Faculty of General Dental Practice (UK)
The Royal College of Surgeons of England

Department of Health/Faculty of General Dental Practice (UK)

Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Periodontics

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Contact details	Tony Jenner Dental and Optical Services Division Section 11/035, New Kings Beam House, 22, Upper Ground, LONDON SE1 9BW 020 7633 4143 www.dh.gov.uk/cdo
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Introduction

The *Guidelines for the appointment of Dentists with Special Interests (DwSIs) in Periodontics* is one of a series of framework documents jointly developed by the Department of Health and Faculty of General Dental Practice (UK).

The frameworks aim to provide guidance to Primary Care Trusts (PCTs) on the development of local DwSI services, and include the competencies for the scope of treatment that can be undertaken by DwSIs.

The periodontic guidance has been written in conjunction with the British Society of Periodontology, primary care dentists, specialists, consultants, university departments, dental faculties, PCT managers, Strategic Dental Health leads and patients.

The guidelines apply to England and should be read in conjunction with *Implementing a Scheme for Dentists with Special Interests (DwSIs)* May 2004, and *A Step by Step Guide to Setting up a Dentist with a Special Interest (DwSI) Service* available on the Chief Dental Officer's section of the Department of Health website at www.dh.gov.uk/cdo and the FGDP(UK) website at www.fgdp.org.uk.

Why do we need DwSIs in Periodontics?

1. Periodontology is that branch of dentistry concerned with the diagnosis and treatment of diseases of the tissues comprising the supporting structures of the teeth.

2. Because of the nature of the diseases and the periodontal tissues, periodontics interfaces with most other dental disciplines and frequently requires complex diagnostic and treatment planning skills. It is the basis of all preventively orientated management of restorative dental treatment and in the case of the more susceptible patient it forms a **life-long** basis for their management. It is the need for comprehensive long term treatment planning that distinguishes it from the more task-driven disciplines.

3. The working group tasked to develop these guidelines has taken the view, which is evidence-based, that there is considerable under-diagnosis and treatment at the basic level and a shortage of access to periodontal specialist care (Chapple 2004, BDJ: 196, 505, White *et al* 2004, J Dent Res: 84, in press, Morgan 2001, BDJ: 191, 436-441). This is likely to get worse over the next ten years or so as those grandfathered onto the specialist list retire and are not replaced as the present training schemes produce only around four specialists per year.

4. It is also the working group's view that there has been a progressive de-skilling of both primary care dentists and hygienists in diagnosis, treatment planning and basic treatment over the years due to the impact and limitations of the General Dental Services (GDS) fee scales and regulations. The Dental Practice Board records are unlikely to show accurate evidence of skills as many keen dentists have opted out of the GDS in respect of adult treatment and there are serious doubts about the quality of periodontal management within the GDS (Morgan 2001, BDJ:191, 436-441).

5. The competencies produced will enable a PCT to identify suitably qualified and experienced dentists for appointment to posts created to try to address the problem of periodontal therapy within primary care.

6. The term "Dentist with Special Interest" refers to an appointment, not to a qualification, and, upon vacating such a post, the former post holder does not remain as a DwSI in periodontology, unless appointed to another such post by another PCT.

Definition of a DwSI in Periodontics

7. A DwSI in Periodontics is a primary care dentist who

   - Is able to demonstrate a continuing level of competence in his/her generalist activity;
   - Is able to demonstrate an agreed level of competence in periodontics; and
   - Is contracted to a PCT or PCTs, as a DwSI, to manage a number of patients requiring periodontal treatment to an agreed level of complexity.

