Peer Review for the Dental Team: National Toolkit

July 2022

About the Shropshire and Staffordshire Local Dental Network

The Local Dental Network (LDN) is key in providing sustainable leadership for the NHS. The LDN is hosted and supported by the Area Team of NHS England. The LDN has specifically been set up to be clinician led and focused on improving patient care.

The LDN has several aims including improving dental care and the oral health of the population of Shropshire and Staffordshire. We work with key stakeholders on the development and delivery of local priorities and provide local clinical leadership.

"Working together to improve oral health"

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About the North Staffordshire, Shropshire and South Staffordshire Local Dental Committees

The Local Dental Committee (LDC) and its elected members support dentists in their locality. They can offer support with practice issues or assist with liaisons with the Local Area Team. The LDCs are committed to being a source of support, advice and reference for all dentists in the North Staffordshire, Shropshire and South Staffordshire areas.

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Published July 2022


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OFFICE OF CHIEF
DENTAL OFFICER
ENGLAND


THE BRITISH ASSOCIATION OF DENTAL NURSES
Founded
1940


Faculty of
Dental Surgery
ROYAL COLLEGE OF SURGEONS OF ENGLAND


dental
Professionals
Alliance


BSDHT
The British Society of Dental Hygiene & Therapy


SOCIETY OF BRITISH DENTAL NURSES


THE ROYAL
COLLEGE OF
SURGEONS
OF EDINBURGH
The Faculty of Dental Trainers


THE ORTHODONTIC NATIONAL ALGROUP


THE ROYAL
COLLEGE OF
SURGEONS
OF EDINBURGH
The Faculty of Dental Surgery


S
B
R
D


BISOM
The British & Irish Society for Oral Medicine
Clinical Care | Research | Education


BOS
BRITISH ORTHODONTIC SOCIETY


Local Dental Network Shropshire & Staffordshire
LDN
"Working together to improve oral health"


Lincolnshire
Local Dental
Committee


West Sussex
Local Dental Commitee


nottinghamshire
local dental
committee

Barnet LDC


Dorset Local Dental Committee


NHS
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Local Dental Network

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Acknowledgements

The Shropshire and Staffordshire Local Dental Network would like to acknowledge the steering group members who shared their expertise in producing this toolkit. In addition, it must be acknowledged that the extensive range of bespoke templates could not have been created without the expertise and knowledge of a number of dental professionals.

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Preface

The publication of Peer Review in General Dental Practice in 2018 led to the formation of 11 peer review groups which were funded by the Shropshire and Staffordshire LDN and supported by the North Staffordshire, Shropshire and South Staffordshire LDCs. This was a local policy document that provided the governance and funding structure for setting up peer review groups in the Shropshire and Staffordshire region. To date, over 60 peer review group meetings have taken place and over of 120 hours of CPD. Although this demonstrates a level of success for peer review in the local area, it was understood that more practices could be involved in the scheme; there are over 200 NHS dental practices in Shropshire and Staffordshire. In addition, there was a lot of variation in how each group operated. For example, one group had 25 participants whilst another had 8. Furthermore, verifiable CPD certificates were not always provided and the number of meetings per cycle ranged from 3 to 6.

The COVID-19 pandemic caused the majority of peer review groups to cease running. Rules on social distancing and meeting in public places led to all but one of the groups to continue to meet regularly. This group held virtual meetings during which it was realized that remote meetings come with several benefits including no travel commitment or food and venue expenses. However, the value of meeting face to face was also recognized during the pandemic.

The Shropshire and Staffordshire LDN understood that in order to maintain the quality of guidance offered, the 2018 toolkit for Peer Review in General Dental Practice needed to be reviewed. Furthermore, there is no national peer review guidance for all members of the dental team.

The Shropshire and Staffordshire LDN are delighted to present the national peer review toolkit for the dental team. This document builds on the previous edition published in 2018, and includes guidance for hosting meetings virtually. The forms have been redesigned to a simpler format for ease of completion. Several bespoke meeting templates have also been included covering a range of interesting and current dental subjects.

We hope that this toolkit will serve as a useful guide for NHS and private dental practices, community dental services, secure settings, secondary care providers and any member of the dental team intending to start a peer review group.

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Background

In April 1992, a voluntary pilot peer review scheme aimed at General Dental Practitioners (GDPs) was introduced. This was overseen by the clinical audit and peer review assessment panels. Positive reports from the panels allowed the scheme to continue. In April 1997, a scheme for clinical audit was introduced and ran in parallel to the peer review scheme.[1]

In October 2001, the Department of Health made the clinical audit and peer review scheme in dental practice mandatory (a terms of service requirement). All GDPs with a General Dental Services (GDS) contract would be required to demonstrate they have participated in a minimum of 15 hours of clinical audit or peer review by the end of a 3 year period. Activity would be monitored by Local Assessment Panels under the guidance of a Central Assessment Panel, who would frequently meet to approve activities for payment.[1]

Although continual professional development has been an important part of all dental professionals' careers, since the advent of the 2006 dental contract, participation in peer review has declined. **Yet the benefits of peer review groups are clear:**[2]

- **Support reflective practice**
- **Identify learning needs**
- **Share best practice**
- **Promote high standard of practice**
- **Enhance inter-practice communication**
- **Promote mutual understanding**
- **Pastoral support**
- **Support underperforming dental professionals**
- **Encourage positive changes in services**

Introduction

Peer review is central to effective quality assurance, ensuring that best practice is followed and highlighting improvements needed to address shortfalls in the delivery of care. Peer review enables groups of dental professionals to work together to improve the quality of service. **They do this by:**

Reviewing aspects of practice
Sharing experiences
Identifying areas for change

Peer review activities are considered to be part of all dental professionals' compulsory continuing professional development (CPD). All registered dental professional are required to complete a specified amount of CPD in order to maintain their registration. The General Dental Council (GDC) requires all registrants to keep a written record of CPD activity, and to produce this record if requested.

The Regulation of Dental Services Programme Board (RDSPB) whose members include the GDC, Care Quality Commission (CQC) and NHS England (NHSE) are keen to implement a quality improvement framework across the dental sector. They have shared this concept with key national stakeholders and Local Dental Network (LDN) members. They are looking for the profession to participate in the self-help process, in particular, to consider time for peer review. They are looking for LDNs to assist and Local Dental Committees (LDCs) to support the organisation of local peer review and shift the balance of regulation upstream.
The CQC has stated that it expects providers of primary care dental services to participate in peer review and audit in order to:[3]

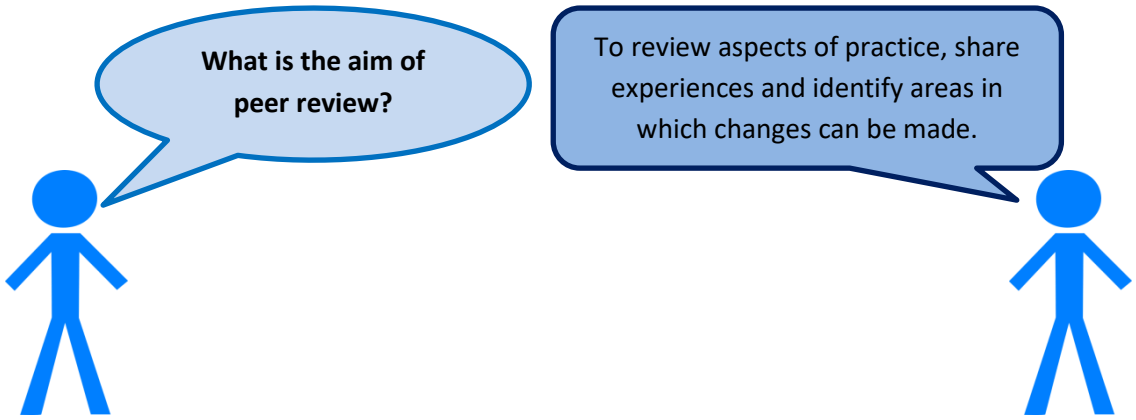
- Demonstrate **good governance** (Regulation 17);
- Deliver **care and treatment safely** (Regulation 12); and
- Ensure **premises and equipment** are clean and suitably maintained (Regulation15).

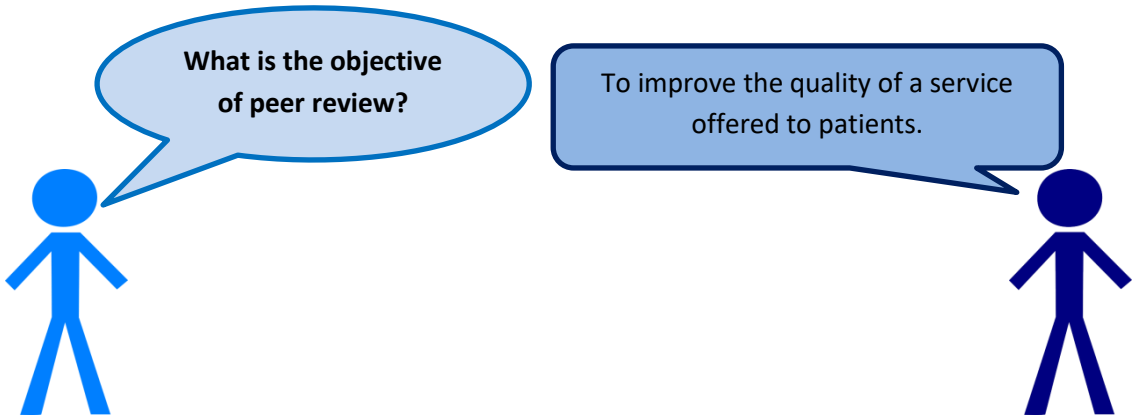
In 2018, the GDC commissioned a literature review on CPD in order to inform their policy proposals for CPD development. **The findings of the review highlighted the significant value of peer learning, which is summarised below:**[2]

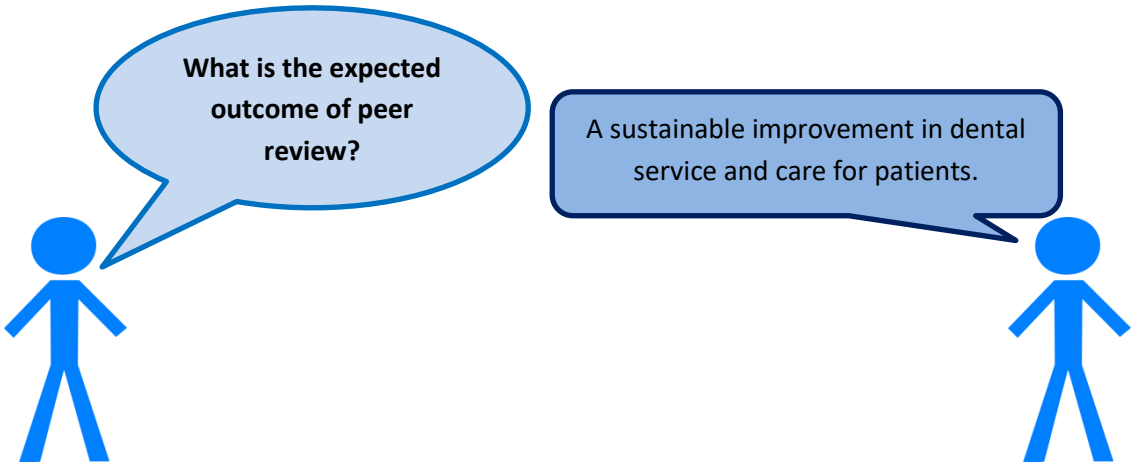
- Peer learning takes on a number of forms including peer review, peer support, peer feedback, peer observation, peer audit, peer discussion groups, peer interaction, peer mentoring and coaching, and use of peer facilitators.
- Peer learning facilitates sharing of best practice and promotes high standards of practice which can be especially valuable for lone practitioners. Working together and interacting was reported beneficial and more likely to lead to positive changes in practice.
- Peer learning supports reflective practice and identification of learning needs. Furthermore, its value in terms of pastoral support is also recognised.
- Peer learning can support interaction across professionals at all levels of expertise. Peer review groups can enhance inter-professional and inter- practice communication, learning and engagement. They also strengthen relationships and promote mutual understanding.

The purpose of this toolkit is:

- To facilitate the establishment of peer review groups;
- To encourage participation of all dental professionals in peer review;
- To support group facilitators in conducting meetings appropriately;
- To provide the required documentation for creating a peer review group;
- To provide peer review groups with bespoke meeting templates for a range of dental subspecialties; and
- To set the minimum standards that would have to be met to enable payment of funds to peer review groups.


What is the aim of peer review?
To review aspects of practice, share experiences and identify areas in which changes can be made.


What is the objective of peer review?
To improve the quality of a service offered to patients.


What is the expected outcome of peer review?
A sustainable improvement in dental service and care for patients.

Who can use this toolkit?

Participation in peer review is open to all members of the dental team. Peer review is an excellent opportunity for learning and development. This toolkit can be used by any dental professional working in any healthcare setting across the United Kingdom who would like to start a peer review group. This can be funded with the support of an organisation such as a Local Dental Network or Local Dental Committee, or non-funded.

♦ **Dentists**	♦ **NHS dental practices**
♦ **Dental nurses**	♦ **Private dental practices**
♦ **Dental hygienists**	♦ **Community dental services**
♦ **Dental therapists**	♦ **Secure settings**
♦ **Dental technicians**	♦ **Secondary care settings**
♦ **Orthodontic therapists**	

Peer review meetings can include a group of individuals with the same professional role, or it can be a mix of different professional roles within the dental team. Any member of the group, provided they possess the appropriate skills, can lead and facilitate a peer review meeting.

Peer review can bring the dental team together to discuss important subjects outside of clinical time. It can allow all members of the dental team to share their views and perspectives equally. Peer review nurtures all dental professionals including those just starting their career.

All members of the dental team should participate in peer review as they:

Offer unique insight from different professional roles
Are involved in patient care
Have relevant experiences to share with their peers
Can initiate and improvement

Each member of the dental team is involved in the patient journey, and as such there should be no barriers that inhibit or discourage them from sharing experiences and ideas with their peers. Peer review must be inclusive of the entire dental team. Everyone's voice matters.

How to use this toolkit

There are two step-by-step guides in this toolkit, one of which can be used to understand how to set up a peer review group that is funded by your LDN/LDC or other organisation. The other can be used to understand how to set up a peer review group that will not be funded. Please see pages 16-17 for more information.

