COMMENT

Letters to the editor

Send your letters to the Editor, *British Dental Journal,* 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.
Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

Special care dentistry

Dementia-friendly

Sir, I write in response to Emanuel and Sorensen's recent study.[1] The Alzheimer's Society estimated that in 2015 there were 850,000 people in the UK living with the disability of dementia, or 1.3% of the population, with the cost of dementia to society standing at £26.3 billion, of which £4.3 billion were healthcare costs.[2]

The critical findings of Emanuel and Sorensen's study come at a time when the United Nations Committee on the Rights of Persons with Disabilities reported that the UK's government has not upheld disabled people's rights in healthcare, amongst others, and has not placed measures to safeguard disability rights once the UK leaves the EU, in what the report described as a grave and systematic violation of the rights of persons with disabilities.[3]

In response, the Alzheimer's Society, along with the Dementia Policy Think Tank, Three Nations Dementia Working Group and Young Dementia Network, forwarded a number of recommendations to the UK's government.[4] These recommendations emphasised the need to recognise that impairment caused by dementia is indeed a disability; the need for a person-centred care model, as opposed to a medically-driven one; the allocation of necessary funds and resources for integration of health and social care; and raising awareness of dementia through the introduction of compulsory education and training programmes on disability and dementia to all healthcare professionals in addition to the workplace, schools and universities.

There are two main educational resources offering valuable information to dental healthcare professionals on dental disease prevention and dementia clinical care and management. The *Delivering better oral health* toolkit[5] presents general guidance on caries, periodontal disease and tooth wear prevention based on varying grades of existing evidence. More recently, the Faculty of General Dental Practice published their Good Practice Guidelines for dementia-friendly dentistry.[6]

K. E. Ahmed, by email

1. Emanuel R, Sorensen A. A study of oral health prevention behaviours for patients with early stage dementia. *Br Dent J* 2018; **224:** 38–42.
2. Alzheimer's Society. Dementia UK Update. 2014. Available at: https://www.alzheimers.org.uk/download/downloads/id/2323/dementia_uk_update.pdf.
3. United Nations Office of the High Commissioner. Committee on the rights of persons with disabilities. Inquiry concerning the United Kingdom of Great Britain and Northern Ireland carried out by the Committee under article 6 of the Optional Protocol to the Convention. 2016. Available at: http://www.ohchr.org/EN/HRBodies/CRPD/Pages/InquiryProcedure.aspx.
4. Alzheimer's Society UK. Submission to the UNCRPD Committee on dementia. 2017. Available at: https://www.alzheimers.org.uk/downloads/file/3631/submission_to_uncrpd_committee_on_dementia.
5. Public Health England. *Delivering better oral health: an evidence-based toolkit for prevention.* 3rd edition. 2017. Available at: https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/605266/Delivering_better_oral_health.pdf.
6. Faculty of General Dental Practice. *Dementia-friendly dentistry*. Good Practice Guidelines. 1st edition. 2017. Available at: https://www.fgdp.org.uk/publication/dementia-friendly-dentistry.

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NHS dentistry

Culture of fear

Sir, it was with great interest that I read the article *State-sponsored dental terrorism?*[1]

As a dentist who has worked in an NHS practice I can identify with Mr Kelleher's words and I too have experienced the fear of complaints constantly hanging over my head. I witnessed colleagues who suffered with complaints and subsequently had their names exposed on the GDC website as though they were criminals, even before any investigation had taken place. This action is extremely derogatory and can ruin dentists' reputations.

I believe the current state of affairs has led to many dentists now practising 'defensive dentistry'. It is easier to refer the problem on than to deal with it and risk incurring a complaint.

I am currently working in an oral and maxillofacial unit and I see several referrals for dental extractions every day. The unit implemented a new system for triaging referrals in late 2014, with the purpose of ensuring that only appropriate referrals would be accepted. Despite this, the number of referrals has been increasing every year and we see a large number of inappropriate referrals. There are several cases of moderately difficult or sometimes even simple extractions that are referred to our unit, under the claim that the patients are 'nervous'. Most of the time we will find that this is a false pretense and that patients are indeed able to cope well with dental treatment; however, dentists will make that claim to avoid rejection of the referral.

It is very worrying to see that so many dentists nowadays feel so afraid that 'something might go wrong'[1] and that patients might complain that they will resort to lying just so they don't have to deal with the problem. Of course, another issue is the fact that multiple extractions under the NHS are worth nothing more than three UDAs (the same as a single extraction). Who can blame dentists for not wanting to do their work for free?

As Mr Kelleher pointed out, it is not only the dentists who are affected by this flawed system, but also (and more importantly) the patients. Patients who are referred to hospitals wait longer to receive treatment and on multiple occasions are left in pain whilst waiting for an appointment.