8. A level of care has been identified that is considered to be appropriate to the upper level of general dental practice. In this we have relied on the British Society of Periodontology document *Parameters of Care*. (Appendix 1). This document identifies firstly, a basic level of complexity of care that should be practised by all primary care dentists (complexity 1) and secondly, a level which a primary care dentist with an interest in the discipline may wish to carry out as part of general dental practice (complexity 2). It also defines a third level of greater complexity that is appropriate for referral to a specialist. It is this second level that is considered appropriate for a DwSI. A DwSI may also undertake maintenance of patients initially treated by a specialist or may undertake parts of a treatment plan devised by a specialist which are within his or her levels of competence. The only modification to a DwSI performing complexity 2 work, relates to the provision of periodontal surgery. The latter is only appropriate if competency in the proposed techniques can be demonstrated. Normally this would be limited to resective surgery.

9. Whilst not offering the same breadth of activity in terms of the complexity of cases treated, the DwSI will be required to practice to a standard consistent with that expected from established specialists who cover this area of clinical expertise.

General Requirements

10. In order that PCTs might satisfactorily contract with a primary care dentist to carry out an agreed area of special interest work the PCT should, first and foremost, ensure that the primary care dentist is a competent and experienced generalist.

11. In addition, it is recommended that the PCT satisfies itself that a primary care dentist wishing to be contracted as a DwSI in Periodontics is able to satisfactorily demonstrate that they:

    a. Are able to manage patients to an agreed level (complexity 2).

    b. Recognise their limitations of knowledge and competence, and be aware of the appropriate time to refer on for treatment.

    c. Have knowledge and skills, reflecting an approved period of postgraduate experience.

12. The criteria are defined so that a PCT may appoint a primary care dentist with evidence of more advanced skills to a post with responsibilities for more complex treatment or to provide periodontal specialist services if on the Specialist List. If there are no appropriately skilled candidates, the PCT may consider sponsoring a suitably motivated local primary care dentist on an appropriate programme to acquire the necessary competencies.

13. As funding and treatment regulation for periodontal management has been a major issue in the development of the current situation, PCT funding for those taking DwSI contracts should recognise this and wherever possible make adequate funding available to allow for adequate treatment planning and effective treatment both by the DwSI and by dental care professionals (DCPs), who are an essential part of periodontal treatment. PCTs should also recognise the long-term and ongoing nature of some periodontal treatment.

Competency Framework for a DwSI in Periodontics

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Academic	**Knowledge pertaining to Periodontology**	• Anatomy, physiology, biochemistry, microbiology, immunology and periodontal health and disease, • Processes and clinical course of healing, • Pathobiology including impact of systemic disease and common periodontal diseases • Epidemiology – population and clinical • Pharmacology and therapeutics • Prevention and management of risk factors • Instrumentation and technology in periodontics • Behavioural aspects of therapy • Evidence base for current recommended practices • Legal framework within which PCDs work	Acquisition and appropriate use of knowledge	Portfolio Structured discussion at interview

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Clinical	**History**	• Be aware of the impact a patient's medical history may have on their periodontal health and proposed management strategies (e.g. diabetic control HbA1C, drugs). • Be aware of the potential impact of periodontal management upon a patient's medical health (e.g. renal patients, those with cardiac complications etc.). • Be able to gather a comprehensive history, including occupational, social (smoking, stress), nutritional, family, previous and current medical and dental histories, and to expand upon responses relevant to their periodontal condition.	Comprehensive history taking skills	Portfolio (case histories written up with reflective comments) Video of interview of patient consultation Structured discussion at interview
Clinical	**Examination and Clinical Investigations**	• To screen and comprehensively examine the periodontal, oral and dental tissues, as appropriate. • To competently perform an appropriate examination of the head and neck. • To order and perform appropriate clinical investigations, relevant to the periodontal condition. In particular appropriate radiological assessment, accounting for IRMER 2000 guidelines and the detailed interpretation and reporting of these within the clinical record. Study models and vitality testing would also form part of this process.	Ability to screen/examine and perform and interpret appropriate clinical investigations Organise radiography within the practice	Portfolio (case histories and radiographic protocols used within the practice) Video of interview of patient consultation Practice visit Objective Structured Clinical Examination (OSCE)

