Dental Tribune

The World's Dental Newspaper · United Kingdom Edition

Published in London | September 2013 | Vol. 7 No 11

News in Brief

Stress fuels cancer spread
Scientists have linked the activation of a stress gene in immune-system cells to the spread of breast cancer to other parts of the body. The study, published in the *Journal of Clinical Investigation*, suggests that the gene, ATF3, may be the crucial link between stress and cancer, including the major cause of cancer death – its spread, or metastasis. Tsonwin Hai, professor of molecular and cellular biochemistry at the Ohio State University and lead author of the study said: "If your body does not help cancer cells, they cannot spread as far. The rest of the cells in the body help cancer cells to move, to set up shop at distant sites. And one of the unifying themes here is stress."

P&G call for relaxed teeth whitening laws
Procter & Gamble is asking European regulators to loosen rules that stop it from selling teeth-whitening products. P&G's Whitestrips contain between six and ten per cent bleach, and its 3DWhite mouthwash contains 1.5 per cent bleach. Under EU regulations, products in which the bleach or hydrogen peroxide content is between 0.1 and six per cent can only be offered by dentists. Products higher than six per cent are illegal in the EU. A P&G executive has said that the US group was pushing Brussels to ease the restrictions.

Dentist struck off for offering female circumcision surgery
A dentist has been struck off by the GDC after it was found that he conducted an inappropriate intimate examination on a woman and offered to perform female circumcision on two children. The allegations against Omar Sheikh Mohamed Addow included meeting with a woman at his surgery, conducting an intimate examination of the woman's private areas despite not being a doctor registered with the GMC; and offering to perform female circumcision, otherwise known as 'female genital mutilation' (FGM), upon two children. The Committee stated: "Mr Addow's conduct fell far short of the standards expected of a registered dental practitioner when he performed an intimate examination upon the journalist in his dental surgery. He also acted in a manner that was totally unacceptable for a registered dentist when he talked with her about, and planned to perform, FGM on two children." DT

News

Earnings
Earnings down for dentists

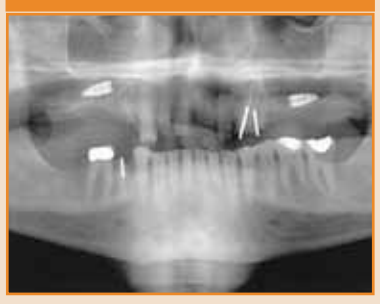
▸ page 2

Comment

Amit's corner
Amit Rai on the CQC

▸ page 8

Implant Tribune



Stem cells
Dr Pelegrine discusses regenerative medecine

▸ pages 13-16

Implant Tribune

Guided treatment
Dr Kunkela sings the praises of CAD/CAM and CBCT

▸ pages 17-20

Steve Field named CQC Chief Inspector of General Practice

Professor Steve Field has been named as the Care Quality Commission's (CQC) first Chief Inspector of General Practice

Prof Field will lead the CQC's inspection services

Professor Field, a GP and past Chair of the Royal College of General Practitioners, joins CQC from NHS England, where he was its deputy national medical director responsible for addressing health inequalities.

The Chief Inspector of General Practice will lead CQC's inspection and regulation of providers of primary care services across the public, private and independent sectors.

Professor Field's new role will involve working in the interests of people who use primary medical and dental services and make judgments about the quality of care provided. He will ensure that the CQC is providing assurance that the health and adult social care services join up from the perspective of people who use services.

He will also introduce a ratings system for registered primary care providers. The system will identify good as well as poor care in order to support commissioning decisions and a more informed user choice, as well as providing assurance that the fundamental standards are met and action is taken where improvements are needed.

Professor Field said: "I am thrilled at being appointed the first Chief Inspector of General Practice in England. I see this as a wonderful opportunity to highlight what's good in general practice and dentistry, and to shine a light on what isn't. It's an opportunity to make sure that all organisations are encouraged to live up to the standards of the best.

"I have had a long-standing commitment to address health inequalities and this role will enable me to ensure that primary medical services put this increasingly important issue high on their agendas. It will also allow me to focus on making sure that people receive health and care services that are integrated.

"I am sad to be leaving NHS England, and the great team that we've established, but I am looking forward to working with Mike Richards again and joining David Behan's executive team, which has been making great strides in moving the CQC forward in a very positive direction."