Please read all sections to gain an appreciation for:

- What peer review is and why it is important
- How to set up a peer review group
- How to organise and facilitate meetings
- The roles of the facilitator and peer review group members
- The role of the LDN/LDC or any organisation that is funding a peer review scheme
- The resources available to peer review groups, including meeting templates
- The forms required to complete for a funded peer review group

Access to this toolkit

This toolkit is available from multiple online sources including, but not limited to:

1. Shropshire and Staffordshire Local Dental Network Mobile App (available on Google Play and Apple App stores)

2. South Staffordshire Local Dental Committee website > Peer Review

https://southstaffsldc.com/peer-review/

3. Care Quality Commission website > Guidance for providers > Dentists > Mythbusters and tips for dentists > Dental mythbuster 17: Audit and improvement in primary dental services

https://www.cqc.org.uk/guidance-providers/dentists/dental-mythbuster-17-audit-improvement-primary-dental-services

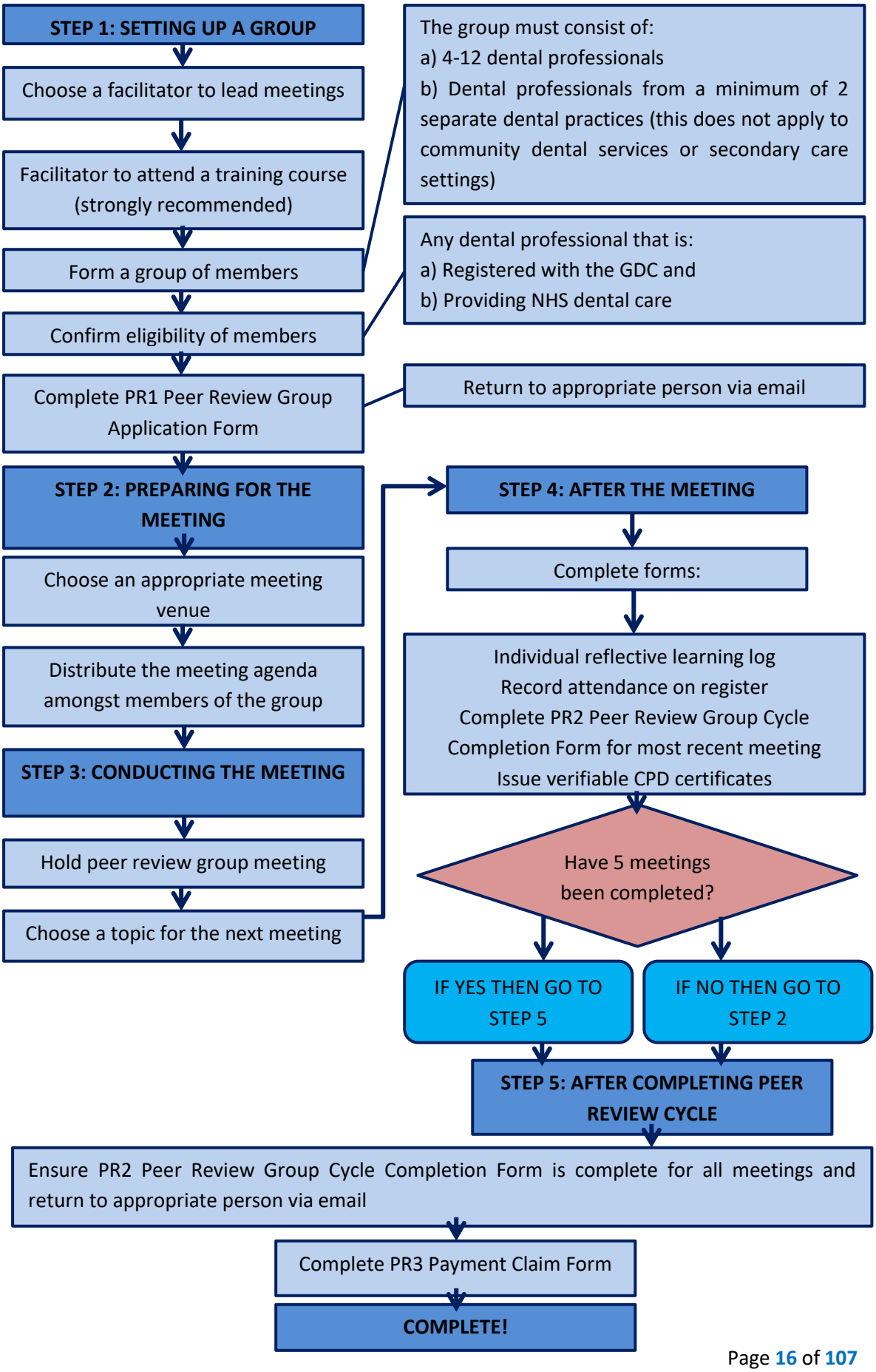
Resources

This toolkit includes a range of resources which any dental professional in the United Kingdom can use freely, for non-commercial educational purposes.

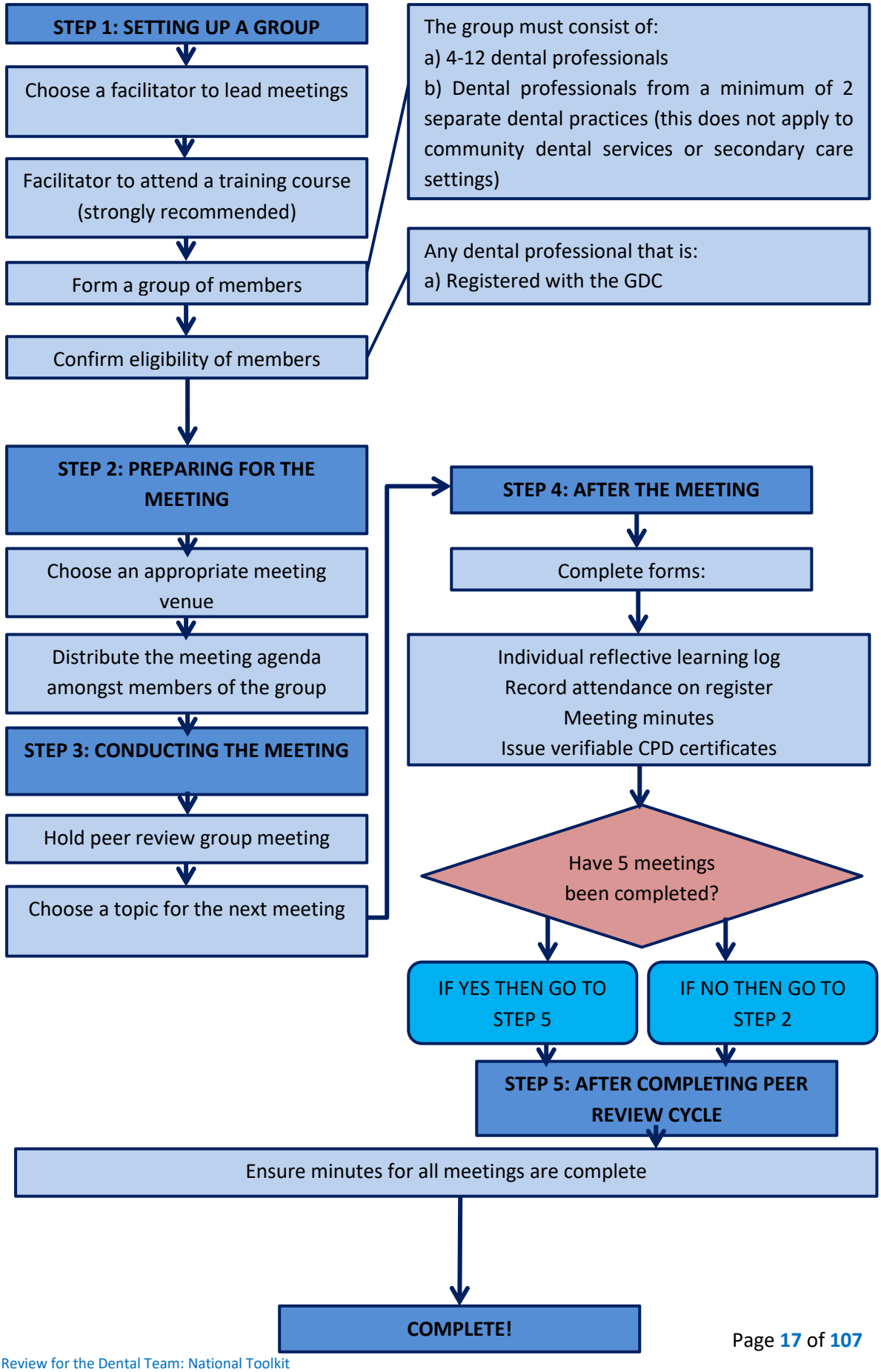
For peer review groups that are funded by an LDN/LDC or other organisation, bespoke forms should be made available that will differ to the generic forms included in this toolkit.

Appendix 1	PR1 Peer review group application form
Appendix 2	PR2 Peer review group cycle completion form
Appendix 3	PR3 Peer review facilitator payment claim form
Appendix 4	Meeting agenda template
Appendix 5	Meeting attendance register
Appendix 6	Individual reflective learning log
Appendix 7	Meeting evaluation form
Appendix 8	Verifiable CPD certificate template

Step-by-step guide: Creating a funded peer review group



Step-by-step guide: Creating a non-funded peer review group



Conditions for undertaking a funded peer review group

This section will outline the specific requirements an LDN/LDC or other organisation will be expected to adhere to in order to set up a peer review scheme that is funded.

Starting a group	
Eligibility of members	All dental professionals that are regulated by the GDC and provide NHS dental care The members of the group must be from a minimum of two separate dental practices. This does not apply to community dental services, secure settings or secondary care providers. A dental professional can only be a member of one group in each peer review cycle.
Eligibility of facilitator	Facilitator training is strongly recommended and consists of a CPD verifiable facilitator training webinar, which is available online and is free to access on YouTube. Training is available to all dental professionals that want to become a facilitator. The facilitator can only organise one group at any one time in each peer review cycle.
Group name	The facilitator, with the approval of the group members, must provide a name for the peer review group.
Group size	Groups must consist of 4-12 dental professionals.
Application	The facilitator of the group must submit a PR1 peer review group application form (Appendix 1) to the relevant person in the supporting organisation.

Meetings	
Cycle period	One peer review cycle consists of 5 meetings in a 12 month period The cycle begins from the date of the first peer review meeting.
Meeting agenda	Prior to each meeting, an agenda must be created with a relevant topic to discuss The agenda must include the following information: - Meeting date, time and venue - Name of meeting facilitator - Meeting aims - Meeting objectives
Venue	Meetings must be held in appropriate venues with consideration being given to clinical discussions. They must not take place in public spaces. Meetings can be held virtually, face to face, or a combination.
Meeting length	Meetings should generally last between one and two hours.
Recording attendance	An attendance register (Appendix 5) should be kept for all meetings.
Recording minutes	The minutes for each meeting must be recorded using the PR2 peer review group cycle completion form (Appendix 2). It is advisable to complete the minutes at the end of each meeting. This way, after completing a cycle of 5 meetings the report is ready to submit to the relevant person.
Meeting evaluation	All group members should complete a meeting evaluation form (Appendix 7).
Reflection	All group members should complete an individual reflective learning log (Appendix 6).
CPD	All group members will be able to obtain verifiable CPD (Appendix 8) as part of their attendance and participation in meetings.

Cycle completion	
Forms to submit	PR2 peer review group cycle completion and PR3 facilitator payment claim forms (Appendices 2 and 3) must be submitted to the relevant person/organisation.

It is recommended that each participant of peer review is paid the same amount to promote equality and equity. The value of peer review should not be undermined. In particular, dental professionals providing NHS care who attend meetings that occur during normal working hours should be paid for their participation. The recommendation in this toolkit is that each participant should be paid the guild rate. This is the respected funding benchmark within the dental profession and NHS England and Improvement.

If an LDN, LDC or professional organisation decides to set up a peer review scheme, it is their decision how they will fund the scheme. As this toolkit aims to provide the governance structure to support smaller organisations and committees in setting up local/regional peer review schemes, it is suggested that a nominal fee of £500 is allocated per cycle.

Funding
Only the facilitator of the peer review group will be eligible for payment.
At the first meeting, the facilitator must discuss with the group how the claimed funds will be used. This must be recorded in the minutes.
As the facilitator holds the most responsibility before, during and after meetings, it is reasonable to suggest the majority if not all of the payment is allocated to the facilitator alone. However, the facilitator can also use the claimed funds to: - Hire a suitable venue, - Purchase refreshments, and - Reward members for their participation, thus promoting equality and equity.
A payment of £350 can be claimed by the facilitator for initially recruiting members to the group and holding the first 2 meetings. A further payment of £50 per meeting can also be claimed up to a maximum of £150 for further meetings.
A facilitator can therefore claim up to a maximum of £500 for setting up a group and holding 5 meetings over a 12 month period.
The facilitator can claim for funds upon completion of the peer review cycle and submission of forms PR2 and PR3 (Appendices 2 and 3).
All payments will be made upon completion of a satisfactory peer review report and only after approval by the respective LDN/LDC/organisation which the peer review group is funded by.

Exceptions for undertaking a non-funded peer review group

PR1, PR2 and PR3 forms (Appendices 1-3) do not need to be completed. However, minutes must be completed for every meeting. All other conditions described above should be followed.

Role of an organisation that is funding a peer review scheme

Funding for a peer review group may come from several streams, including but not limited to:

Local Dental Network
Local Dental Committee
Professional organisation
Specialty organisation
Health Education England
NHS England Commissioning - Health and Justice
Dental Body Corporate

The role of an organisation that supports a funded peer review scheme is outlined below. As an example, the role of an LDN and LDC working collaboratively will be used.

The LDN will:

- Provide information concerning peer review to dental professionals who request it.
- Provide tailored resources for peer review groups to use. This includes:
  - PR1, PR2 and PR3 forms (Appendices 1-3)
  - Meeting agenda template (Appendix 4)
  - Meeting attendance register (Appendix 5)
  - Individual reflective learning log (Appendix 6)
  - Meeting evaluation form (Appendix 7)
  - Verifiable CPD certificates (Appendix 8)
- Acknowledge receipt of all PR1 (Appendix 1) applications for setting up a new peer review group.
- Scrutinise applications from facilitators to ensure that all the information has been provided before applications are accepted.
- Receive PR2 peer review group cycle completion and PR3 facilitator payment claim forms (Appendices 2 and 3).
- Pass the completed PR2 peer review group cycle completion form (Appendix 2) to the relevant LDC for scrutiny before any payments are made.
- Release payment to the facilitator once the PR2 peer review group cycle completion form (Appendix 2) has been approved by the LDC.

The LDC will:

- Convene a decision panel that will consider the PR2 peer review group cycle completion form (Appendix 2).
- The membership of the decision panel will be up to each LDC to determine.
- Consider the PR1 application and PR2 peer review group cycle completion forms (Appendices 1 and 2) sent to them by the LDN and scrutinise these to see that all the relevant information has been included.
- Ask for additional information, if necessary, before deciding on approval following submission of a PR1 application form (Appendix 1).
- Ask for additional information, if necessary, before deciding on approval following submission of a PR2 peer review group cycle completion form (Appendix 2).
- Give an explanation for its decision when an application is turned down, or a report is deemed insufficient.
- Aim to give its decision within 4 weeks of receipt of the PR1 application and PR2 peer review group cycle completion form (Appendices 1 and 2).
- Reconsider PR1 applications and PR2 peer review group cycle completion forms (Appendices 1 and 2) which have earlier been rejected.
- Provide feedback to help dental professionals improve their practice, giving examples of best practice.