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Clinical	**Diagnosis and Prognosis**	• To assess systemic and local risk factors and manage these appropriately in both short and longer term treatment planning. • To assess the occlusal and restorative condition and prognosis as part of the initial prognostic planning procedure. • To determine an initial prognosis at the tooth, whole mouth and patient level. • To formulate a differential, provisional and definitive diagnosis in line with contemporary classification systems and be aware of how this may change during management.	Risk assessment at the patient, whole mouth and tooth/site level. Treatment planning Diagnostic skills	Portfolio Practice visit Video of interview patient consultation Structured discussion at interview Portfolio (case histories and radiographic protocols used within the practice)
Clinical	**Treatment Planning**	• To be able to explain to patients, in terms they understand, their individual periodontal status and the impact of their periodontal condition on their oral and whole body health, and also the impact of the latter upon their periodontal health and prognosis. • To be able to counsel a patient and support or refer appropriately for management of relevant systemic risk factors for their periodontal disease (e.g. smoking cessation, nutritional advice etc.). • To formulate an initial treatment plan, that takes account of the patient's personal, social and occupational behaviours and attitudes and to understand the role of the patient's lifestyle in this process.	Communication skills Counselling skills Treatment planning skills	Practice visit Video of interview of patient consultation Structured discussion at interview

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Clinical	**Therapy**	• To be able to correct or prescribe the correction of local risk factors that may impact upon therapeutic endpoints. • To carry out, and adequately supervise hygienists/ therapists to perform efficient and effective non-surgical therapy, including education, oral hygiene instruction, non-surgical instrumentation, monitoring and supportive care. • Be aware of the indications for and limitations of pharmacological therapy as an adjunct to non-surgical management. • Manage intra- and post-operative emergencies and complications of periodontal therapy, including periodontal abscesses, gingival recession, root caries and dentine sensitivity.	Clinical skills Leadership skills Acquisition and appropriate application of knowledge	Portfolio (case histories and radiographic protocols used within the practice) OSCE Structured discussion at interview
Clinical	**Outcome Assessment**	• To personally review the results of the non-surgical phase of therapy and assess the biological and behavioural response to therapy, at the patient, whole mouth, tooth and site level. • To review the management of systemic and local risk factors and their relationship to treatment outcome. • To understand the need for an endpoint to treatment and what form that may take for the individual patient. This may include maintenance of the result already achieved, progression to more complex therapy (e.g. surgery) or palliative care. Where there is a need for secondary care, to be able to write an appropriate referral letter and to provide relevant documentation and copies of investigations.	Clinical and diagnostic skills Analytical skills Communication skills	Portfolio Practice visit OSCE Structured discussion at interview

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Clinical	**Future Planning**	• To plan and implement supportive periodontal and restorative care to be provided either by the referring primary care dentist and their team, or by their own team. This should include recommendations on suitable monitoring intervals and procedures. • To be aware of the restorative implications for the treated periodontal patient and the consequences of inappropriate restorations to periodontal integrity and stability.	Treatment planning skills Analytical skills	Portfolio (case histories, communi-cations and reflective comments) Structured discussion at interview
Communi-cation	**With patients/ carers**	• To be able to explain to patients/carers, in terms they understand, their individual periodontal status and the impact of their periodontal condition on their oral and whole body health and also the impact of the latter upon their periodontal health and prognosis. • To involve patients in their care through feedback, motivation and decision making.	Communication skills Counselling skills	Portfolio (case histories, letters, practice leaflets, etc.) Video of interview of patient consultation OSCE
Communi-cation	**With referring practitioners**	• To communicate treatment plan and other key stages of therapy, verbally and in writing. • To communicate the planning and implementation of supportive periodontal and restorative care to be provided either by the referring primary care dentist and their team, or by their own team. This should include recommendations on suitable monitoring intervals and procedures. • To be able to communicate the restorative implications for the treated periodontal patient and the consequences of inappropriate restorations to periodontal integrity and stability.	Treatment planning skills Communication skills	Portfolio (patient histories, with supporting letters. Practice protocols for communi-cations and examples of these) OSCE