CQC Chief Executive, David Behan said: "It is important that the Chief Inspector of General Practice is trusted not only by his peers in primary care, but leaders, staff, and managers throughout the NHS. Steve Field is known and respected across healthcare and is the ideal person to lead our work in primary medical and dental services as well as to ensure that those services link well with other health services and with social care." DT

Study boosts confidence in dental implants

Results from two of the largest international clinical studies performed to date with dental implants have just been published and demonstrate excellent clinical performance. Together, the studies have evaluated more than one thousand Straumann Bone Level implants in Europe, the US and Australia.

The studies both reported very high implant survival rates of more than 98 per cent with practically no bone loss around the implants.

The first study was a randomised controlled clinical trial (RCT) at 11 clinical centres in Europe, USA and Australia.

This RCT has evaluated 106 patients each treated with one implant and followed for three years. The investigators compared the outcomes of two different approaches – the first involving two surgical steps, in which the implant is covered with gum tissue ('submerged') during healing, and the second involving just a single step, in which part of the implant is left exposed ('transmucosal') thus saving a second surgical operation. Only a single implant was lost, yielding three-year implant-survival rates of 98.1 per cent and 100 per cent for the transmucosal and submerged groups respectively.

Because bone loss around implants has been documented as a common undesirable effect of implant treatment, this study looked carefully at bone level changes. It showed that bone level was impressively stable over three years after implant placement, with mean decreases of less than 0.7 mm and 0.6 mm in the submerged and transmucosal groups respectively.

While RCTs demonstrate that products or treatments work well, they are usually conducted by specialists in selected and strictly-controlled populations. This study was performed by dental practices and University clinics that are highly specialised in dental implantology, which raises the question of whether its excellent results can be reproduced in daily dental practice. To answer this, a large study using the same implant was conducted in Europe and the US, in which the dentists had to follow the product guidelines but were able to use the implant as they would in normal daily practice. The strength of this type of investigation, which is known as 'non-interventional study' (NIS), is that it documents real-life situations, in which indications, patients and conditions all vary widely.

In this study, a total of 908 implants were evaluated in 538 patients at more than a hundred dental practices in six countries, revealing an implant survival rate of 98.5 per cent after one year (the risk of failure is highest in the first year after implant placement). Besides the very high survival rates, the bone level remained very stable in the majority of cases. The investigators therefore concluded that treatment with Straumann Bone Level Implants yielded very successful outcomes in 'real life' conditions. DT

Earnings down for dentists

The annual 'Dental Earnings and Expenses' report has now been published.

The report covers England and Wales 2011-12, and provides a detailed study of the earnings and expenses of full and part time self-employed primary care dentists who carried out some NHS work in England or Wales during 2011-12.

The report found that the average taxable income from NHS and private dentistry for Providing-Performer dentists was £112,800, compared to £61,800 for Performer Only dentists. For all self-employed primary care dentists this figure was £74,000.

The average gross earnings for Providing-Performer dentists were £358,400, compared to £96,200 for Performer Only dentists. The average total expenses for Providing-Performer dentists were £245,600, compared to £34,500 for Performer Only dentists.

These figures are down from last year's report, which showed that the all incomes and expenses were higher in 2010-11. DT

Dentist hopes to clone John Lennon

In 2011, dentist Michael Zuk purchased John Lennon's tooth at auction and has since made a line of DNA pendants from it. Now he has gone one step further, and given the tooth to scientists in the hope that they will be able to use the DNA and clone Lennon.

"I am nervous and excited at the possibility that we will be able to fully sequence John Lennon's DNA," he said. "With researchers working on ways to clone mammoths, the same technology certainly could make human cloning a reality." DT

Michael Zuk hopes to clones Lennon from his tooth

Welsh cancer patients 'denied new drugs'

Cancer patients in Wales are more than four times less likely to receive a newer drug on the NHS than those in England, it is claimed.

The Rarer Cancers Foundation (RCF) said the Welsh government's figures show the full extent of inequality in access to cancer drugs across the country. Health ministers in England set up a special fund worth £200m a year in 2010, to help pay for expensive new cancer drugs. In contrast, patients in Wales have to make individual requests for funding through their doctor if a new medicine has not yet been approved by the watchdog NICE.

Andrew Wilson, chief executive of the RCF, claims cancer patients in Wales are paying the price for a failure to fix the broken system. "The Welsh Assembly Government's own figures reveal the extent of inequality in access to cancer drugs in Wales. Cancer patients are paying the price for a failure to fix this broken system.