Privacy policy notice

This notice sets out how any organisation involved in funding a peer review group will collect, store and handle personal data.

This notice should only serve as a guide for any organisation involved in a funded peer review scheme. This notice should be adapted according to the requirements of the organisation. Peer review group members should receive a privacy notice prior to commencing meetings.

For facilitators

Facilitators will collect the following information from members of their peer review group:

- Title and Name
- Job role
- GDC number
- Performer number (if applicable)
- Place of work
- Email address
- Attendance at meetings

This information will not be shared with anyone outside of the group, unless it is required by an organisation that provides funding for the peer review group.

For an organisation that is funding a peer review group

The following information will be collected by a facilitator from members of their peer review group, who may send this information to the relevant organisation responsible for funding the peer review group:

- Title and Name
- Job role
- GDC number
- Performer number (if applicable)
- Place of work address
- Email address
- Attendance at meetings

This information will not be shared with anyone outside of the relevant organisation.

For recorded meetings

If a recording is necessary, you should consider why this is the case and if so, whether an audio recording would be sufficient.

If a face-to-face or virtual meeting is being recorded, then the facilitator must seek verbal consent from every member of the group prior to commencing a recording.

The facilitator will be responsible for:

- Recording the meeting
- Storing the recording securely
- Ensuring only those who need access to the recording are given access
- Ensuring the recording is kept for only as long as necessary

For all meetings

All peer review group members must ensure:

- No patient identifiable information is used
- For clinical photos, valid patient consent has been obtained

All personal data will be kept securely in line with GDPR regulations.

The lawful basis for processing the above information is legitimate interests: the processing is necessary for your legitimate interests or the legitimate interests of a third party, unless there is a good reason to protect the individual's personal data which overrides those legitimate interests.

Confidentiality and respect agreement

Peer review group members must follow the 9 principles set out by the GDC at all times.[4]

- Putting the patients' interests first
- Maintaining and protecting patients' information
- Having a clear and effective complaints procedure
- Working with colleagues in a way that is in patients' best interests
- Maintaining, developing and working within your professional knowledge and skills
- Raising concerns if patients are at risk
- Making sure your personal behaviour maintains patients' confidence in you and the dental profession
- Communicating effectively with patients
- Obtaining valid consent

All peer review projects belong to the group. All information and data from quality improvement or audit projects that are submitted to the group are strictly confidential. The facilitator needs to ensure that they are anonymous, before submitting them to the supporting organisation (should they be requested).

Continuing professional development

Participants of peer review meetings should receive verifiable CPD certificates provided the GDC requirements are met.[5] The facilitator will be responsible for issuing verifiable CPD certificates following a peer review group meeting. For the CPD to be verifiable, the certificate must include:

- The subject, learning content, aims and objectives
- The anticipated GDC development outcomes of the CPD
- The date(s) that the CPD was undertaken
- The total number of hours of CPD undertaken
- The name of the professional who has participated in the CPD activity andtheir GDC number
- That the CPD is subject to quality assurance, with the name of the person or body providing the quality assurance
- Confirmation from the provider that the information contained in it is full and accurate

Further information about the GDC requirements on verifiable CPD can be found on their website.[5]

Roles and responsibilities of peer review group members

- ✓ To be willing to be a part of a peer review group
- ✓ To attend all meetings, or as many as possible
- ✓ To be an active participant of the group
- ✓ To contribute to discussions
- ✓ To share your experiences where appropriate
- ✓ To review aspects of your own practice and share this information with your peers
- ✓ To be open to implementing changes within your own work setting to improve the quality of service offered to patients
- ✓ To come up with relevant subjects to discuss at future meetings
- ✓ To be prepared to take the lead on a topic and prepare for and facilitate a meeting
- ✓ To be responsible for keeping your own reflective learning log (Appendix 6)

Top tips for peer review group members

- ★ **Respect all participants**
- ★ **Support the meeting facilitator**
- ★ **Be courteous at all times**
- ★ **Practice active listening**
- ★ **Take notes**
- ★ **Do not be afraid to express your views**
- ★ **Invite others to share their experiences/thoughts**
- ★ **Do not interrupt someone who is speaking**
- ★ **Write in your reflective learning log immediately after the meeting (Appendix 6)**

Roles and responsibilities of the facilitator

- ✓ Provide the impetus to recruit members to the group
- ✓ Check that each dental professional is eligible under this scheme
- ✓ Complete the PR1 application form (Appendix 1) once a peer review group has been formed (this applies to funded groups only)
- ✓ Organise meetings and distribute the agenda (Appendix 4)
- ✓ Record the aims and objectives of each meeting
- ✓ Ensure that suitable topics are identified
- ✓ Choose an appropriate meeting venue
- ✓ Keep a record of attendance and a summary of each meeting (Appendices 2 and 5)
- ✓ Issue verifiable CPD certificates after each meeting (Appendix 8)
- ✓ Act as a point of contact for other members
- ✓ Ensure the PR2 and PR3 forms (Appendices 2 and 3) are completed and submitted at the end of the peer review cycle (this applies to funded groups only)

Top tips for the facilitator

- ★ **Attend a facilitator training webinar**
- ★ **The goal of facilitation is to have an efficient and inclusive meeting**
- ★ **Ask how everyone is feeling**
- ★ **Assign a note-taker and time-keeper**
- ★ **Involve everyone in discussions and balance participation**
- ★ **Encourage people to speak**
- ★ **Treat everyone as equals**
- ★ **Respect all participants**
- ★ **Practice active listening**
- ★ **Stick to the agenda**
- ★ **Focus on one agenda item at a time**
- ★ **Ensure the meeting is running on time**
- ★ **Take a break to reflect and re-energise!**
- ★ **Clarify and summarise points**
- ★ **Thank everyone for their participation**

Virtual meetings

There are many different platforms that can be used to conduct a virtual meeting. Examples include Microsoft Teams, Zoom and GoToMeeting. Microsoft Teams is a free communication platform that can be accessed on a web browser on a phone/tablet/computer/laptop. It can also be downloaded onto your computer desktop. For more information on how to set up a virtual meeting visit the Microsoft Support website on scheduling a meeting in Teams.[6]

Benefits of virtual meetings:

- Ease of access
- No need to travel
- Time-saving
- Reduce your carbon footprint
- Minimal scheduling needs – no need to book a meeting room
- No food and drinks expenses for meeting host
- Meetings can be recorded

Drawbacks of virtual meetings:

- Less personal contact
- Interactions between participants can be difficult
- More challenging to break the ice
- Cannot always see everyone at the same time
- Distractions in your physical environment
- Requires a reliable internet connection
- Requires reliable device, audio and video software

Top tips for participating in a virtual meeting

★ **Dress appropriately**	★ **Do not go beyond the planned meeting duration**
★ **Use your laptop/computer, NOT your phone**	★ **Stick to the agenda**
★ **Prepare what you want to share before the meeting**	★ **Pay attention!**
★ **Ensure your connection is stable and device (including audio and video) is working properly before the meeting**	★ **Give everyone a chance to speak**
★ **Ensure you are in a quiet space with no distractions in your physical environment**	★ **Use the 'hand raise' function if you want to speak**
★ **Have a neutral background**	★ **Look at the camera**
★ **The facilitators should greet everyone at the start of the meeting**	★ **Have breaks for longer meetings**
★ **Respect all participants**	★ **Turn your video on**

Suggested peer review topics

Here is a list of topics which can be discussed during peer review meetings.

- Antimicrobial stewardship (national toolkit)
- Amalgam regulations
- Autism
- Building rapport
- Career aspirations
- CBCT scans
- Clinical record keeping
- Composite materials
- Conflict resolution
- COVID-19
- CPD, PDP, Appraisals
- Dentine hypersensitivity
- Depression
- Diabetes
- Digital dentistry
- Drug interactions
- Effective leadership
- Effective teamwork
- Emergency care pathways
- Enamel opacities
- Generalised anxiety disorder
- Hidden disabilities
- Implants
- Impression techniques
- Infection prevention and control
- Inhalation sedation
- IV sedation
- Medical emergencies
- Meeting UDA targets
- Moisture control
- NHS rules and regulations
- Obesity
- Oral cancer
- Pregnancy
- Radiographs
- Referral pathways
- Relaxation and behaviour management techniques
- Reporting incidents
- Safeguarding
- Sepsis
- Smoking and alcohol
- Splint therapy
- Systemic disease
- Teeth whitening
- Time management
- Toothpastes and mouthwash
- Treatment following recent myocardial infarction
- Well-being

Meeting templates

This section provides dental professionals with 42 peer review meeting templates covering a wide range of interesting subject areas. These templates can be used as a guide to creating peer review meeting agendas. It is not expected that groups will follow each template precisely. In actual fact, this would be unreasonable as many templates include multiple reference papers and points of discussion that could span several meetings and hours of discussion.

It is up to the facilitator to create a suitable meeting agenda (Appendix 4) that is not over-complicated and lengthy. Therefore, it is advisable to adapt a template in order to meet the aims and objectives of the meeting.

The aims and objectives should be included in the meeting agenda (Appendix 4) which the facilitator is responsible for creating and sharing with the group. These should be agreed by the group and are one of the GDC requirements for CPD to be verifiable.

The **aim(s)** should provide an overview of what the meeting will achieve.
The **objective(s)** should fulfill the aim.

General Dentistry

- Resin-bonded bridges
- Indirect preparation
- Cementing fixed restorations
- Assessing tooth restorability
- Dental photography
- Endodontic irrigants and dressings
- Management of a sodium hypochlorite incident
- Endodontic obturation
- Root canal classification systems, pre-operative radiographs and endodontic access
- Perforation in endodontics
- Endodontic pain diagnosis
- Complete dentures

Orthodontics

- Management of ectopic maxillary canines
- Management of unerupted maxillary incisors
- Orthodontic retention

Oral Medicine

- Diagnosis and management of oral ulceration
- Management of xerostomia

Special Care

- Dental treatment in patients living with diabetes
- Dental management of patients with dementia
- Wheelchair users in general dental practice
- Aspiration pneumonia

Periodontics

- Classification and diagnosis of periodontal diseases
- Periodontal assessment for children and adolescents
- Prescribing antimicrobials for the management of periodontitis

Oral Surgery

- Management of pericoronitis
- Infective endocarditis
- MRONJ
- Temporomandibular disorders
- Anticoagulants and antiplatelets

Paediatrics

- Dental trauma in the primary dentition
- Luxation injuries in the secondary dentition
- Fracture injuries in the secondary dentition
- Dental avulsion injuries
- Delivering better oral health
- Fluoride applications and fissure sealants
- Stainless steel crowns, silver diamine fluoride and caries removal
- Management of poor prognosis first permanent molars
- Behaviour management techniques and delivering anaesthesia
- Dental radiographs in paediatric dentistry
- Record keeping for paediatric dentistry

Miscellaneous

- Complaints
- Case discussions

Peer Review Group Meeting: Resin-bonded Bridges

1. Introduce topic of discussion - Resin-bonded bridges

2. Group to discuss topic

- Share existing practice

- When do you place/offer a resin-bonded bridge (RBB)?
- How long do you tell your patients the resin-bonded bridge will last?
- How do you explain what a RBB is?
- How much are you charging for a RBB?
- Do you prepare the tooth or not?
- Cementation protocol
- Have your bridges failed and if so how?
- Application of Dahl principle
- What do you advise patients to do to maintain oral hygiene around a resin-bonded bridge?
- Do you discuss reasons for failures regarding RBB with patients?

- Literature

- Resin Bonded Bridges: Techniques for Success (Durey et al., 2011)
- Resin-Bonded Bridges - the Problem or the Solution? Part 1: Assessment and Design (Gulati et al., 2016)
- Survival characteristics of 771 resin-retained bridges provided at a UK dental teaching hospital (King et al., 2015)
- A systematic review of the survival and complication rates of resin-bonded bridges after an observation period of at least 5 years (Pjetursson et al., 2008)

- Guidelines

n/a

- Policy

n/a

- Share experiences

- I struggle to keep the bridge seated firmly whilst cementing
- I struggle removing excess cement interproximally
- Patient struggles with oral hygiene, should I still go ahead with bridge work?
- Patient says the bridge feels high, but I am following the Dahl concept, what do I do?
- Patient has a buried root under the planned bridge, should I extract?

- Review existing practice in light of discussion

- Am I over-prepping the abutment tooth?
- Do I need to prep the abutment tooth?
- Am I choosing the right teeth to use for abutments?
- Should I follow the Dahl concept?
- Should I change the cement I am using or the cementation protocol?
- Am I explaining to patients how to keep RBBs clean well enough?
- Is the pontic under too much occlusal load?
- Did I check the occlusion in both static and dynamic occlusion?
- Should I sandblast the metalwork before cementation?

- Identify areas for change

- Audit failure rate of resin-bonded bridges and reasons for failure
- QI project - oral hygiene education for patients with resin-bonded bridges

Peer Review Group Meeting: Indirect Restoration Preparations

1. Introduce topic of discussion - Indirect restoration preparations

2. Group to discuss topic

- Share existing practice

- Diagnosis and treatment planning
- Pre-operative tooth assessment
    - Clinical and radiographic
    - Occlusal assessment
    - Amount of coronal tooth
    - Tooth in aesthetic zone?
    - Indirect restoration type
- Tooth preparation
    - Amount of reduction - use of depth grooves/silicone indices
    - Type of margin to be prepared
    - Burs to be used
- Impressions
    - Material choice
    - Custom or stock tray
    - Use of retraction cord
- Temporisation and laboratory prescription

- Literature

- Fundamentals of fixed prosthodontics (Shillingburg et al., 1997)

- Guidelines

- Crowns, Fixed Bridges and Dental Implants Guidelines (British Society for Restorative Dentistry)

- Policy

n/a

- Share experiences

- Unable to determine whether to do an onlay or a full gold crown
- Tooth reduction is not uniform. Is it helpful to use depth grooves or silicone indices?
- Impression lacks marginal detail. I did not use retraction cord as I am unsure how to determine the size of cord to place and the technique to use
- Find it difficult to prepare the distal aspect of upper molars. I am unsure how to improve my technique

- Review existing practice in light of discussion

- Do I undertake thorough pre-operative planning?
- Am being conservative when preparing teeth?
- How can I improve my margin position?
- How can I improve on my impression quality?