DOMAIN	MAJOR COMPETENCY	SUPPORTING COMPETENCIES	AREAS OF PERFORMANCE	SUGGESTED SOURCES OF EVIDENCE
Communi-cation	**With specialist services**	• Where there is a need for secondary care, to be able to write an appropriate referral letter and to provide relevant documentation and copies of investigations. • To be able to implement a treatment plan prescribed by a specialist and liaise appropriately and effectively to ensure that seamless care pathways are maintained for patients.	Communication skills Clinical skills	Portfolio (case histories and practice protocols for communi-cations and examples of these) OSCE/ Structured Clinical Operative Test (SCOT)
Communi-cation	**With the team**	• To prescribe, and adequately supervise hygienists/ therapists to perform efficient and effective non-surgical therapy, including education, oral hygiene instruction, non-surgical instrumentation, monitoring and supportive care. • To plan and implement supportive periodontal and restorative care to be provided either by the referring primary care dentist and their team, or by their own team. This should include recommendations on suitable monitoring intervals and procedures. • To ensure ongoing dialogue with hygienists/therapists throughout treatment.	Communication skills Leadership skills Management skills	Portfolio (case histories, with supporting evidence. Protocols for review with DCPs) Audit
Communi-cation	**With medical colleagues**	To communicate about clarity of medical history, precautions necessary and changes in medication to facilitate/improve periodontal outcomes.	Communication skills	Portfolio (case histories, with supporting evidence)
Team Manage-ment	**Governance**	To demonstrate an appreciation of the importance and role of audit and the audit cycle in monitoring self-performance and reviewing practice. Appraisal Job planning.	Governance and self assessment skills Knowledge	Portfolio (written audit projects) Peer review meetings with team

Evidence of maintenance of competencies

14. To ensure maintenance of competencies, any holder of such a contract with a PCT should maintain evidence of the following;

    a. Membership of the appropriate specialist society- e.g. British Society of Periodontology. (Desirable)

    b. Subscription to a specialist journal, normally as part of this membership – e.g. the Journal of Clinical Periodontology. (Desirable)

    c. Continuing Professional Development (CPD) relevant to their special interest area as part of the general and verifiable CPD requirements laid down by the GDC. (Essential)

    d. Continuing appropriate audit of the work undertaken. (Essential)

    e. Ongoing patient feedback, and demonstrate response to this. (Essential)

Accreditation of DwSIs in Periodontics for PCTs

Contract Specification

15. The contract for a service provided by a DwSI should specify:

    15.1 The core activities and the competencies required.

    15.2 The types of patients and clinical problems suitable for the service including age range, minimum caseload, medical status and reasons for referral.

    15.3 The clinical governance, accountability and monitoring arrangements, including links with other periodontic practitioners working in primary care, at PCT level and in Acute Trusts.

    15.4 Remuneration at an appropriate level.

Appointment of DwSIs in Periodontics with PCTs

16. In appointing a primary care dentist with a special interest in periodontics, the PCT should consider:

    16.1 The level of need for periodontal care within the area and the development of a locally managed clinical network appropriate for the delivery of the necessary services.

    16.2 The views of key people in delivering the periodontic services locally, including clinicians and managers in other relevant Acute and Primary Care Trusts, and local primary care dentists. It is important that the primary care dentist with a special interest in periodontics commands the support and respect of others involved in delivering periodontal care and of the potential service users.

    16.3 Evidence of generalist primary dental care competencies. The DwSI will be able to demonstrate a continuing level of competence in their generalist skills. Evidence of training and experience in generalist skills should be provided through a portfolio approach and should demonstrate competence in the following areas:

    Clinical Record Keeping

    Infection Control

    Legislation and Good Practice Guidelines

    Medical Emergencies

    Radiography

    Risk Management and Communication

    Team Training

    The FGDP(UK)'s *Key Skills in Primary Dental Care* is one means by which generalist skills can be demonstrated and independently assessed. The Key Skills assessment is part of the MFGDP(UK) coursework module which provides a portfolio approach to the validation of general fitness to practice. The case and audit requirement of the MFGDP(UK) coursework module can be met through the overall requirements for the assessment of special interest competencies.