"The needs of cancer patients are no less pressing on one side of a border than they are on another, nor are treatments any less effective. Urgent action is needed to end this inequality."

A spokesperson for the Welsh Government said: We care greatly about providing the best care for the people of Wales and our commitment is to provide evidence-based, cost-effective treatments fairly to everyone.

"A cancer drugs fund would unfairly disadvantage many patients with serious conditions other than cancer." DT

DENTAL TRIBUNE
The World's Dental Newspaper · United Kingdom Edition

Published by Dental Tribune UK Ltd

Editor
Lisa Townshend
Tel: 020 7400 8979
Lisa@healthcare-learning.com

Advertising Director
Joe Aspis
Tel: 020 7400 8969
Joe@healthcare-learning.com

Sales Executive
Joe Ackah
Tel: 020 7400 8964
Joe.ackah@healthcare-learning.com

Editorial Assistant
Angharad Jones
Angharad.jones@healthcare-learning.com

Design & Production
Ellen Sawle
Tel: 020 7400 8970
ellen@healthcare-learning.com

Dental Tribune UK Ltd
4th Floor, Treasure House, 19–21 Hatton Garden, London, EC1N 8BA

Editorial comment

Hello all and welcome to the latest edition of Dental Tribune UK. I hope you all had time to enjoy the summer and are back refreshed and ready to go for the rest of the year!

You may have noticed that DTUK has undergone a couple of changes, the biggest of which is how many times it is being published. With immediate effect, Dental Tribune UK will now be published monthly.

The editorial team will still strive to maintain the usual mix of high quality clinical and business articles, news and views. We have our new columnist, Amit Rai, who will be taking a regular look at the world of dentistry and giving his comments. Neel Kothari is as ever a regular feature, and you'll still see plenty of news and analysis.

As always, if you'd like to give feedback or want to contribute with an article or clinical case study please get in touch.

This month the big news is the appointment of Professor Steve Field as the CQC's Chief Inspector of General Practice. Now, we all know that any lead job at the CQC will make you about as popular as, well, an inspector on your doorstep from the CQC, and Prof Field will have his work cut out for him as he brings in a ratings system for inspected services and strives to provide consistency across all inspections, including those of dental practices.

Good luck to Prof Field! DT

Do you have an opinion or something to say on any Dental Tribune UK article? Or would you like to write your own opinion for our guest comment page?

If so don't hesitate to write to:
The Editor,
Dental Tribune UK Ltd,
4th Floor, Treasure House,
19-21 Hatton Garden,
London, EC1 8BA

Or email:
lisa@healthcare-learning.com

Letter to the Editor

Dear Editor,

Last spring it was widely reported that dangerous x-ray machines from China, which emit harmful x-rays both to the dentist operating the machine and the patient, had been bought by some dental practices. I had thought this would have been clamped down on by now by the authorities.

However, the BBC 1 programme "Fake Britain" recently reported that this is still occurring. These fake dental x-ray machines do not have the lead protection inside, so the patient's whole face is exposed to radiation and the operator's hands and body receive x-rays, which can cause cancer. The thyroid gland is particularly damaged by radiation.

The programme stated that all kinds of dangerous fake dental instruments are being sold to dental practices, including drills which could explode and shatter in a patient's mouth while being used. The results could be horrific.

Why are these not being prevented from entering the country, and I wonder if any investigations being done by the authorities to check if dental practices have unknowingly bought dangerous fake dental equipment? This is necessary for the health of both dental staff and patients.

Best wishes,

A. Willis.

Ban lifted on healthcare workers with HIV

Healthcare workers with HIV will be able to return to practice, Chief Medical Officer Dame Sally Davies has announced.

Following independent scientific advice, the Department of Health will lift the ban on healthcare workers with HIV being able to carry out certain dental and surgical procedures. Strict rules on treatment, monitoring and testing will be in place to safeguard patients.

The regulations were brought in after the publicity associated with the death of an American dental patient in 1990, one of six patients believed to have been infected with HIV in an unresolved Florida case. Regulatory bodies in most countries responded to the case differently – the UK banned all HIV-infected healthcare professionals from undertaking exposure-prone procedures, leading to health workers becoming deskilled, losing their careers, or suffering in silence. Since most dental procedures are classified as exposure prone, the ban had a devastating significance for dentists diagnosed with the disease.