- Identify areas for change

- Audit - Review records to assess if pre-operative assessment undertaken prior to tooth preparation visit e.g. did notes indicate occlusal assessment and type of indirect restoration preparation to be undertaken?
- QI project - Review quality of impressions for crown preparations
- QI project - Patient understanding of different indirect restorations as treatment options

Peer Review Group Meeting: Cementing Fixed Restorations

1. Introduce topic of discussion - Cementing Fixed Restorations

2. Group to discuss topic

- Share existing practice

- Current cements used in practice
- Current bonding protocols - e.g. type of bond, moisture control
- Ceramic restorations – bonding, influence of the temporary cement, placement of finish line (enamel)
- Any new cements being used in practice?
- Any dentist use flowable composite?

- Literature

- The anterior all-ceramic crown: a rationale for the choice of ceramic and cement (Mizrahi, 2008)
- Considerations for the selection of a luting cement (Rickman and Satterthwaite, 2010)
- A dental student's guide to luting cements (Dentistry.co.uk, 2021)
- Cement selection criteria for full coverage restorations: A comprehensive review of literature (Ghodsi et al., 2021)

- Guidelines

n/a

- Policy

n/a

- Share experiences

- Altering the preparation to allow a resin based cement
- Choosing a restoration based (in part) upon the cementation technique
- Bonding/cementation failures - why?
- Methods for ensuring excellent moisture control
- Methods for securing the restoration when placing it (i.e. microstix or microbrush with composite)

- **Review existing practice in light of discussion**

- New bonding protocols and cements
- New methods of ensuring moisture control e.g. use of PTFE tape
- Measures to ensure predictable bonding
- Adjusting what restoration is used based upon cement availability

- Identify areas for change

- Assess current rate of debonding, implement new cement/protocol and re assess the rate of debonding after 6 months/1 year

Peer Review Group Meeting: Assessing Tooth Restorability

1. Introduce topic of discussion - Assessing Tooth Restorability

2. Group to discuss topic

- Share existing practice

- Assessing tooth restorability
- Indications for cuspal coverage
- Subgingival finish lines - Yes or no?
- Materials used for fixed restorations in teeth which are borderline restorable
- Margin elevation
- Medico-legal issues

- Literature

- Deep margin elevation: a paradigm shift (Magne and Spreafico, 2012)
- Indications for cuspal coverage (MacInnes and Hall, 2016)
- The Dental Practicality Index - assessing the restorability of teeth (Dawood and Patel, 2017)
- Developing a tooth restorability index (McDonald and Setchell, 2005)

- Guidelines

n/a

- Policy

n/a

- Share experiences

- Difficulty in explaining to patients about the restorability of a tooth
- Failures e.g. crown fracture - why did it happen, dealing with failures
- Cases whereby tooth was borderline restorable
- Choosing one fixed restoration over another to maximise tooth structure remaining e.g. onlay vs. crown
- Different methods to increase the retention and resistance of an indirect restoration in tooth with an uncertain prognosis

- **Review existing practice in light of discussion**

- Applying a restorability assessment index to teeth with an uncertain prognosis
- Methods for improving the retention and resistance form to maximise the longevity of a restoration
- Applying margin elevation to cases over subgingival finish lines

- Identify areas for change

- Documenting the restorability of teeth
- Restorability assessment template in the notes
- Assess teeth in the last 2 years which have had a crown, which ones had an uncertain prognosis and assess its survival
- Implement a tooth restorability index protocol

Peer Review Group Meeting: Dental Photography

1. Introduce topic of discussion - using dental photography for patient records and communication

2. Group to discuss topic

- Share existing practice

- Personal mobile phones may have issues with cloud storage as patient photos can be mixed in with personal photos leading to data protection issues
- DSLR camera vs. Intra-oral camera? Any differences in quality of the pictures taken?
- If using a DSLR camera, what equipment is required - ring flash vs. twin flash?
- Photographs taken for patient communication - to show decay or leaky restorations
- Camera settings including but not limited to: ISO, Shutter Speed, Aperture
- Auxiliary equipment such as mirrors can be used for taking photos of the hard/soft tissues from different angles
- Pictures should be saved in the form of the RAW format for medico-legal evidence should the need arise

- Literature

- Dental Photography: A Practical Guide (Mackenzie and Sharland, 2020)
- Mastering digital dental photography (Bengel, 2006)
- Clinical applications of intra-oral camera to increase patient compliance - current perspectives (Pentapati and Siddiq, 2019)
- Dental Photography in record keeping and litigation (Wander and Ireland, 2014)

- Guidelines

- Photographic Documentation and Evaluation in Cosmetic Dentistry - A Guide to Accreditation Photography (American Academy of Cosmetic Dentistry, 2009-13)
- IMI National Guidelines - Orthodontic Photography (Institute of Medical Illustrators, 2008)
- GDPR

- Policy

- Practice/hospital policy

- Share experiences

- One patient presented with a tooth that has an unrestorable vertical root fracture but doesn't believe that it should be extracted. Close up photo was taken to show the patient this after the removal of the restoration. Patient then consented for extraction.
- Patient has a high lip line and has faint infractures across the rest of their teeth but requires a bridge to replace a missing tooth. Photos were taken of the patient's smile and sent to the lab technician who used the photo to recreate the anatomical features of the adjacent teeth.
- Photographs used for marketing for the practice, which the patient subsequently wants taken down even though there is no identifiable information
- Struggle to take occlusal shots due to the patient's breath and size of the mirror

- Review existing practice in light of discussion

- Practice policy for storing images
- What equipment should I use for taking photos?
- Are nurses trained to assist with the taking of photos?
- Compliance with GDPR

- Identify areas for change

- Audit on whether or not patients find that they understand their condition/teeth better after seeing their pictures
- Consent form audit
- Evaluate the process of transferring photos from the SD card to the computer software program

Peer Review Group Meeting: Endodontic Irrigants and Dressings

1. Introduce topic of discussion - Endodontic irrigants and dressings

2. Group to discuss topic

- Share existing practice

- Rubber dam use
- Current irrigant choice, needle gauge and rationale for current choices
- Volume of irrigant and rate of deposition
- Irrigant activation (heat/sonic/ultrasonic)
- Techniques such as GP pumping and ultrasonic activation
- Single or multiple visit endodontics
- Inter-appointment dressings if 2 visits - current inter-appointment dressing used?
- Temporary sealing material - what is currently used?
- CaOH is the recommended standard dressing. Any alternatives currently used (e.g. odontopaste, vitapex or similar)?

- Literature

- Irrigation in endodontics (Haapasalo et al., 2014)
- Endodontic 'solutions' part 1: A literature review on the use of endodontic lubricants, irrigants and medicaments (Good et al., 2012)
- Modern Endodontic Planning Part 2: Access and Strategy (Darcey et al., 2015)
- Modern Endodontic Principles Part 4: Irrigation (Darcey et al., 2016)
- Endodontics: Part 9 Calcium hydroxide, root resorption, endo-perio lesions (Carrotte, 2004)
- Toxicity of concentrated sodium hypochlorite used as an endodontic irrigant (Gernhardt et al., 2004)
- Guidelines for management of sodium hypochlorite extrusion injuries (Farook et al., 2014)

- Guidelines

- Root canal irrigants and disinfectants (American Association of Endodontists, 2011)

- Policy

- Practice policy on management of sodium hypochlorite extrusion
- Local area referral network for hypochlorite incident (Emergency care)

- Share experiences

- Patient is unable to use a rubber dam, so should I do an RCT without a rubber dam?
- If unable to place a rubber dam on the tooth, should I just use chlorhexidine?
- What concentration of sodium hypochlorite is acceptable?
- The cost of the different irrigants, and where to source them
- Share any complications during/following irrigant use
- Hypochlorite injury and management
- Issues with non-resolution of infections
- Does anyone use EDTA as a final or penultimate rinse? What is the rationale for this?
- Use of sponge or PTFE tape instead of cotton wool pledget in dressings?
- Using GIC may provide a better seal than other materials - issues with removal however - alternative materials (kalzinol?)

- Review existing practice in light of discussion

- If only chlorhexidine is being used, why?
- Am I using the most appropriate needle gauge?
- Am I booking enough time for irrigation to be effective?
- Rubber dam use is essential
- Would anybody use a different irrigant or use their irrigant in a different way following this discussion?
- Would anybody change their choice of temporary restorative material?
- Does everybody warn patients of hypochlorite injury pre-RCT?

- Identify areas for change

- Audit - Documentation of consent for hypochlorite use
- Audit - volume of irrigants used per canal
- QI project - Current irrigation protocol and comparison with best practice
- QI project - Patient experience of using rubber dam and hypochlorite
- Create a patient information leaflet with risks/perceived benefits of RCT

Peer Review Group Meeting: Management of a Sodium Hypochlorite Incident

1. Introduce topic of discussion - Management of a Sodium Hypochlorite Incident

2. Group to discuss topic

- Share existing practice

- Methods to avoid a sodium hypochlorite accident
- Current protocol within practice/secondary care for managing a sodium hypochlorite accident
- Follow up of a sodium hypochlorite incident
- Medico legal issues with sodium hypochlorite accidents

- Literature

- Sodium hypochlorite accident: a systematic review (Guivarc'h et al., 2017)
- Management of Sodium Hypochlorite Accident - Clinical Practice Guidelines (Khandelwal et al., 2020)
- Complications following an accidental sodium hypochlorite extrusion: A report of two cases (Bosch-Aranda et al., 2012)
- Farook SA, Shah V, Lenouvel D, Sheikh O, Sadiq Z, Cascarini L, Webb R. Guidelines for management of sodium hypochlorite extrusion injuries (Farook et al., 2014)

- Guidelines

n/a

- Policy

n/a

- Share experiences

- Case discussion - has anyone had a sodium hypochlorite incident?
- For hospitals, has anyone been referred this in secondary care?

- **Review existing practice in light of discussion**

- Review management
- Review common pitfalls for sodium hypochlorite accident e.g. unrecognised perforation

- Identify areas for change

- Review/create sodium hypochlorite protocol
- QI project - patient experience when using sodium hypochlorite

Peer Review Group Meeting: Endodontic Obturation

1. Introduce topic of discussion - Endodontic obturation

2. Group to discuss topic

- Share existing practice

- Apical gauging and selection of master cone
- Conventional obturation techniques and armamentarium required
    - Cold lateral condensation
    - Warm vertical condensation
    - Single Cone obturation
- Advanced obturation techniques
    - Case selection
    - Mineral Trioxide Aggregate (MTA)
    - Biodentine
- Sealers
    - Properties of a sealer and types

- Literature

- Modern endodontic principles part 5: obturation (Darcey et al., 2016)
- Comprehensive review of current endodontic sealers (Komabayashi et al., 2020)

- Guidelines

- Canal Preparation and Obturation: An Updated View of the Two Pillars of Nonsurgical Endodontics (American Association of Endodontics, 2016)

- Policy

n/a

- Share experiences

- Underfilled or overfilled root canal
- Sealer extrusion beyond apical foramen - is this an issue?
- Voids in root filling
- GP does not go down to working length following canal preparation
- Radiographic reporting post-RCT

- Review existing practice in light of discussion

- Am I following the correct steps for the chosen obturation technique in order to ensure optimal outcomes?
- Am I correctly apical gauging and using the right master cone size?

- Identify areas for change

- Audit - Review if notes make comment on root canal obturation based on post-operative radiograph, including: presence of voids, root filling within 2mm of radiographic apex, and quality of coronal seal (if appropriate)

Peer Review Group Meeting: Root Canal Classification systems, Pre-operative Radiographs and Endodontic Access

1. Introduce topic of discussion - Root canal classification systems, pre-operative radiographs and endodontic access

2. Group to discuss topic

- Share existing practice

- How to assess radiograph pre-op
    - Number of roots
    - Canal outline along full length from coronal to apical?
    - Presence/absence of periapical pathology
    - Periodontal condition
    - Associated anatomical structures
- Root canal classification systems (Vertucci, Weine)
- Access cavity designs
    - Shape of access cavities for incisors, premolars, molars
    - Burs used
    - Obtain straight line access
    - Number of orifices/root canals in different teeth

- Literature

- Guidelines for Access Cavity Preparation in Endodontics (Caicedo et al., 2008)
- Modern endodontic planning part 2: access and strategy (Darcey et al., 2015)
- Root canal anatomy of the human permanent teeth (Vertucci, 1984)
- Canal configuration of the mandibular second molar using a clinically oriented in vitro method (Weine et al., 1988)

- Guidelines

- Endodontic Case Difficulty Assessment Form (American Association of Endodontists)
- Access Opening and Canal Location (American Association of Endodontists, 2010)
- Quality guidelines for endodontic treatment: consensus report of the European Society of Endodontology (European Society of Endodontology, 2006)

- Policy

- Poster of a root canal classification system in surgery
- Posters of access cavity designs in surgery
- Flowchart of endodontic access in surgery

- Share experiences

- Pre-operative radiograph showed possible canal sclerosis but this was not noted until root canal commenced. This could have been preventing through thorough planning and possible onward referral
- Difficulty in accessing MB canal in upper right first molar as access cavity was too central. This was rectified by modifying access more mesially to allow straight line access to root canals
- Finding 4th canal in upper molar

- Review existing practice in light of discussion

- Am I thoroughly assessing the pre-operative radiograph to ascertain the root canal morphology?
- Have I assessed the complexity of the endodontic treatment prior to commencing?
- Am I doing good access cavity preparations, which are conservative and provide straight line access?
- Would magnification aid in my endodontic access?

- Identify areas for change

- Audit - Review whether pre-operative radiographic report includes comment on root canal outline/morphology/possible classification
- QI project - Review access cavity designs with the aid of photographs in a sample of consecutive patients

Peer Review Group Meeting: Perforation in Endodontics

1. Introduce topic of discussion - Perforation in Endodontics

2. Group to discuss topic

- Share existing practice

- Assessment of anatomy of the pulpal chamber and canals before commencing RCT
- Use of the endo Z bur, gooseneck and ultrasonic to minimise the risk of a perforation
- Careful instrumentation of the canals
- Negotiating sclerotic or curved canals
- Identifying a perforation
- Materials for use for repair of the perforation

- Literature

- Comparative evaluation of push-out bond strength of ProRoot MTA, Biodentine, and MTA Plus in furcation perforation repair (Aggarwal et al., 2013)
- Access cavity and endodontic anatomy (Castellucci, 2004)
- A practical guide to endodontic access cavity preparation in molar teeth (Patel and Rhodes, 2007)
- High Risk In Root Canal Negotiation In Elderly Patients: Clinical Case Series (Perlea at al., 2015)
- Clinical Practice Guidelines for the Management of Endodontic Perforation (Thamilselvan and Ramesh, 2020)

- Guidelines

n/a

- Policy

- Local policy on management of perforation

- Share experiences

- Has anyone perforated during endodontic treatment?
- How was it managed?
- What are the different methods of identifying a perforation that anyone has used?
- Did the tooth that the perforation occurred on survive and if not why did it fail?