16.4 Evidence of successful acquisition of the defined special interest competencies. While an appropriate diploma or proper formal training process would usually be a credible source of evidence of the acquisition of competencies, many applicants will offer other experience based evidence.

16.5 Before the service can be delivered, the following should be in place:

- The support of the local population, primary care dentists and periodontic practitioners, PCTs and Acute Trusts.
- Induction, support and continuing professional development arrangements for the DwSI and team.
- Local guidelines on the use of the service, developed by the PCT in consultation with the clinical network.
- Monitoring and clinical audit arrangements.
- Appropriate indemnity cover. If the primary care dentist is employed directly by the PCT or Acute Trust, he/she will be covered by the Clinical Negligence Scheme for Trusts run by the NHS Litigation Authority. The PCT should notify or discuss the proposed scheme with the NHS Litigation Authority and its own legal advisors. If the primary care dentist is an independent contractor, then he/she will normally be covered by his/her professional indemnity provider. However, in all circumstances the primary care dentist should notify his/her medical defence organisation.

Monitoring of the Periodontic Service

17. The PCT, in reviewing the service and the DwSI's work (through clinical governance, annual appraisal, annual review of the contract and future revalidation requirements), should seek the following:

17.1 Evidence that the guidelines for use of the service are being followed.

17.2 Evidence that the caseload is appropriate.

17.3 Evidence of relevant continuing professional development in general and special interest area, clinical audit, exploration of the views of patients, carers and other health professionals, peer observation and compliance with future revalidation requirements.

17.4 Evidence of involvement in appropriate clinical governance arrangements, including when appropriate in the local Acute Trust(s).

17.5 Evidence of satisfactory process and outcomes of care, including patient views.

17.6 Evidence that the individual's generalist service is not being adversely affected.

18. Dentists who are appropriately registered in EU countries and who apply for DwSI posts or contracts will need to demonstrate the competencies through equivalence.

Primary Care Trusts – needs assessment and delivery

19. Primary Care Trusts should identify their priorities in the context of key national policies, (e.g. NHS Plan, National Service Frameworks) local needs and local service delivery. In order to meet a priority, a service may require reconfiguration. Primary Care Trusts in an area should work together or singly to consider the options for service development. These options will include hospital outreach, community based clinics, periodontal specialists or the appointment of a primary care dentist with a special interest. In deciding how to develop the service the PCT may also wish to consider the views of other trusts and of the current periodontal service providers. Dental public health colleagues may provide an assessment of needs and demands to determine if the service is a priority for development.

20. If it is decided to appoint a primary care dentist with a special interest in periodontics as part or all of a service development, then the PCT (acting singly or as a lead PCT for local PCTs) should make an appointment after due process in line with this guidance and in collaboration with relevant stakeholders including clinicians and providers.

21. In the circumstances where there are no appropriately skilled candidates, the PCT (acting singly or as a lead PCT for local PCTs) may consider sponsoring a suitably motivated local primary care dentist on an appropriate programme to acquire the necessary competencies.

22. As in all commissioning decisions, the PCT should review the appointment regularly. In the case where the PCT is both commissioner and provider, there is a special responsibility to review service quality rigorously. In doing so, it will wish to take into account the views of the local health community and service users, clinical governance and audit data, and outcomes from appraisal. It will need to be satisfied that the post continues to meet a local priority.

System of assessment and evidence required to demonstrate competence

Sources of Evidence

23. Applicants will be able to offer a range of evidence as confirmation of competency which may include both formal qualifications and/or experiential evidence as presented in the applicant's portfolio of evidence.

24. The portfolio should be in four parts comprising the following:

Professional Development

25. This will include:

- Details of training, experience, higher qualifications and evidence to support these. This will include evidence to support the development of generalist skills to at least the level of the FGDP (UK)'s *Key Skills in Primary Dental Care.*

- CPD for the last five years with evidence.