This change will bring the United Kingdom in line with most other Western countries. Under the new system, patients will have more chance – around one in five million – of being struck by lightning than being infected with HIV by a healthcare worker. There is no record of any patient ever being infected through this route in the UK. There have been just four cases of clinicians infecting patients reported worldwide and the last of these was more than a decade ago.

The policy will be put in place from April 2014. Decided on a case-by-case basis, HIV-infected healthcare workers may be allowed to undertake certain procedures if they are on effective combination antiretroviral drug therapy (cART); have an undetectable viral load; and are regularly monitored by their treating and occupational health physicians.

The British Dental Association's scientific adviser Professor Damien Walmsley said: "Dentists in the UK comply with rigorous infection control procedures to protect both patients and the dental team against the risk of transmission of blood-borne infections.

"The announcement brings England into line with nations including Sweden, France, Canada and New Zealand, and is good news for patients and HIV-positive dentists alike. We look forward to seeing its implementation."

Kevin Lewis, Dental Director at Dental Protection, said: "This is a huge victory for human rights. After decades of living in fear and dealing with prejudice, dentists can finally return to their professional calling, although regrettably it is too late for some to do so. Patient safety should be at the forefront of healthcare, but the original rules were introduced as a reaction to a mysterious and exceptional case, the likes of which we have not seen before or since."

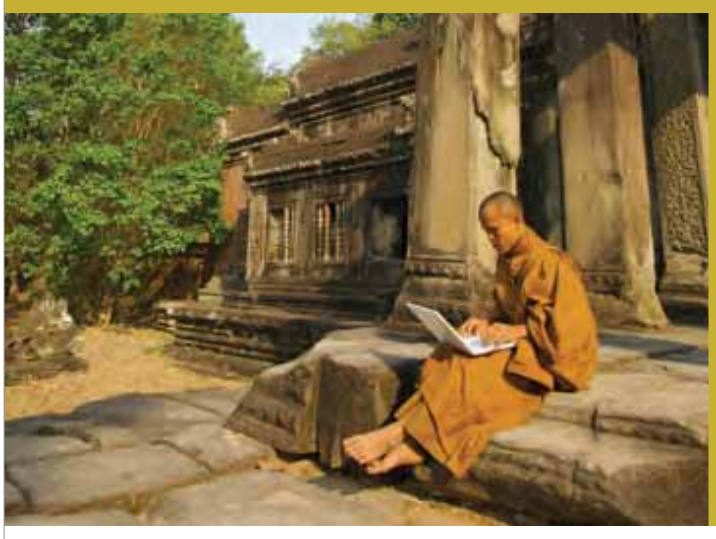
Allan Reid is a dentist with HIV, and as a result has been unable to practice since 2008. Speaking to *Dental Tribune UK*, he said the lift on the ban was "a great step forward. It's the correct thing to do; there's a massive body of evidence that healthcare workers won't pass on the virus to patients, but the timescale [from implementing the ban to lifting it] has been huge."

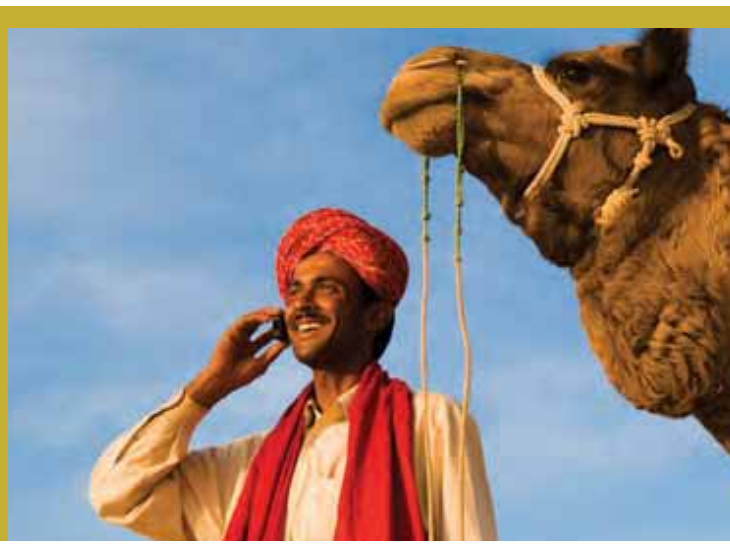
He is, however, concerned about the level of support healthcare workers will receive if they want to return to practice: "I'm worried about the number of careers that have been lost, and I hope these people won't be forgotten about. It's really important that those who want to go back into practice are re-trained and given full support."