- **Review existing practice in light of discussion**

- Review techniques of avoid perforation during access cavity preparation
- Review instrumentation techniques, rotary vs. hand filing
- Stock materials for perforation repair

- Identify areas for change

- Change the material used for repair of a perforation if not biodentine and review the longevity of the teeth
- Create a protocol for management of a perforation and assess the if the protocol helps the dentists within the practice to manage perforations

Peer Review Group Meeting: Endodontic Pain Diagnosis

1. Introduce topic of discussion - Endodontic pain diagnosis

2. Group to discuss topic

- Share existing practice

- Pain history - SCORATES
- Special tests - PA radiography
- Sensibility/pulp testing
- Selective anaesthesia
- Extirpation/pulpectomy/pulpotomy/disinfection and dressing
- Extraction
- Easy when there is a PA area and a non-responsive pulp, more difficult with pulpitic pain. Reversible or irreversible? To extirpate or not?

- Literature

- Minimally invasive endodontics: a new diagnostic system for assessing pulpitis and subsequent treatment needs (Wolters et al., 2017)

- Guidelines

- Endondontic diagnosis (American Association of Endodontists, 2013)
- Information and advice on triage and management for primary dental care and other healthcare providers during the COVID-19 pandemic (British Endondontic Society, 2021)

- Share experiences

- Difficulty in diagnosing pain which is poorly controlled - patient demanding treatment but unsure which tooth (e.g. severe pulpitis lower molar, could be one of two or more teeth)
- Patient comes back following emergency treatment and still in pain
- Patient demanding antibiotics for pulpitic pain with no signs of spreading infection or systemic involvement

- **Review existing practice in light of discussion**

- Consider less invasive endodontic treatments
- Would your diagnoses change in light of updated literature regarding the regenerative ability of the pulp?

- Identify areas for change

- Audit on recording pain

Peer Review Group Meeting: Complete Dentures

1. Introduce topic of discussion - Complete dentures

2. Group to discuss topic

- Share existing practice

- Diagnosis and treatment planning
- Primary impressions
    - Material choice e.g. impression compound, High viscosity alginate
- Secondary impressions
    - Design of custom tray
    - Impression materials – e.g. Zinc Oxide Eugenol, silicone
- Role of green stick for border moulding
- Jaw registration
    - Use of patient's past clinical photos with natural dentition
    - Facial profile/lip support
    - Buccal corridor
    - Marking centre line/smile line/canine line position
    - Position of upper and lower teeth
    - Choosing shade and mould of denture teeth
- Trial denture stage
    - Post-dam carving
- Fit Dentures
- Copy dentures - technique
- Good communication between clinician and laboratory technicians
- Patient complaints

- Literature

- A clinical guide to complete denture prosthetics (McCord and Grant, 2000)
- Current concepts and techniques in complete denture final impression procedures (Petropoulos and Rashedi, 2003)
- A contemporary review of the factors involved in complete denture retention, stability, and support. Part I: retention (Jacobson and Krol, 1983)
- A contemporary review of the factors involved in complete dentures. Part II: stability (Jacobson and Krol, 1983)
- A contemporary review of the factors involved in complete dentures. Part III: support (Jacobson and Krol, 1983)

- Guidelines

- Guides to standards in prosthetic dentistry - Complete and partial dentures (BSSPD, 2005)
- Finley and Rowans Complete Denture Construction Manual

- Policy

- Disinfection protocol for lab work and impressions

- Share experiences

- Unable to obtain good depth of sulcus in secondary impressions. What can I do to improve my custom tray?
- Unretentive lower dentures as lower teeth cramping tongue. Should I have set teeth in the neutral zone? Could I have used narrower posterior teeth?
- Lack of balanced occlusion
- Difficult complete denture patients - severely resorbed ridges, tricky occlusion
- Techniques for ensuring a good impression e.g. modification of stock trays
- Different materials for a complete denture impression e.g. Zinc Oxide and Eugenol paste
- Dealing with flabby ridges
- Getting the RVD and OVD
- Creating a new OVD
- How to modify wax rims
- How to assess support, retention and stability
- Methods for jaw registration and checking occlusion

- Review existing practice in light of discussion

- Am I taking good quality primary and secondary impressions?
- Is my custom tray design correct?
    - Correct spacing for impression material
    - Correct extensions?
    - Could I use greenstick to aid capturing the correct anatomical regions
- Did I undertake a thorough jaw registration allowing the technician to place the denture teeth in the correct set-up?
- Modification of stock trays, when, how and why

- Identify areas for change

- Audit - Review how many repeat denture stages or complete denture remakes needed for a cohort of patients
- QI project - Use a patient satisfaction questionnaire, which should include questions about retention, support and stability.
- QI project - Review whether primary and secondary complete denture impressions capture the full anatomical denture bearing area and landmarks needed for success denture outcomes

Peer Review Group Meeting: Management of Ectopic Maxillary Canines

1. Introduce topic of discussion - Management of Ectopic Maxillary Canines

2. Group to discuss topic

- Share existing practice

- Observe, palpate, radiograph
- Observe – bulge/colour/position of adjacent teeth/retained deciduous teeth
- Palpate canine in buccal sulcus if maxillary canine unerupted. The favourable canine is usually palpable buccal to the resorbing deciduous tooth by the age of 10-11.
- Radiographic examination (presence/position/pathology) to identify if maxillary canine present and any root resorption to adjacent teeth. The concept of parallax.
- Referral to Orthodontist for opinion and treatment, various treatment options as follows:
  A: Interceptive treatment by extraction of the primary canine
  B: Surgical exposure and orthodontic alignment
  C: Surgical removal of the ectopic permanent canine
  D: Autotransplantation
  E: No active treatment/leave and observe

- Literature

- Guidelines for the Assessment of the Impacted Maxillary Canine (Counihan et al., 2013)
- Interceptive management of palatally displaced canines: evidence based clinic guidelines (Alkadhimi et al., 2022)
- The management and 'fate' of palatally ectopic maxillary canines (Seager et al., 2020)

- Guidelines

- Management of the Palatally Ectopic Maxillary Canine (Royal College of Surgeons Of England, 2016)
- Managing the developing occlusion: a guide for dental practitioners (British Orthodontic Society, 2010)

- Policy

- Practice policy on management
- Orthodontic department policy on management

- Share experiences

- Patient age 10-11 years, with unerupted or ectopic canine attending general practice for examinations - what does the GDP do and when do you refer?
- Adult patients with ectopic canine complained that GDP has not assessed or referred appropriately when GDP saw them when they were young

- Review existing practice in light of discussion

- Am I looking out for patient's canines when assessing young patients?
- Am I referring to Orthodontist appropriately in a timely manner?

- Identify areas for change

- Quality improvement project or Audit: Assessment of canines for children age 9-11 years in general practice
- Audit age of patients being referred to orthodontics with impacted canines. If referrals are being made late, analyse why.

Peer Review Group Meeting: Management of Unerupted Maxillary Incisors

1. Introduce topic of discussion - Management of Unerupted Maxillary Incisors

2. Group to discuss topic

- Share existing practice

- GDP to examine any primary incisors retained significantly beyond their normal exfoliation dates/asymmetry in eruption pattern >6 months
- Radiographic examination to identify if maxillary incisor present, physical obstruction (i.e. supernumerary tooth) and any pathology
- Extract retained primary incisor
- Referral to Orthodontist for opinion and treatment, various treatment options as follows:
  - A: Removal of a physical obstruction e.g. supernumerary tooth only
  - B: Removal of the obstruction with creation of space
  - C: Surgical intervention (open exposure or closed eruption technique)
  - D: Incisor removal
  - E: Autotransplantation
  - F: Monitoring of further dental development

- Literature

- National clinical guidelines for the management of unerupted maxillary incisors in children (Seehra et al., 2018)

- Guidelines

- Management of Unerupted Maxillary Incisors (Royal College of Surgeons Of England, 2016)
- Managing the developing occlusion: a guide for dental practitioners (British Orthodontic Society, 2010)

- Policy

- Practice policy on management
- Orthodontic department policy on management

- Share experiences

- Young patients with unerupted permanent maxillary incisor attending general practice for examinations - what does the GDP do and when do you refer?

- Review existing practice in light of discussion

- Am I confident with assessing and managing (if appropriate) unerupted maxillary incisors in practice?
- Am I referring to Orthodontist appropriately in a timely manner?

- Identify areas for change

- Quality improvement project or Audit - timing of orthodontic referrals for unerupted maxillary incisors.

Peer Review Group Meeting: Orthodontic Retention

1. Introduce topic of discussion - Orthodontic retention and the role of the general dental practitioner. Also discuss the need for life-long retention following orthodontic treatment.

2. Group to discuss topic

- Share existing practice

Patient attends for routine examination or emergency appointment and has problem with orthodontic retainer i.e. lost removable retainer (Essix or Vacuum-formed retainer) or broken bonded retainer

- Contact Orthodontist for advice
- Re-refer back to Orthodontist if patient has finished orthodontic treatment within the last 12 months and has not been discharged back to GDP following their treatment (usually 12 months is the period of retention following orthodontic treatment)
- Construct new removable retainer in practice on NHS if patient <18 years old or privately if patient > 18 years old
- Repair existing bonded retainer or replace if GDP has sufficient clinical experience

- Literature

- Orthodontic retention and the role of the general dental practitioner (Molyneaux et al., 2021)
- Retention procedures for stabilizing tooth position after treatment with orthodontic braces (Littlewood et al., 2016)

- Guidelines

- Clinical guidelines: Orthodontic retention (British Orthodontic Society, 2013)
- 'Hold that smile' national campaign on the importance of wearing retainers (British Orthodontic Society)

- Policy

- Practice policy

- Share experiences

- Adult patient attending general practice having completed orthodontic treatment years ago, now has broken fixed retainer and unsure where they had orthodontic treatment completed
- Adult patient presenting with mobile tooth due to broken fixed retainer
- Paediatric patient presenting with lost removable retainer (Essix or Vacuum-formed retainer)

- Review existing practice in light of discussion

- Am I confident in knowing when to manage retention in practice or refer to orthodontist?
- Do I know enough about retention devices and which to provide to patients?
- Am I confident in removing bonded retainers?
- Am I confident with repairing bonded retainers or should I re-refer to the orthodontist?

- Identify areas for change

- QI project - Improving communication between orthodontists, patients and general practitioners
- Audit - Orthodontic retainer related emergency in general practice

Peer Review Group Meeting: Diagnosis and Management of Oral Ulceration

1. Introduce topic of discussion - Diagnosis and management of oral ulceration

2. Group to discuss topic

- Share existing practice

- Discuss causes of oral ulceration:
    - Oral lichen planus
    - Immunobullous diseases (pemphigus, pemphigoid variants)
    - Erythema multimorme
    - Recurrent Aphthous Stomatitis - RAS (Minor, Major, Herpetiform)
    - Other types of recurrent oral ulceration e.g. Behçet's disease
    - Viral infections (herpes simplex amongst others)
    - Iatrogenic / medication related (Methotrexate, Nicorandil)
    - Traumatic ulcer (including factitious ulceration)
    - Malignancy
- Assessment and diagnosis of ulcers - what history would practitioners take?

  Example history:
    - History of presenting complaint:
        - Acute episode, recurrent, or chronic persistent?
        - If acute episode:
            - Onset and associations at onset (e.g. widespread ulceration in childhood might indicate primary herpetic gingivostomatitis, a new dental restoration prosthesis or appliance might indicate traumatic ulceration)
            - Exclude malignant cause (constitutional symptoms, smoking and alcohol history)
        - If recurrent:
            - Age at first onset
            - Frequency
            - Number in a crop
            - Size
            - Location
            - Pain / symptoms / prodromal symptoms
            - Time taken to heal
            - Impact on daily activities
            - Associated skin or genital lesions ((Behçet's)
            - Visual disturbance or red eye (Behçet's)
        - If chronic persistent:
            - Onset
            - Associations at onset (new medications, dental restoration)
            - Pain / symptoms
            - Associated skin or genital lesions (mucous membrane pemphigoid, pemphigus, Lichen planus)
            - Visual disturbance or red eye (mucous membrane pemphigoid)?
            - Impact on daily activities

    - Medical, dental, and social history
        - New dental appliance or restoration?
        - Medication history including recent dose change (e.g. Nicorandil, methotrexate, local application of aspirin, lichenoid inducing medications)
        - Constitutional symptoms – weight loss and malaise
        - Smoking, oral tobacco and pain history (including recent history of smoking cessation in adult-onset RAS)
        - Alcohol intake
        - Occupation
- Examination:
    - Widespread / bilateral (RAS, lichen planus, immunobullous)
    - Isolated / unilateral (traumatic ulcer including factitious ulceration, lichenoid reaction, iatrogenic / medication related, malignancy)
    - Striae (lichen planus)
    - Shape
        - Round / oval (RAS)
        - Irregular (lichen planus, immunobullous, traumatic ulcer including factitious ulceration)
    - Desquamative gingivitis (lichen planus, immunobullous)
    - Depth of ulceration
        - Shallow and red (pemphigus)
        - Deep and yellow (oral lichen planus, RAS, pemphigoid variants, traumatic ulcer including factitious ulceration)
    - Sinister features (rapidly evolving, exophytic or fungating, firm / indurated, fixation, erythroleukoplakia, papillary/nodular base, haemorrhage, associated lymphadenopathy)
- Management in primary care:
    - Photograph ulcers and describe them accurately in notes
    - If traumatic causes suspected, adjustment of new oral prosthesis - dentures/ortho appliances or smoothing of sharp tooth / cusp and then review to check for healing
    - If patient using Bonjela advise patient not to use this as it can aggravate oral ulceration and delay healing
    - Recommend fluoridated sodium Lauryl Sulphate free toothpaste (Sensodyne Pronamel or rapid relief toothpaste, Oranurse original toothpaste)
    - Topical pain relief - Benzydamine hydrochloride 0.15% prn or Lidocaine 5% ointment as per SDCEP drug prescribing guidance
    - Chlorhexidine mouthwash to prevent superinfection of the ulcer
    - Topical steroid prescription – betamethasone 500 mcg soluble tablets used as a mouthwash (in the dental practitioners formulary)
    - Consider referral if no response to management in primary care or if systemic or malignant cause suspected
        - Consider signposting to GP requesting full blood count and haematinics if managing in primary care
        - Refer to OMFS if no regional Oral Medicine unit
        - Refer to Oral Medicine unit if available locally

- Literature
- Oral ulceration: an overview of diagnosis and management (Thakrar and Chaudhry, 2016)

- Guidelines
- Management of acute dental problems (SDCEP, 2013)
- Drug Prescribing for Dentistry (SDCEP, 2016)
- BISOM patient information leaflets (https://bisom.org.uk/clinical-care/patient-information/)

- Policy
- Practice policy on management and referral systems for urgent/routine care
- Maxillofacial department policy on diagnosis and management

- Share experiences
- How can I reassure a patient who is anxious about the healing of an ulcer without sinister features?
- Would you write a prescription for Benzydamine hydrochloride 0.15% or advise the patient to purchase OTC?
- Benzydamine hydrochloride 0.15% spray v mouthwash?
- If I think it could be cancer, what do I say to the patient?
- I struggle to describe ulcers accurately in the clinical notes
- How do I liaise with GP for systemic concerns?
- When should I prescribe pain relief/topical steroids?
- When and how should I refer for suspected oral cancer?