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If the GDC's premise is 'protecting patients', then they are not doing a very good job at it.

The GDC has created a culture of fear amongst dentists which has impacted on how dentistry is practised and delivered. This together with an extremely flawed and unfair UDA system has led to many patients not receiving the standard of care they need.

I believe these times call for a change of culture in the GDC and an urgent revision of the NHS UDA system imposed by the Government.

M. Cabral, by email

1. Kelleher M. State-sponsored dental terrorism? *Br Dent J* 2017; **223:** 759–764.

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Dental volunteering

An invaluable experience

Sir, I am a recently qualified dentist (graduated June 2016) and have participated in a dental volunteer programme (DVP) with the charity, Bridge2Aid. Bridge2Aid has been providing dental training since 2004 allowing over 4 million people in Tanzania access to safe emergency dental treatment. My foundation training educational supervisor is a keen supporter of the charity and after hearing all of her stories I jumped at the opportunity to volunteer.

The aim of the programme is to train six Tanzanian clinical officers in simple, safe tooth extraction. Clinical officers have undergone higher education and have a community clinic for which they are responsible. Their day-to-day activities range from first aid, setting fractures, working a HIV clinic to delivering babies. However, there is no dental training. Many patients attend with dental pain and traditionally, out of necessity, this has been managed with antibiotics. We all are acutely aware of the problems arising from this. Following completion of the Bridge2Aid programme, they should be able to identify sources of dental pain, manage simple cases and know when to refer.

We travelled to the most rural aspects of Tanzania and every day there were 100+ patients waiting, desperate for care. Some of them had walked for hours and older patients would wear their best clothes as a sign of respect. I was astounded at the amount of caries I encountered. Children aged eight years left with only the roots of their first permanent molars was not an uncommon sight. The clinical officers are trained in oral health promotion and dietary advice and must demonstrate their ability to communicate this to their patients as part of the programme.

Teaching is always something that I have considered as part of my dental career pathway and I have been extremely lucky to be able to gain some invaluable teaching experience in such a unique manner so early in my career. This is also something very appropriate for a DCT portfolio. I have also gained a lot of experience and confidence with extractions from this trip. My DVP team were from all backgrounds: young and retiring associates, former lecturers, private dentists, nurses and therapists with a fantastic team spirit. I would strongly urge any new graduates to get involved. More information can be found via: https://bridge2aid.org/ or their Facebook page.

R. Crozier, by email

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Workforce planning

Meeting future needs

Sir, Health Education England (HEE) would like to clarify its position on the Advancing Dental Care: Education and Training Review following the editorial written by Peter Ward, Chief Executive of the BDA (*Dentistry Jim: But not as we know it!* published on 12 January, Volume 224, No. 1, page 1).

HEE has a statutory duty to support the delivery of excellent healthcare and health improvement in England through the education, training and development of the current and future healthcare workforce. This is reflected in our recently published draft workforce strategy *Facing the facts, shaping the future*. It is therefore appropriate that we consider what the dental team should look like to meet future needs, and whether existing training structures and funding models should be adapted to deliver that quality workforce more effectively – indeed we would be failing in our duty if we did not consider such issues.

At the same time, we acknowledge that this is not straightforward; the issues are complex, multifactorial and dependent upon a wide range of variables. There are also different perspectives and views to consider. For these reasons we can say unequivocally HEE's review has no pre-set agenda or pre-determined outcomes.

The intention is to appraise the composition of the dental team, with a view to making best use of the full range of clinicians' scope of practice, whilst recognising any model should recognise the dentist as a highly skilled diagnostician and team leader.

But we also believe we should be creative and consider new and radical ideas – innovative solutions may be required to address the issues of tomorrow. It may transpire these ideas are not workable and will not be progressed – but the aim of our review is to get such ideas 'on the table' and give them due consideration.

It is right that the full dental workforce is consulted and their opinions considered. We, of course, include the BDA in that, and welcome constructive arguments and robust evidence from all stakeholders in order to formulate the best recommendations for the future of the dental professions.

We are part way through the review and our soundings to date suggest there is a strong case for change; however, to reiterate, no decisions will be taken without exploring a range of options and consulting widely. On completion of the review, we will submit a report with recommendations to HEE's Executive Team. The next steps beyond that cannot be predicted at this stage.

However, our aim is to future-proof the workforce – delivering flexibility and sustainability in the context of demographic and technological change within the available funding envelope. We strongly believe that quality patient experience and outcomes, and positive public perception can only be delivered by a satisfied and motivated workforce. We want to provide the next generation of dentists and DCPs with careers that are intellectually stimulating, professionally rewarding and offer financial stability.

We hope our colleagues in the dental professions will contribute and support this important review to meet that ambition and help develop the workforce best placed to meet future needs.

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