Services Authority (BSA), previously the Dental Practice Board (DPB), held meaningful data. Such data are indeed available!

In 1991 a suitable dataset was established (of which we were fortunate enough to be part of the working group) at the DPB. A sample of the data was subjected, after ten years, to modified Kaplan Meier survival analysis,[1] showing the survival of the 'humble' occlusal amalgam (57%)[2] to the survival rates before re-intervention of crowns (68% for metal crowns, 62% for metal-ceramic and 48% for all-ceramic),[3] veneers (53%),[4] and most recently, bridges (similar survival to crowns).[5]

A previous publication summarises our work on directly placed restorations,[6] in which several common themes emerged including that restoration age at re-intervention decreased with increasing age of the patient,[7] and that in the GDS, patients with high frequency of attendance and higher mean gross spend on treatment *per annum* have restorations which survive less well.[4,7] It therefore follows that, for this group of high treatment need (which could be considered a proxy for high caries activity) patients, the restorations represent poorer value for money, for patients who pay charges or for the taxpayer for patients whose charges are remitted. Further, common throughout the analyses was that patients who changed dentist received restorations which did not survive as long as those placed for patients who did not change dentist. This may be considered to occur, perhaps, because dentists tend to judge their own restorations more kindly than those of other dentists.

We agree that these data can be useful when obtaining consent, but we also consider that the data could inform Government on treatments which are appropriate use of taxpayers' money. In this regard, we are excited to advertise the establishment of a new database. The BSA has now deposited an anonymised large longitudinal sample of its data with the Economic and Social Data Service, soon to become part of the UK Data Service. This sample contains the dental treatment details of over a million patients tracked over the period October 1990-March 2006. This dataset is now freely available to all researchers, and indeed the first piece of work from this new dataset, *Factors associated with patients changing dentist* was seen at the Helsinki IADR PER meeting in September 2012.

F. J. T. Burke, S. Lucarotti, by email

1. Lucarotti P S K, Burke F J T. Analysis of an administrative database of indirect restorations over 11 years. *J Dent* 2009; **37:** 4–11.
2. Lucarotti P S K, Holder R L, Burke F J T. Outcome of direct restorations placed within the general dental services in England and Wales (Part 1): variation by type of restoration and re-intervention. *J Dent* 2005; **33:** 805–815.
3. Burke F J T, Lucarotti P S K. Ten-year outcome of crowns placed within the General Dental Services in England and Wales. *J Dent* 2009; **37:** 12–24.
4. Burke F J T, Lucarotti P S K. Ten-year outcome of porcelain laminate veneers placed within the General Dental Services in England and Wales. *J Dent* 2009; **37:** 31–38.
5. Burke F J T, Lucarotti P S K. Ten-year outcome of bridges placed within the General Dental Services in England and Wales. *J Dent* 2012; **40:** 886–895.
6. Burke F J T, Lucarotti P S K. How long do direct restorations placed within the General Dental Services in England and Wales survive? *Br Dent J* 2009; **206:** E2.
7. Burke F J T, Lucarotti P S K, Holder R L. Outcome of direct restorations placed within the general dental services in England and Wales (Part 2): variation by patients' characteristics. *J Dent* 2005; **33:** 817–826.

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HELPING FAMILIES ACCESS CARE

Sir, I have read with great interest the opinion article *Child dental neglect: is it a neglected area in the UK?* (*BDJ* 2012; **213:** 103–104) and the subsequent letter *Taking prevention to the child* (*BDJ* 2012; **213:** 376). Both highlight the challenges involved with the diagnosis and treatment of child dental neglect. While I do agree that community fluoride varnishing schemes are very effective and that school based intervention programmes also have a place, they do not reach all of these vulnerable children. Some of the most vulnerable children in society are those from families who refuse to engage with all services whether those are health services, social services or education. For example, in school or nursery based intervention or screening programmes, the children may have poor attendance rates and not be present on the screening or intervention day. How can we as dentists then help these children to access dental services?

One model that has been effective is that recently set up in NHS Greater Glasgow and Clyde. In this model children with welfare concerns are referred to the child protection unit based at the Royal Hospital for Sick Children in Glasgow and can be appointed for a comprehensive medical assessment. This assessment includes a comprehensive oral assessment by a dentist. The assessments normally take place in a local health centre or child development