- Review existing practice in light of discussion
- Am I diagnosing the condition correctly?
- Am I giving the correct first line advice and treatment for patients?
- Am I explaining the condition well enough to patients?
- Am I referring appropriately to the oral medicine/maxillofacial department?

- Identify areas for change
- Audit - Appropriate referrals of oral ulceration
- QI project - Pain control in oral ulceration

Peer Review Group Meeting: Management of Xerostomia

1. Introduce topic of discussion - Management of xerostomia

2. Group to discuss topic

- Share existing practice

- Discuss causes of dry mouth:
    - Drug induced xerostomia
    - Age related hyposalivation
    - Sjögren's syndrome
    - Graft versus host disease or following head and neck radiotherapy
- Assessment and diagnosis of dry mouth - what history would practitioners take?

  Example history:
    - History or presenting complaint:
        - Onset
        - Impact on activities of daily living (eating and speaking)
        - Medication history including any new medications or recent dose changes (anticholinergic drugs, antihistamines, antidepressants, antipsychotics, antimuscarinics, antihypertensives, diuretics, and antiparkinsonian drugs, proton pump inhibitors).
        - Systemic features
            - Dry eyes
            - Joint pain or swelling
            - Salivary gland swelling
        - History of haemopoietic stem cell transplant or head and neck radiotherapy
- Examination:
    - Mirror sticking to oral mucosa
    - Glassy appearance of oral mucosa
    - Depapillation of the dorsal surface of the tongue
    - No saliva pooling in the floor of the mouth
    - Debris on palate
    - Saliva not expressible from salivary duct orifices
    - Caries
    - Evidence of oral candidiosis
- Management in primary care:
    - Recommend increased fluid intake
    - Increased night-time humidity (bowl of water by the bed)
    - Recommend sugar free sweets or chewing gum or prescribe a sialagogue (Saliva Stimulating Tablets and Salivix pastilles can be prescribed on dental practitioners formulary). SST tablets should be used with care as they are acidic)
    - Prescribe saliva substitute (BioXtra Mouth spray, BioXtra Moisturising Gel, Glandosane, and Saliveze can be prescribed on dental practitioners formulary. Avoid Glandosane in dentate patients as it is acidic)
    - Recommend massage of the salivary glands
    - Treat oral candidosis if present (Nystatin oral suspension, Miconazole gel, and Fluconazole tablets can be prescribed on the dental practitioners formulary
    - Treat dental caries

- Diet advice – avoid sugar and dry/hard/crunchy/acidic foods
- Optimize oral hygiene
  - Oral hygiene instruction
  - Denture hygiene
  - Regular prophylaxis
  - High fluoride toothpaste and/or fluoride mouthwash
- Consider referral if no response to management in primary care or systemic cause suspected
  - Consider signposting to GP if:
    - for medication review if drug-induced xerostomia suspected
    - if Sjogren's syndrome suspected and no local Oral Medicine unit, they could refer to Rheumatology
  - Refer to OMFS if no regional Oral Medicine unit
  - Refer to Oral Medicine unit if available locally

- Literature

- Treating patients with dry mouth: general dental practitioners' knowledge, attitudes and clinical management (Abdelghany et al., 2011)

- Guidelines

- Palliative Care - Oral Management, Scenario: Dry Mouth (NICE, 2021)
- UK Medicines Information Q&A on saliva substitutes, found at: (https://www.sps.nhs.uk/articles/what-should-be-considered-when-choosing-or-prescribing-saliva-substitutes/)
- BISOM patient information leaflets (https://bisom.org.uk/clinical-care/patient-information/)

- Policy

- Referral criteria
- Policy for management of xerostomia as advised by local oral medicine unit

- Share experiences

- Finding it difficult to find the cause of xerostomia
- Difficult to diagnose xerostomia
- Patient is complaining of dry mouth but presenting clinically with normal saliva flow
- Does the patient understand/remember the advice being given to them?

- Review existing practice in light of discussion

- Am I offering suitable treatment modalities for xerostomia?
- Am I educating patients well enough on xerostomia?
- Do I need to improve my diagnostic skills for xerostomia?
- Am I explaining the aetiology of xerostomia in a way that patients are able to understand?

- Identify areas for change

- QI project - patient education. Create a leaflet for patients to take away to inform them what xerostomia is, its aetiology and management.

Peer Review Group Meeting: Dental Treatment in Patients Living with Diabetes

1. Introduce topic of discussion - Dental treatment in patients living with diabetes

2. Group to discuss topic

- Share existing practice

- Importance of timing of appointments, medication, and late cancellations when patients are unwell
- Link between diabetes and periodontitis
- Measurement of blood glucose levels prior to dental treatment
- Management of medical emergencies: hypoglycaemia
- Liaison with GMP and/or diabetic specialist services
- Referral to Special Care Dentistry (SCD) or Salaried Dental Services and periodontist

- Literature

- Diabetes mellitus: an update for the general dental practitioner (Domahet et al., 2018)
- The diabetic patient and dental treatment: an update (Wray, 2011)
- The impact of diabetes on treatment in general dental practice (Yeung and Chandan, 2018)
  - ***Resources for patients***
    - https://www.diabetes.co.uk/Diabetes-and-dentistry.html
    - https://www.bsperio.org.uk/patients/gum-disease-and-diabetes

- Guidelines

- Commissioning standard: dental care for people with diabetes (NHSEI, 2019)

- Policy

- Local policy for treating patients with diabetes

- Share experiences

- Lived experiences of medical emergencies (e.g., hypoglycaemia, diabetic ketoacidosis) in the dental practice
- Measurement of blood glucose level prior to dental treatment and when to defer treatment
- Rapid progression of dentoalveolar infections in patients with diabetes
- Delayed healing following surgical procedures in patients with diabetes

- Review existing practice in light of discussion

- Review of referrals to SCD/Salaried Dental services
- Shared care approach between primary and secondary dental care services
- Information given to patients living with diabetes about the bidirectional association between periodontitis and diabetes

- Identify areas for change

Taken from 'Commissioning standard: dental care for people with diabetes' (NHSEI, 2019):

- In-practice audits of the number of patients with diabetes seen. Ensure these patients are offered regular periodontal surveillance and support
- The MCN should involve practices in design of short-term and longer-term clinical audits of the effectiveness of patient motivation on self-care and effectiveness of periodontal treatment of periodontal (gum) health

Peer Review Group Meeting: Dental management of patients with dementia

1. Introduce topic of discussion - Dental management of patients with dementia

2. Group to discuss topic

- Share existing practice

- Role of the dental team recognising early cognitive changes on long-term patients at your dental practice
- Early treatment planning: 'thinking ahead to avoid provision of complex dental treatment that cannot be maintained in the long-term'
- Preventative measures
- Reasonable adjustments (e.g., time of appointments, longer appointments to discuss treatment)
- Decision-making and MCA (2005)
- Involvement of families and carers
- Denture replacement
- Palliative dentistry
- Domiciliary care
- Referral to Special Care Dentistry (SCD) or Salaried Dental Services

- Literature

- Dementia and dentistry (Edwards et al., 2015)
- Palliative dentistry (Gonzalez Malaga and Manger, Health Education England)
- Dental Management of Patients with Dementia in Primary Dental Care (Moosajee et al., 2015)

- Guidelines

- Dementia-friendly dentistry: good practice guidelines (College of General Dentistry, 2017)
- Dementia and decision-making (Social Care Institute for Excellence, 2020)

- Policy

- Referral criteria for Community Dental Services/Special Care Dentistry

- **Patient advice**

- Dental care (Alzheimer's Society website)

- Share experiences

- The family demands new dentures in a patient with advanced dementia who is unable to tolerate dental treatment
- A patient with dementia refuses dental treatment but his/her family tries to convince the dentist to treat despite the patient's decision
- Supporting longstanding patients with dementia to remain in general dental practice: shared-care approach
- Lasting power of attorney, advanced decisions to refuse treatment and DNACPR

- Review existing practice in light of discussion

- Am I referring patients too early to the CDS/Salaried dental services?
- What can I do to involve and support patients, families, and carers in the patient's dental care and decision making?

- Identify areas for change

- QI project - how dementia-friendly is our dental practice? (e.g., signs, leaflets, colours in the practice etc.)

Peer Review Group Meeting: Wheelchair Users in General Dental Practice: Reasonable Adjustments

1. Introduce topic of discussion - Wheelchair users in general dental practice: reasonable adjustments

2. Group to discuss topic

- Share existing practice

- Types of wheelchairs (e.g. manual, powered, reclining chairs)
- Reasonable adjustments: 'Can treatment safely be carried out in the patient's wheelchair without reclining?'
- Assessment of patient's individual needs
- Provision of dental care in wheelchair vs. safe transfer to dental chair
- Referral to Special Care Dentistry (SCD) or Salaried Dental Services

- Literature

- Access to special care dentistry, part 1: Access (Dougall and Fiske, 2008)
- Wheelchair users: a guide (Ramirez and Dickinson, 2018)
- Equality Act 2010

- Guidelines

n/a

- Policy:

- Manual handling local policies

- Share experiences

- Dental treatment limitations when provided in a wheelchair
- Continuing to provide dental treatment in a patient's wheelchair is no longer an option. Discussion with patients and obstacles experienced when having these conversations
- How much assistance should dental teams give to patients needing help to transfer to the dental chair?
- Occupational hazards: back strain following treatment in a wheelchair

- Review existing practice in light of discussion

- Risk assessment for dental treatment provision in wheelchair users

- Identify areas for change

- Access audit to evaluate the accessibility to the practice for people with physical disabilities
- Development of a Standard Operating Procedure and risk assessment tool for wheelchair users in dental practice
- Review of appropriateness of referrals to SCD/Salaried Dental services

Peer Review Group Meeting: Aspiration Pneumonia

1. Introduce topic of discussion - Aspiration pneumonia

2. Group to discuss topic including:

- Understanding the link between poor oral hygiene and aspiration pneumonia
- Understanding risk factors of aspiration pneumonia

- Share existing practice

- Check oral hygiene
- Check existing recurrent chest infections
- Check medical history (MH)
- Current medication
- Check diet, do they have thickeners in their drinks?
- Risk of choking

- Literature

- Aspiration pneumonia (Bennet and Vella, 2022)
- Oral hygiene reduces the mortality from aspiration pneumonia in frail elders (Muller, 2015)
- Association between oral health and incidence of pneumonia: a population-based cohort study from Korea (Son et al., 2020)
- Managing aspiration (Mann et al., 2012)

- Guidelines

- Pneumonia in adults: diagnosis and management clinical guideline (NICE, 2019)

- Policy

n/a

- Share experiences

- 50-year-old male with multiple sclerosis attended with mother who is main carer. Was booked in for hand scaling. MH stated regular occurrence of chest infections and requirement of thickeners for drinks. When updating MH mum mentioned hospital admission 2 months prior for aspiration pneumonia. Hand scaled with high volume suction. Discussed signs and symptoms of aspiration pneumonia. Reinforced oral hygiene instructions.

- Review existing practice in light of discussion

- Importance of an up-to-date medical history
- Importance of carers and those attending with patient knowing them well and awareness of their essential information including MH.
- Ensure carers are made aware of link between poor oral hygiene and aspiration pneumonia to reduce future risk

- Identify areas for change

- Audit of up-to-date medical history and medication
- Oral Health education for carers, support workers and residential facilities for patients at risk of aspiration pneumonia

Peer Review Group Meeting: Classification and Diagnosis of Periodontal Diseases

1. Introduce topic of discussion - Classification and diagnosis of periodontal diseases

2. Group to discuss topic

- Share existing practice

- Current uptake and application of the latest BSP Implementation of the 2017 World Workshop Classification
- Whether individuals are still using the previous chronic/aggressive periodontitis classification

- Literature

- Periodontal diagnosis in the context of the 2017 classification system of periodontal diseases and conditions - implementation in clinical practice (Dietrich et al., 2019)
- Periodontal health and gingival diseases and conditions on an intact and a reduced periodontium: Consensus report of workgroup 1 of the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions (Chapple et al., 2018)
- Periodontitis: Consensus report of Workgroup 2 of the 2017 World Workshop on the Classification of Periodontal and Peri-Implant Diseases and Conditions (Papapanou et l., 2018)

- Guidelines

- BSP Guidelines: Implementing the 2017 Classification of Periodontal Diseases to reach a diagnosis in clinical practice (See BSP website)

- Share experiences

- Challenges in implementing the classification in daily practice and why
- Particulars of the classification and its application (gaps in knowledge)
- Particular case examples and debate over diagnoses/classification

- Review existing practice in light of discussion

- Implementing BSP classification and diagnosis of periodontal diseases based on clinical findings (e.g. BPE, radiographs, etc)
- Record keeping templates for periodontal disease

- Identify areas for change

- Record keeping audit looking at recording of diagnosis/classification in clinical notes correctly
- CPD for the dental team with interactive cases to test knowledge and application of the classification

Peer Review Group Meeting: Periodontal Assessment for Children and Adolescents

1. Introduce topic of discussion - Periodontal Assessment for Children and Adolescents

2. Group to discuss topic

- Share existing practice

- Simplified Basic Periodontal Examinations (sBPE) carried out on all four first permanent molars, and first incisors, for patients under age of 18
- Periodontal assessment for all recall appointments
- Appropriate periodontal treatment carried out according to sBPE scores
- How periodontal health is assessed in children of all ages
- What age is sBPE used from and is it used at all?

- Literature

- A new classification scheme for periodontal and peri-implant diseases and conditions - Introduction and key changes from the 1999 classification (Caton et al., 2018)

- Guidelines

- Guidelines for Periodontal Screening and Management of Children and Adolescents Under 18 Years of Age (British Society of Periodontology, 2021)

- Policy

n/a

- Share experiences

- Some younger patients may not have BPEs completed, due to not liking the sensation of the WHO probe, or being generally non-compliant /dental phobic
- I struggle to differentiate pseudopocketing from periodontal disease
- Visual assessment of periodontal health in cases where patients will not allow BPE probe use

- Review existing practice in light of discussion

- At what age are BPEs starting to be taken for younger patients?
- Should I include a visual assessment of periodontal health in the patient clinical record?
- Am I taking radiographs appropriately?