As for Allan, he is currently training as a consultant in public health, but says he would very much like to go back to practicing dentistry – provided he is given the appropriate training to make up for five years that he has been unable to practise. DT

The World's First Online

MSc in Restorative & Aesthetic Dentistry





Master of Science in Restorative & Aesthetic Dentistry

'The Best of Everything'

Two of the UK's most respected education and academic organisations have joined forces to provide an innovative, technology driven MSc in Restorative and Aesthetic Dentistry. Healthcare Learning Smile-on, the UK's pre-eminent healthcare education provider and the University of Manchester, one of the top twenty-five universities in the world, have had the prescience to collaborate in providing students with the best of everything – lecturers, online technology, live sessions and support.




Convenience

The majority of the learning resources on this programme will be online. The masters will combine interactive distance learning, webinars, live learning and print.

Ownership

The programme is designed to encourage the student to take responsibility for his/her own learning. The emphasis is on a self-directed learning approach.

Community

Students will be able to communicate with a diverse multi-ethnic global community of peers, with who they will also share residential get-togethers in fantastic settings around the world.

Opportunity

This innovative programme establishes the academic and clinical parameters and standards for restorative and aesthetic dentistry. Students will leave with a world recognised MSc.

Online | **Face to Face** | **Hands-on** | **Together**

Call Healthcare Learning Smile-on to find out more:
tel: 020 7400 8989 | **email:** info@healthcare-learning.com
web: www.smile-on.com/msc

smile-on healthcarelearning
inspiring better care

MANCHESTER 1824
The University of Manchester

The rot runs deep

Stephen Hudson discusses modern dentistry

In my mind, there is a problem that the profession is not addressing, which can easily be displayed by the publication you are presently reading. I want you to scan though it and look at all the adverts for postgraduate courses:

What do you see?

You see lots of courses on how to do smile makeovers, ortho, veneers, implants and aesthetics.

What don't you see?

You see nothing on perio, rapport building, diagnostics, LA techniques, minimal intervention dentistry, caries removal or hands on RCT.

Not the fault of the *Dental Tribune*, because they have no control over the advertising sent to them. And whilst on a local level there is a fair bit of these latter courses offered though the deaneries, whenever I go on these courses, it's always the same faces I keep seeing. And many of the courses are mediocre at best, with some notable exceptions of course.

And then I hear that at least one dental school has dropped the "treatment of a patient under exam conditions" from the finals exam. That makes no sense to me whatsoever. I just can't comprehend the thinking behind that and am amazed that (assuming they have been told of this event) the GDC inspections have allowed it. I'm also hearing reports that graduates are leaving dental school never having done a molar endo, and never having made a F/F. Now I'm sure the powers that be know what they are doing, and it all looks a little short sighted from where I'm sat.

It worries me.

Now have a chat with any dental adviser from DPL or DDU and they will tell you how claims are rising, even with the governments actions on no win no fee. And barring the fact that "stuff happens" that we can't predict, claims are rising because of two main factors:

Dentists are doing things they shouldn't be doing on people they shouldn't be treating; and dentists aren't doing things on people they should be treating.

We are making a rod for our own backs, and the lawyers, often quite rightly, are getting very rich because of it. Then we hear that some figures state that almost 30 per cent of all claims are down to what one dentist says about another dentist's work (usually without being in full awareness of all the facts) and there is a huge tsunami threatening to wash over the "profession".

It's a tsunami of our own making, and down to either our own greed and egos, or the fact that many practitioners, devoid of passion and hope end up in a spiral of despair, doing as little as possible with retirement the only thing keeping them going. And then we season with one more statistic; that all the complaints received by dentists often make up just three per cent of those who COULD legitimately complain. It actually looks like we've been getting off lightly.

> *'Dentists are doing things they shouldn't be doing on people they shouldn't be treating; and dentists aren't doing things on people they should be treating'*

So, what exactly am I saying?

I am saying that, on the whole, we have lost our way. I am not saying there is anything wrong with doing six veneers on a patient, but I am saying that if you didn't specifically warn that patient of the risks and the chances of having to redo all that work on a regular basis, then I'm going to give you a concerned look. If that patient didn't walk into having that treatment with the eyes wide open and the knowledge that the UL2 could blow up and need endo, then that treatment wasn't done in the patient's best interest. Hiding those warnings in a seven-page treatment plan that the patient probably didn't read doesn't absolve you in my book.