- CPD directly related to periodontology over the last three years with evidence to support these including, normally, membership of the British Society of Periodontology.

- A reflective commentary of not more than 500 words with references for a paper or meeting that has changed the way the applicant practices periodontology.

- Supporting letters from any specialists in periodontology under whose supervision the applicant has worked.

- Supporting letters from dentists who have referred patients to the applicant.

The Practice

26. This will include anonymised used copies of:

    - All clinical record forms used for management of periodontal patients.
    - Protocols for the receipt of patients, communication with referring dentists and specialists.
    - Protocols for communication with DCPs and from DCPs to the DwSI.
    - All practice radiographic protocols and copies of Local Rules.
    - All practice infection control protocols and statements.
    - Evidence (photographic) of adequate provision of facilities and equipment. Lists of equipment available in the practice specifically for periodontal examination and treatment to the level of complexity and the patient load the applicant intends to provide.

Treatment

27. This will comprise:

    - Eight treatment records, suitably anonymised, with full documentation of the cases and a short reflective commentary about each patient of not more than 500 words. These cases must demonstrate all levels of complexity that the PCT wishes to contract for.
    - An additional two cases may be submitted to cover different complexity levels if the eight cases do not adequately demonstrate this.
    - The cases submitted must show evidence of compliance with the practice clinical, administrative and record protocols.

Communication Skills

28. This will comprise:

    - Four anonymised prescriptions to DCPs.
    - Four anonymised communications to referring dentists and specialists.

29. In the absence of supporting letters from any specialists in periodontology under whose supervision the applicant has worked, a PCT may also wish to include, for example, an OSCE, practice visit and/or patient treatment observation as part of the accreditation process. If this is considered necessary then the applicant must be notified beforehand to enable appropriate arrangements to be made. Additional evidence items are highlighted in the competency framework and should be used at the discretion of the accrediting PCT.

Process

30. The process will usually be an evaluation of the evidence presented in the applicant's portfolio of evidence.

31. The evaluation should be carried out by a local accreditation panel, which would normally include a specialist in periodontology from the British Society of Periodontology, a local consultant in restorative dentistry, an FGDP(UK) representative, representing primary care dentistry, a Local Dental Committee representative and a PCT representative.

32. PCTs may consider it appropriate to interview potential candidates for accreditation as DwSIs.

References

Competency Document – OMFS/SHO Working Group" – Dr Linda Prescott, June 2001

Appendix 1
The British Society of Periodontology, Referral Policy and Parameters of Care

THE BRITISH SOCIETY OF PERIODONTOLOGY

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REFERRAL POLICY AND PARAMETERS OF CARE

Referral of patients with periodontal problems, to either specialist practitioners or hospital consultants depends on several factors:-

1. The GDP's knowledge and ability to treat patients which will vary considerably.
2. The patient's desire to see a specialist or undergo specialist treatment.
3. The age and general health status of the patient.
4. The complexity of treatment required.

It is difficult to be absolute in determining referral policy guidelines but if a basic periodontal examination is carried out (outlined below) then based upon its criteria **Complexity 1** cases may be treated in general practice, **Complexity 2** cases either referred or treated by the GDP and **Complexity 3** cases mostly referred. It is worthy of note that sometimes apparently simple periodontal treatment may have to be delivered by Specialists as part of a more complex integrated treatment strategy in order to maintain the integrity of the restored dentition. Equally, patients falling into the **Complexity 3** category may not necessarily require care from a specialist.