- Identify areas for change

- Audit - Compliance with BSP guidance for recording sBPE in children and adolescents

Peer Review Group Meeting: Prescribing Antimicrobials for the Management of Periodontitis

1. Introduce topic of discussion - Prescribing Antimicrobials for Management of Periodontitis

2. Group to discuss topic

- Share existing practice

- Rarely prescribed in practice by general practitioners
- Metronidazole
- Azithromycin
- Unclear as to when to prescribe
- Indications for prescribing
    - Necrotising Periodontal Diseases - Metronidazole
    - Stage III, IV periodontitis Grade C in patients aged <40-45years - Amoxicilln with Metronidazole, or Azithromycin
    - Periodontal Abscesses

- Literature

- A systematic review on the effect of systemic antimicrobials as an adjunct to scaling and root planing in periodontitis patients (Herrera et al., 2002)

- Guidelines

- Antimicrobial Prescribing in Dentistry, 3rd Edition (College of General Dentistry)

- Policy

n/a

- Share experiences

- Unsure about exact indications for prescribing antimicrobials in periodontal disease
- How to assess success of antimicrobial therapy
- Not sure if I should be prescribing antimicrobials before or after
- Dose and duration
- Repeat courses of antibiotics

- Review existing practice in light of discussion

- When should I prescribe antimicrobials in periodontal disease?
- Am I correctly prescribing antimicrobials in the right cases of periodontal disease?

- Identify areas for change

- Audit - Antimicrobial prescribing in periodontal diseases

Peer Review Group Meeting: Management of Pericoronitis

1. Introduce topic of discussion - Management of pericoronitis

2. Group to discuss topic

- Share existing practice

- Reinforce oral hygiene
- Irrigation with chlorhexidine
- Salty mouthrinses
- Using corsodyl gel/mouthwash
- Simple analgesia PRN
- Antibiotics where appropriate
- Occlusal adjustment of opposing tooth
- Extraction
- Referral

- Literature

- Pericoronitis: treatment and a clinical dilemma (Moloney and Stassen, 2009)

- Guidelines

- 3rd molar guidelines (RCS England FDS, 2021)
- Pericoronitis, antibiotic prescribing (HSE, 2021)

- Policy

- Practice policy on management
- Maxillofacial department policy on management

- Share experiences

- Patient demanding antibiotics because they were given a course before
- Unsure if it was UR8 or LR8 that was causing inflammation
- Mistaking TMJ disorder for pericoronitis
- No clinical or radiographic signs of pathology associated with an impacted LR8 that is causing pain, but the LR7 has a large distal lucency below that contact point, what do you do?
- Patient demands I remove the LL8 which is partially erupted and outside my scope of practice

- Review existing practice in light of discussion

- Am I overprescribing antibiotics?
- Am I explaining the condition well enough to patients?
- Am I referring cases appropriately for removal?

- Identify areas for change

- Audit - Antibiotic prescribing in pericoronitis
- QI project - Pain control in acute pericoronitis with no signs of spreading infection or systemic involvement

Peer Review Group Meeting: Infective Endocarditis

1. Introduce topic of discussion - Management of patients at risk of infective endocarditis

2. Group to discuss topic

- Share existing practice

- Enquire about medical history including cardiac disease, surgery, history of IE, cardiologist details
- Methods of contacting cardiologist
- OHI and early management of infection to prevent IE in at risk patients
- Patient discussions for informed consent
- Risk assessment for procedure (invasive vs. non-invasive procedures)
- Risk/benefit of antibiotic cover
- Choice of antibiotics

- Literature

- Guidelines on prophylaxis to prevent infective endocarditis (Thornhill et al. 2016)
- Dental procedures, antibiotics prophylaxis, and endocarditis among people with prosthetic heart valves: nationwide population based cohort and a case crossover study (Tubiana et al., 2017)
- Epidemiology of infective endocarditis before vs. after change of international guidelines: a systematic review (Williams et al., 2021)

- Guidelines

- Prophylaxis against infective endocarditis: antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures (NICE, 2016)
- Antibiotic prophylaxis against infective endocarditis (SDCEP, 2018)
- Antibiotic prophylaxis 2017 update (American Association of Endodontists, 2017)

- Policy

- Practice policy on management
- Maxillofacial department policy on management

- Share experiences

- Before/after NICE guidance change
- Liaising with cardiologist and how long does it take for them to get back to you?
- Patient preference for antibiotic cover

- Review existing practice in light of discussion

- Am I over-referring cases that could be managed in practice?
- Am I explaining the risk of infective endocarditis and reasons for antibiotic cover well enough to patients?

- Identify areas for change

- Audit - compliance with NICE and SDCEP guidance
- QI project to check understanding of what infective endocarditis is and how dental treatment can increase risk

Peer Review Group Meeting: MRONJ

1. Introduce topic of discussion - Management of patients at risk of medication-related osteonecrosis of the jaw (MRONJ)

2. Group to discuss topic

- Share existing practice

- Enquire about medical history including cancer, autoimmune diseases, bone disease and drug history (including historical bisphosphonate use, duration of treatment and use of -nibs/-mabs and other immunosuppressant drugs)
- OHI and early management of infection to prevent MRONJ in at risk patients
- Risk assessment for dental procedure
- Risk/benefit of drug holiday, chlorhexidine and/or antibiotic cover
- Liaising with medical team
- Referral to secondary/tertiary care

- Literature

- Medication-related osteonecrosis of the jaw unrelated to bisphosphonates and denosumab - a review (King et al., 2019)
- American Association of Oral and Maxillofacial Surgeons position paper on medication-related osteonecrosis of the jaw - 2014 update (Ruggiero et al. 2014)
- Oncology agents and medication-related osteonecrosis of the jaw (American Dental Association, 2021)
- Osteoporosis medications and medication-related osteonecrosis of the jaw (American Dental Association, 2019)

- Guidelines

- Oral health management of patients at risk of medication-related osteonecrosis of the jaw (SDCEP, 2017)
- Medication-related osteonecrosis of the jaw: guidance for the oncology multidisciplinary team (Royal College of Physicians, 2019)

- Policy

- Practice policy on management
- Oral Surgery/Maxillofacial department policy on management

- Share experiences

- Preventing MRONJ in at risk patients
- Discussing risk and treatment options with a patient
- Diagnosing MRONJ
- Liaising with the patient's medical team
- Decision to refer to secondary/tertiary care
- Managing emergency patients who are at risk of MRONJ
- Do you see patients at risk of MRONJ in practice?
- Do you prescribe antibiotics pre-/post-operatively or if MRONJ is present?
- Do you extract teeth in patients with MRONJ in practice?
- Has anyone seen MRONJ?
- How do you explain the risk of MRONJ and is this quantifiable?

- Review existing practice in light of discussion

- Am I identifying at-risk patients and newer medications that have potential to cause MRONJ (i.e. not just bisphosphonates, but also patients with autoimmune conditions like Crohn's)?
- Am I over-referring cases that could be managed in practice?
- Am I explaining the risk and management well enough to patients?

- Identify areas for change

- Audit - compliance with SDCEP guidance
- QI - use of patient information leaflets and impact on PREMs

Peer Review Group Meeting: Temporomandibular Disorders

1. Introduce topic of discussion - TMD assessment and management

2. Group to discuss topic

- Share existing practice

- Taking a history for facial pain conditions
- Risk factor assessment (including medical history, dental history & social history)
- Clinical assessment of joint & musculature
- Types of TMD (muscular vs. joint-related)
- Conservative management and advice (heat therapy, massage, analgesics, jaw exercises, stress management, habit avoidance, splints)
- Preventing exacerbation of dislocation/muscular TMD during dental treatment
- When to refer

- Literature

- Diagnostic criteria for temporomandibular disorders (DC/TMD) for clinical and research applications: recommendations of the international RDC/TMD consortium network and orofacial pain special interest group (Schiffman et al. 2014)
- International classification of orofacial pain, 1st edition (ICOP, 2020)
- The effectiveness of self-management interventions in adults with chronic orofacial pain: a systematic review, meta-analysis and meta-regression (Aggarwal et al., 2019)
- Oral splints for temporomandibular disorder or bruxism: a systematic review (Riley et al., 2020)

- Guidelines

- Temporomandibular disorders (TMDs): An update and management guidance for primary care from the UK specialist interest group in orofacial pain and TMDs (RCS England, 2013)
- Chronic pain (primary and secondary) in over 16s: assessment of all chronic pain and management of chronic primary pain (NICE, 2021)

- Policy

- Oral surgery/maxillofacial department policy on management and accepting referrals

- Share experiences

- Differential diagnosis with other facial and dental pain
- Patient requests for drug therapies
- Implementing conservative management and effectiveness, including choice of splint design
- Managing patient expectations and compliance
- Follow-up interval and when to expect improvement from conservative management strategies
- Referral to secondary/tertiary care

- Review existing practice in light of discussion

- Am I providing all conservative management options to patients?
- Am I over-referring cases that could be managed in practice?
- Does my practice use patient information leaflets (e.g. own leaflets, BAOS leaflets or those provided by local maxillofacial/oral surgery department) to relay conservative advice?

- Identify areas for change

- Audit - compliance with RCS guidance
- QI - use of patient information leaflets impact on PROMs, PREMs and clinical time for TMD management

Peer Review Group Meeting: Anticoagulants and Antiplatelets

1. Introduce topic of discussion - Management of patients taking anticoagulant and/or antiplatelet medications

2. Group to discuss topic

- Share existing practice

- Enquire about medical history including dose, frequency and duration, what condition is being treated, if still under hospital care, surgical interventions
- Interaction of warfarin with other drugs
- INR testing
- NOAC drugs and when to miss a dose
- Risk assessment for procedure
- Delay procedure/limit treatment area
- Treat early in the day
- Local haemostatic measures
- Referral

- Literature

- Antiplatelet therapy and exodontia (Schreuder and Peacock, 2015)
- Special care dentistry: part 2. Dental management of patients with drug-related acquired bleeding disorders (Nizarali and Rafique, 2013)
- Exodontia in dual antiplatelet therapy: the evidence (Nathwani and Martin, 2016)

- Guidelines

- Management of dental patients taking anticoagulants or antiplatelet drugs (SDCEP 2nd edition, 2022)

- Policy

- Practice policy on management
- Maxillofacial department policy on management

- Share experiences

- Patient poor historian on what medication they are taking/dose
- Prolonged bleed
- Patient with INR >4
- Referring patients on these medications
- Drug interactions and increased bleeding

- Review existing practice in light of discussion

- Am I over-referring cases that could be managed in practice?
- Am I explaining the management well enough to patients?
- Am I confident with suturing?

- Identify areas for change

- Audit - compliance with SDCEP guidance
- Audit - how long does it take for sutures to resorb or be removed?

Peer Review Group Meeting: Dental Trauma in the Primary Dentition

1. Introduce topic of discussion - Management of dental trauma in the Primary Dentition

2. Group to discuss topic

- Share existing practice

- Obtain a detailed trauma history
- Factors to consider: other injuries, loss of consciousness, extra oral/ dry time, delayed presentations etc.
- Dental examination including sensibility testing/ 'trauma chart'
- Use of radiographs when managing dental trauma
- Leave/allow to exfoliate/extract/refer
- Safeguarding

- Literature

- Trauma to the Primary Dentition and its Sequelae (Ranka et al., 2013)
- *Useful apps: Tooth SOS (access to IADT guidelines)*
- *Useful websites: IADT and Dental Trauma UK*

- Guidelines

- International Association of Dental Traumatology guidelines (IADT, 2020)

- Policy

- Practice policy regarding primary dental trauma
- Practice policy regarding referral to Oral and Maxillofacial surgery teams - where to refer (local teams), what information to provide etc
- Practice policy regarding management of non-accidental injuries (safeguarding standard operating procedure)

- Share experiences

- Difficulties faced when attempting to perform examination - alternative techniques e.g. lap-to-lap exam
- Decision reached monitor and awaiting exfoliation - when to review and factors to consider (e.g. development of symptoms)
- Unsure if severe intrusion/fracture/avulsion - difficulties in reaching diagnosis
- Concerned about underlying adult tooth - discussing this with parents

- Review existing practice in light of discussion

- Am I confident when assessing and diagnosing dental trauma?
- Am I aware of what radiographs should be recorded when managing dental trauma?
- Am I comfortable discussing long term sequalae following dental trauma, including risks to permanent dentition?
- Am I referring appropriately?

- Identify areas for change

- Audit - dental record keeping for dental trauma patient
- Audit - how is dental trauma managed within the practice, are IADT guidelines followed?
- Audit - are all necessary materials and equipment available to manage emergency trauma?
- Quality improvement project: Service evaluation - are referrals being made to appropriate services e.g. OMFS, CDS, dental hospital?
- Quality improvement project: Patient information leaflet - Types of dental trauma and consequences

Peer Review Group Meeting: Luxation Injuries in the Permanent Dentition

1. Introduce topic of discussion - Luxation injuries in the permanent dentition

2. Group to discuss topic

- Share existing practice

- Obtain a detailed history (date of injury, mechanism of injury, delayed presentation)
- Extra oral examination (record any soft tissue/ bony trauma)
- Intra oral examination (record any soft tissue/ bony trauma)
- Identify traumatised teeth - mobility, positioning, fractures
- Use of dental radiographs when managing dental trauma
- Sensibility testing of traumatised teeth and adjacent teeth
- Recall intervals
- Safeguarding

- Literature

- Dental Trauma Part 1: Acute Management of Luxation/ Displacement Injuries (Djemal et al., 2016)
- *Useful apps: Tooth SOS (access to IADT guidelines)*
- *Useful websites: IADT and Dental Trauma UK*

- Guidelines

- International Association of Dental Traumatology guidelines (IADT, 2020)
- Dental Trauma UK

- Policy

- Practice policy on management - recording a trauma history, management and follow up.
- Practice policy regarding management of non-accidental injuries (safeguarding standard operating procedure)

- Share experiences

- Tooth appears to be missing - intrusion vs. avulsion injuries
- Patient attends with a lateral luxation, why does applying pressure to the apical region aid repositioning?
- Patient attends with an extrusion injury - why does a watch winding motion aid repositioning?

- Review existing practice in light of discussion

- Am I aware of the different radiographic and clinical signs of each luxation injury?
- Am I confident treating the differing types of luxation injuries?
- Am I aware of what radiographs should be recorded when managing this dental injury?
- Am I confident regarding dental trauma splinting - materials, number of teeth, duration?
- Am I appropriately referring to secondary care services?
- Am I confident when describing long term consequences of dental trauma to patient?
- Am I aware of recall intervals following dental trauma?