Of course, that's just my opinion. It doesn't mean I'm right, it just means I have an opinion. I think sticking porcelain on people's teeth should be way down the list of options and should be considered as a last resort. For example, I struggle to see how a dentist can sell a "course of veneers" on one of those cut price deals websites without even seeing the patient first.

I just don't get it.

There is of course the media image of the celebrity smile which some patients clamour for, and it is surely our duty to say "hold on, that might not be right for you". I often hear dentists who want to be the next Dr X, or the next Dr Y, sucked into the glow of being a "dental celebrity" which lets the ego get in the way of the important things. Like the fact that happiness and self respect come from the inside, not from the external. That our interpretation of what we look like is a thousand miles away from what other people see. That most people don't notice your slightly rotated upper left central, because they are too bothered worrying about how their own image is being perceived by those around them. If we think our slightly crooked smile, or our darkened teeth will effect how others view you, we will often manifest evidence to prove this. If we don't that evidence often strangely doesn't appear.

The true judge of an individual is not their perceived physical attractiveness. The true judge is the person's character.

Maxwell Maltz became one of New York's most successful plastic surgeons from a squat practice, by sending his patients away for 30 days to do visualisation exercises to change their self perception of what they deemed to be their problem. Fifty per cent of his clients reported that they no longer needed the surgery at the end of the 30 days. But the referrals from the patients who respected him so much kept him busier than ever.

And so I ask; where is the training?

There are 30,000 dentists in this country. Where is the mandatory national training pathway that we should be following? Airline Pilots can't get off the ground without being tested every six months, and surgeons can't operate without regular peer reviewed examination. Why does this not apply to us? Oh I know FGDP do a pathway of sorts, but it's not cheap and has limited places.

Go into any lab in the country and ask them to show you the preps they are making crowns on. Look at the imps they are being sent. It will shock you; it certainly shocked me when I last did it. There aren't many courses out there that get you to cut a posterior gold onlay prep in peer reviewed conditions. But there are plenty of courses to show you how to coat teeth with porcelain.

'When I talk to the oral surgeons that I know, they tell me that at least 40 per cent of all the implants placed in this country are badly done. **Forty per cent'**

When I talk to the oral surgeons that I know, they tell me that at least 40 per cent of all the implants placed in this country are badly done. Forty per cent. If correct, that's a staggering number and one that I am sure the indemnity providers are seriously worrying about. Whilst I know we have to start somewhere, we should not be doing treatments we are not competent to do. We shouldn't be doing treatments that aren't in the best interest of the patients, and we shouldn't be doing treatments solely because it will pay for the next instalment on the Jag. And most of all, we shouldn't be doing such advanced treatments (some would argue any treatments) on patients we don't have rapport with.

That's not what dentistry is about.

We need courses that are comprehensive, that cover the basics and which cover the more advanced stuff. Failing to spot and treat perio problems is one of the biggest case loads facing dental indemnifiers at the moment. Where are the nationally run hands on courses to correct this? Why are dentist allowed to place implants after a weekend course at Gatwick? Why do the GDC's core subjects not cover anything to do with clinical dentistry? That's obscene. Ok, you can handle a complaint, but how's about having rapport skills so that the complaint never arose, and the clinical skills that meant your six veneers didn't keep dropping off in the first place.

What I do know is that we, as a profession, will not correct this ourselves. We will spiral down into a hole of our own making until someone turns around and MAKES us change. And then we will likely end up like the USA where everything gets farmed out to specialists, increasing the costs, and increasing the inconvenience to the patient.

And you know what; I have no idea how to correct this. That's my confession. It will take a smarter person than me to build a barrier against the incoming tsunami.

That's the way it looks from here. DT

About the author

Dr Stephen Hudson BDS, MFGDP, MSc is a dental practice owner working in Chesterfield. When he qualified in 1995, he soon realised that the way most dentists treadmilled their dentistry was slowly killing them, and decided he needed to try and do something to reverse this trend. This was why he set up the website www.gdpresources.co.uk.

Amit's Corner

Close Quarters Combat (CQC)

The Sale of Goods Act 1979 (as amended) lays down conditions that all goods sold by a trader must meet, including those of the goods being "fit for purpose". These three words have also been increasingly used to question the role of the CQC following the recently alleged "cover up" of their failure to spot problems within the University Hospitals of Morecambe Bay Foundation Trust.