Parameters of Care

- It is the responsibility of the dentist to monitor/screen patients for the presence of periodontal diseases including the use of relevant radiographs to make a diagnosis and institute a treatment plan with defined therapeutic goals.
- Like many other conditions the treatment of periodontal disease depends to a large extent on patient compliance.
- An assessment should be made of rate of disease progression and related to age in the overall context of oral health management. Consequences of no treatment should be explained.
- For reasons of poor general health, lack of effectiveness of plaque control or non-compliance with good oral hygiene regimes, the patient's own wishes or the operators' decision, appropriate treatment to control disease may be deferred or declined.
- In certain cases, because of the severity and extent of the disease, the age and health of the patient, treatment that is not intended to attain optimal results may be indicated. In these cases initial therapy may become the end point.
- All periodontal assessments should be written in the notes particularly with regard to probing depths, attachment levels, bleeding sites, plaque scores and mobility and outcome assessments must be carried out in relation to the balance of the health/disease axis and the comfort function and aesthetics of the patient.
- If the results of initial treatment resolves the periodontal condition, maintenance therapy should be scheduled at appropriate time intervals.

The Periodontal Treatment Assessment was drawn up by the Clinical Audit Committee RCS (Eng.), following consultation with the British Society of Periodontology.

BPE - Basic Periodontal Examination

The Basic Periodontal Examination requires that the periodontal tissues should be examined with a standardised periodontal probe using light pressure to examine the tissues for bleeding, plaque retentive factors and pocket depth:

Code	
0	No bleeding or pocketing detected
1	Bleeding on probing - no pocketing > 3.5mm
2	Plaque retentive factors present - no pocketing > 3.5mm
3	Pockets > 3.5mm but <5.5mm in depth
4	Pockets > 5.5 mm in depth

PERIODONTAL TREATMENT ASSESSMENT

Modifying Factors that are Relevant to Periodontal Treatment

A modifying factor can only increase complexity by one increment. Multiple factors are not cumulative.

- Co-ordinated medical (e.g. renal : cardiac) and / or dental (e.g. oral surgery : orthodontic) multi disciplinary care
- Medical history that significantly affects clinical management (See below)
- Special needs for the acceptance or provision of dental treatment.
- Mandibular dysfunction
- Atypical facial pain
- Undiagnosed facial pain
- Presence of a retching tendency
- Limited operating access
- Concurrent mucogingival disease (e.g. Erosive Lichen Planus)

Medical History that Significantly Affects Clinical Management

- Patients requiring IM or IV medication as a component of clinical management.
- Patients with a history of head / neck radiotherapy.
- Patients who are significantly immuno compromised or immuno suppressed.
- Patients with a significant bleeding dyscrasia / disorder.
- Patients with a potential drug interaction.

Periodontal Treatment Assessment

Based upon the Basic Periodontal Examination (BPE) Criteria

Criteria	Complexity
• BPE Score 1 - 3 in any sextant	= Complexity 1
• BPE Score of 4 in any sextant • Surgery involving the periodontal tissues	= Complexity 2
• Surgical procedures associated with osseointegrated implants • Surgical procedures involving periodontal tissue augmentation and / or bone removal (e.g. Crown lengthening surgery). • BPE score of 4 in any sextant and including one or more of the following factors: ✍ Patients under the age of 35 ✍ Smoking 10+ cigarettes daily ✍ A concurrent medical factor that is directly affecting the periodontal tissues ✍ Root morphology that adversely affects prognosis ✍ Rapid periodontal breakdown >2mm attachment loss in any one year	= Complexity 3

The index of treatment needs for periodontal treatment assessment administered through the Clinical Audit Committee of the RCS/Eng is based on the most widely used practitioner oriented Basic Periodontal Examination (BPE) as devised by the British Society of Periodontology. It sets complexity codes in a simplistic manner with the addition of a list of modifying factors that are relevant to periodontal treatment and an outline of medical histories that significantly affect clinical management.

It is strictly a complexity assessment and does not address either the motivational aspects of treatment or a prioritisation of treatment.

Nevertheless it is a very useful tool not only for providing guidelines of complexity but also for indicating according to complexity where treatment should be carried out. The only area of possible contention may be the smoking issue with a BPE of 4 in any sextant. Recent work has suggested that the treatment of smokers with periodontal disease should be kept as simple as possible.

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