The CQC began operating in April 2009, as the single regulator for health and adult social care, replacing the Healthcare Commission, the Commission for Social Care Inspection and the Mental Health Act Commission. This integrated approach gave rise to a generalist system of inspections and an inherent conflict of interest whereby the CQC was involved in both the identification and rectification of quality of care issues. Many commentators have said that this generalist system evidences the way in which the previous government actively sought to dis-empower clinicians in inspections - possibly because they would speak the uncomfortable truth. With the recent NHS reforms placing the emphasis right back on grass roots clinicians, perhaps this could change.

The events of Morecambe Bay have certainly cast the spotlight back on the CQC's methods of inspections post-Francis. And Jeremy Hunt, health secretary, has touched upon what most of us have been thinking for years, how can the same inspector reliably inspect such different facilities as a dental practice, a GP surgery, a hospital and a care home?

Anecdotally, this is perhaps the reason many GDPs fear CQC inspections, sometimes referring to them as Close Quarters Combat (CQC) – defined as a type of warfare in which small units (one or two inspectors) engage the enemy (GDP teams) with weapons (clipboard and pen) at very short range.

Although many professions may jump to their own defence with cries of "uniqueness", the practise of general dentistry is truly unique in that the investigation, diagnosis, prevention and treatment of disease all takes place within the same four walls, by the same clinician.

A cursory scan of the thread of comments provided by readers in response to the HSJ article Investigators reveal CQC 'cover up' over Morecambe Bay reveals some support for the CQC to conduct more unannounced inspections. However, many would argue that the "dawn raid" of services won't really provide an indication of the quality of care being provided, but rather an indication of how well registered managers and their teams act under pressure.

It strikes many as rather ironic that the same regulator which advocates patient feedback and positively acting upon criticism has been blamed for not tolerating it, according to Dr Heather Wood, a former CQC inspector.

These are certainly tough times for the CQC as they have openly named the people, including former chief executive Cynthia Bower, present when the decision was taken to allegedly suppress a report identifying weaknesses in their inspections of the University Hospitals of Morecambe Bay Foundation Trust. However, as Hunt noted, this action is a "sign that the NHS is changing". Time will tell whether this change is for the better, but irrespectively, we should all spare a thought for the families of the up to 16 babies and two mothers feared to have died in the maternity unit at the Barrow-in-Furness hospital between 2001 and 2012.

*The views expressed in this column are those of the author and do not reflect the views of, and should not be attributed to, any organisation or institute he works for.

About the author

Amit Rai is a General Dental Practitioner, Dental Educator and Advisor with a Dento-Legal background.

A guide to the NHS England National Performers List

If you are a dentist who currently performs NHS treatment or a dentist wishing to begin performing NHS treatment then this article provides a practical guide to assist

Dentists who would like to carry out treatment under an NHS contract must be registered on the NHS England National Performers List, which was introduced on 1st April 2013 following the abolition of the PCTs.

The list was set up to provide additional reassurance to the public that health care providers like dentists were suitably qualified, trained including having appropriate language skills and that they had passed other requirements such as having a clear Disclosure and Barring Service check (the old eCRB check).

New Performers
A dentist who has never performed NHS treatment prior to 1st April 2013 must apply to be registered on the NHS England National Performers List.

A completed Performers List Application Form will need to be submitted to the Local Area Team in charge of the area the dentist wishes to work in together with the following documents:

'The list was set up to provide additional reassurance to the public that health care providers like dentists were suitably qualified, trained including having appropriate language skills and that they had passed other requirements'

a. Passport or photo driving licence

b. Full registration with the GDC

c. Graduation certificate

d. Completion of Vocation Training Certificate or Certificate of Prescribed/Equivalent Experience

e. Recent Occupational Health Report (if available)

f. A detailed Curriculum Vitae or details of your work history

g. Language Knowledge Certificate or alternative

h. The outcome of a recent appraisal (if available)

i. Work permit (if applicable)

j. Evidence of membership of a recognised defence organisation

k. Completed DBS form or existing eCRB (not more than three months old) together with further documents as may be required by the Disclosure and Barring Service in order to provide a DSB check

If the dentist is making the application from outside of England then there are only six specialised Area Teams

→ DT page 10