- Identify areas for change

- Audit - referrals of dental trauma to secondary care
- Audit - are national guidelines regarding recall interviews adhered to following dental trauma
- Audit - are all necessary materials and equipment available to manage emergency trauma?
- Quality improvement project: Patient information leaflet -long term consequences of dental trauma

Peer Review Group Meeting: Fracture Injuries in the Permanent Dentition

1. Introduce topic of discussion - Management of fractures

2. Group to discuss topic

- Share existing practice

- Obtain a detailed history (date of injury, mechanism of injury, delayed presentation)
- Extra oral examination (record any soft tissue/ bony trauma)
- Intra oral examination (record any soft tissue/ bony trauma)
- Identify traumatised teeth - mobility, positioning, fractures (are the location of fragments know. Consider soft tissue radiographs if fragments missing and location unknown)
- Sensibility testing of traumatised teeth and adjacent teeth
- Determine extent of fracture (enamel, enamel/dentine, enamel/ dentine pulp/ root fracture/ crown root fracture)
- Use of dental radiographs when managing dental trauma
- Stabilisation/ splinting
- Definitive restoration/ fragment re-attachment
- Recall intervals
- Safeguarding

- Literature

- Dental Trauma 2 - Acute Management of Fracture Injuries (Djemal et al., 2016)
- Technique Tips: A Complicated Crown Fracture: The Cvek Pulpotomy (Barratt et al., 2017)
- Pocket Dentistry - Managing traumatic injuries in the young permanent dentition (website)
- *Useful apps: Tooth SOS (access to IADT guidelines)*
- *Useful websites: IADT and Dental Trauma UK*

- Guidelines

- **International Association of Dental Traumatology guidelines (IADT, 2020)**
- Dental Trauma UK

- Policy

- Practice policy on management - recording a trauma history, management and follow up
- Practice policy regarding management of non-accidental injuries (safeguarding standard operating procedure)

- Share experiences

- Location of fragment unknown, firm mass in lower lip laceration. Soft tissue radiograph demonstrates fragment in lip
- Complicated crown fracture - Cvek Pulpotomies and outcomes
- How do you bond a tooth fragment?

- Review existing practice in light of discussion

- Am I confident regarding dental trauma splinting - materials, number of teeth, duration?
- Am I appropriately referring to secondary care services?
- Am I confident when describing long term consequences of dental trauma to patient?
- Am I aware of what radiographs should be recorded when managing this dental injury?
- Am I aware of recall intervals following dental trauma?

- Identify areas for change

- Audit - referrals of dental trauma to secondary care
- Audit - are national guidelines regarding recall interviews adhered to following dental trauma
- Audit - are all necessary materials and equipment available to manage emergency trauma?
- Quality improvement project: Patient information leaflet - long term consequences of dental trauma

Peer Review Group Meeting: Dental Avulsion Injuries

1. Introduce topic of discussion - Management of an avulsion injury

2. Group to discuss topic

- Share existing practice

- Obtain a detailed trauma history
- Primary or permanent tooth? Primary - Stop do not replant tooth
- Factors to consider: other injuries, loss of consciousness, extra oral/ dry time, delayed presentations etc.
- Appropriate storage mediums
- Use of dental radiographs when managing dental trauma
- Handle avulsed tooth by crown NOT root
- Sensibility testing of adjacent teeth
- Replant tooth and splint
- Use of antibiotics
- Safeguarding

- Literature

- Primary care dentists' experience of treating avulsed permanent teeth (Kenny et al., 2015)
- Immediate management of avulsion injuries in children (Kirby et al., 2017)
- *Useful apps: Tooth SOS (access to IADT guidelines)*
- *Useful websites: IADT and Dental Trauma UK*

- Guidelines

- International Association of Dental Traumatology guidelines (IADT, 2020)
- Treatment of avulsed permanent teeth in children (BSPD, 2012)
- Dental trauma UK - Information for patients 'Pick it, Lick it, Stick it'

- Policy

- Practice policy on management of an avulsed tooth
- Practice policy for telephone advice for parents/ guardians regarding an avulsed tooth
- Practice policy regarding management of non-accidental injuries (safeguarding standard operating procedure)
- Practice policy regarding emergency appointments for trauma patients (how soon should they be seen?).

- Share experiences

- Tooth found but root appears damaged, what should you do next?
- Attempted to replant tooth but firm stop felt, what could this be caused by?
- How long should you splint a tooth following replantation?
- Tooth that has been reimplanted has a closed apex, what further treatment would this tooth require?
- A tooth was reimplanted but as the patient enters teenage years, the tooth appears shorter than the contralateral tooth, what could cause this?
- What are long term consequences following an avulsion injury? What are appropriate recall intervals?

- Review existing practice in light of discussion

- Would I be comfortable giving advice regarding reimplantation over the phone, do I explain each step clearly?
- Am I aware of what radiographs should be recorded when managing this dental injury?
- Am I confident when replanting an avulsed tooth?
- Am I confident regarding dental trauma splinting - materials, number of teeth to be splinted, duration?
- Am I aware of recall intervals following dental trauma?
- Am I confident of escalating a case to appropriate teams where I am concerned regarding delayed presentation/ non accidental injuries?
- Are reception staff confident regarding advice that can be given to an emergency trauma patient?

- Identify areas for change

- Audit - dental record keeping for trauma patients
- Audit - are all necessary materials and equipment available to manage emergency trauma?
- Quality improvement project: Dentists experience of managing an avulsed permanent tooth
- Quality improvement project: Patient information leaflet - dental first aid, guidance for replanting a tooth
- Quality improvement project: Patient information leaflet - long term consequences of a dental avulsion

Peer Review Group Meeting: Biological Approach to Caries Management
Part 1: Delivering Better Oral Health

1. Introduce topic of discussion - Delivering Better Oral health toolkit

2. Group to discuss topic

- Share existing practice

- Baby: breastfeeding/ formula, free flow cup, weaning, brushing baby teeth, fluoride concentration
- Ascertain patient's current oral hygiene habits
- Reinforce oral hygiene & tooth brushing instructions, age appropriate fluoride concentrations, interdental cleaning etc.
- Perform dietary analysis - eat well plate
- Fluoride Varnish application - dose and intervals
- Fluoride toothpaste prescription - age and dose
- Fluoride mouthwash prescription - age
- Sugar-free medications
- Smoking and alcohol use
- Prevention of erosion
- Recall intervals

- Literature

Delivering better oral health on the go (Gallagher and Godson, 2021)

- Guidelines

- Delivering Better Oral Health Toolkit (November 2021)
- Dental Check by 1 campaign

- Policy

- Policy regarding key questions that should be asked at new patient/ recall appointments to identify caries risk status and appropriate interventions

- Share experiences

- 6 year old brushing independently
- 11 year old using children's toothpaste as prefers taste
- 3 year old has bottle of milk/ juice at night
- 2 year old on demand breast feeding

- Review existing practice in light of discussion

- Am I providing detailed OHI, TBI and diet advice?
- Am I assessing a child's caries risk and giving advice appropriately?
- Am I prescribing high fluoride toothpastes appropriately?
- Am I referring to therapists/ hygienists for OHI, TBI and diet advice?
- Am I able to help patients/ parents/ guardians chair their behaviours?

- Identify areas for change

- Audit - determining patient caries risk status and giving tailored advice and recall intervals
- Audit - are we appropriately prescribing sodium fluoride toothpaste?
- Quality improvement project - creation of practice toothbrushing charts and diet diaries
- Quality improvement project: patient information leaflet - how to look after my child's teeth
- Quality improvement project: Practice oral health ambassador: promote and develop skills in the practice to ensure key areas of delivering better oral health are met

Peer Review Group Meeting: Biological Approach to Caries Management
Part 2: Fluoride applications and Fissure sealants

1. Introduce topic of discussion - Fluoride applications and Fissure sealants

2. Group to discuss topic

- Share existing practice

- Ascertain patient's current oral hygiene habits
- Reinforce oral hygiene & tooth brushing instructions
- Perform dietary analysis
- Use of dental radiographs when managing dental caries
- Fluoride Varnish application
- Fluoride toothpaste prescription
- Fluoride mouthwash prescription
- Fissure sealants, indications, technique, material, longevity, moisture control, cooperation
- Sealing caries and monitor radiographically

- Literature

- Outcomes of the conventional and biological treatment approaches for the management of caries in the primary dentition (BaniHani et al., 2017)
- Indications for fissure sealants and their role in children and adolescents (Mejare, 2011)

- Guidelines

- Delivering Better Oral Health Toolkit (November 2021)
- Scottish Dental Clinical Effectiveness Programme: Prevention and Management of Dental Caries in Children (May 2018)
- Dental Check by 1 Campaign

- Policy

- Practice policy/ involvement in Dental Check by 1 Campaign
- Patient information leaflets e.g. Looking after Children's teeth/ diet diary/ toothbrushing charts

- Share experiences

- Patient diagnosed with widespread caries but parents say child does not eat sweets
- 10 year old using children's toothpaste as does not like adult toothpastes
- 5 year old brushing on own and unsupervised
- Child unable to cooperate for conventional fissure sealant, use of GIC fissure sealants
- Minimal, enamel only caries - sealing with fissure sealants
- Struggling to achieve moisture control with cotton rolls and tongue keeps moving
- 4 handed dentistry when placing sealants

- Review existing practice in light of discussion

- Am I providing detailed OHI,TBI and diet advice?
- Do I assess patient caries risk and apply fluoride varnish/ prescribe fluoride toothpaste as appropriate?
- Am I encouraging parents of young children to attend for a check-up before the age of 1?

- Identify areas for change

- Audit - application of fluoride varnish paste
- Audit - prescription of high fluoride toothpastes
- Quality Improvement project - Patient information leaflet: Looking after my child's teeth

Peer Review Group Meeting: Biological Approach to Caries Management
Part 3: Stainless steel crowns, silver diamine fluoride, caries removal

1. Introduce topic of discussion - Stainless steel crowns, silver diamine fluoride and caries removal

2. Group to discuss topic

- Share existing practice

- Reinforce oral hygiene & tooth brushing instruction
- Perform dietary analysis
- Use of dental radiographs when managing dental caries
- Placement of separators and stainless steel crowns (Hall technique vs. conventional technique)
- Indications and contraindications for SSC
- Methods of removing excess cement
- Methods to reduce foul taste of cement
- Child-friendly language
- Post-operative instructions
- Previous knowledge or use of SDF, indications
- Complete caries removal vs. partial caries removal

- Literature

- Outcomes of the conventional and biological treatment approaches for the management of caries in the primary dentition (BaniHani et al., 2017)
- Effectiveness of silver diamine fluoride in caries prevention and arrest: a systematic literature review (Contreras et al., 2017)
- Sealing caries in primary molars: randomised control trial, 5-year results (Innes et al., 2011)
- Managing caries in primary teeth (Innes and Evans 2015)
- Use of stainless steel crowns in the permanent dentition of paediatric dental patients: A guide for GDPs (Wright, sdmag, 2019)

- Guidelines

- Delivering Better Oral Health Toolkit (November 2021)
- Scottish Dental Clinical Effectiveness Programme: Prevention and Management of Dental Caries in Children (May 2018)
- British Society of Paediatric Dentistry : Resources - Silver Diamine Fluoride: Standard Operating procedure, Patient information leaflet, consent form, background information

- Policy

- Practice policy on use of Silver Diamine Fluoride, off licence use

- Share experiences

- Placement of separators - floss vs. pliers
- Separators lost prior to SSC fit and unable to fit crown (Hall technique vs. conventional)
- Multiple cavitated carious lesions (child not reporting pain/ reversible pulpitis), parents do not want teeth extracted. Patient unable to tolerate restorations, what are your options?
- Caries extending close to pulp within a permanent tooth, risk pulp exposure if all caries removed, what are your options?
- Do you take any precautionary steps when trialling crown size, to prevent aspiration?
- I place toothpaste on the tongue to distract from the foul taste of the cement
- Does anyone use a cotton roll to bite onto for fit or do you press on the crown with you finger?
- A parent is concerned about the crown coming off
- A parent is concerned about the metal appearance of the crown
- A parent is concerned about not removing the tooth decay when placing a crown
- Can I place SCCs on opposing teeth at the same time?
- How to use SDF

- Review existing practice in light of discussion

- Am I explaining the use, appearance and off licence use of SDF clearly to patients?
- Am I referring cases appropriately for removal?
- Taking radiographs before SSC
- Using more child-friendly language
- I can use floss to place separators on

- Identify areas for change

- Audit - Appropriate use of GIC as definitive restorations in carious primary molars
- Audit failure rate of SCCs
- QI project - parent and child education of what a SSC is, why they are used, how they are placed and aftercare
- Quality improvement project - Patient information leaflet: Looking after my child's teeth
- Quality improvement project - Use of SDF

Peer Review Group Meeting: Management of Poor Prognosis First Permanent Molars

1. Introduce topic of discussion - Management of Poor Prognosis First Permanent Molars

2. Group to discuss topic

- Share existing practice

- Causes of poor prognosis first permanent molars: caries, molar incisor hypomineralisation etc.
- Recording a pre, peri and post-natal history to aid diagnosis of MIH
- Radiographs to be recorded to aid diagnosis and treatment planning
- Restoration choice (GIC/Composite)
- Other treatment options - root canal treatment /extraction
- Refer for orthodontic opinion
- Refer to community dental services/paediatric services

- Literature

- Interceptive extractions for first permanent molars: a clinical protocol (Ashley and Noar, 2019)
- Molar Incisor Hypomineralisation (MIH), a BSPD position paper on the dental condition affecting 1m UK children (BSPD, 2020)

- Guidelines

- A Guideline for the Extraction of First Permanent Molars in Children (RCS England, 2014)
- Prevention and Management of Dental Caries in Children (SDCEP, 2018)
- Delivering Better Oral Health: an evidence-based toolkit for prevention (Department of Health, 2021)

- Policy

- Practice policy for referrals e.g. age of referral, images recorded, options discussed etc.

- Share experiences

- Referred child but long waiting time for treatment - how to manage in interim?
- Difficulties in determining long term prognosis of hypomineralised 6s
- When to balance/compensate/refer for orthodontic opinion
- 7s erupted by the time of referral/late referral
- Grossly unrestorable first permanent molars, decision to extract without the need for an orthodontic opinion
- Parent does not want upper 6's to be compensated, how would you manage?

- Review existing practice in light of discussion

- How to assess 'ideal age of extraction' e.g. bifurcation of 7's and position of 5's?
- Am I referring children at the ideal age?
- Am I explaining what could happen if I am referring children onwards, discussion of treatment modalities that may be offered e.g. LA only, LA and IHS, GA?
- Am I confident discussing treatment options available: root canal treatment/ extractions, risks and benefits of each?
- Am I confident describing what MIH is and potential causes?
- Three monthly recalls for children identified with MIH

- Identify areas for change

- Audit of orthodontic/paediatric referrals - what is the practice referring?
- Quality improvement project: Patient information leaflet - compensating extractions, what are they and why are they recommended?

Peer Review Group Meeting: Behaviour Management Techniques & Delivering Anaesthesia

1. Introduce topic of discussion - Behaviour management techniques and delivering anaesthesia in children

2. Group to discuss topic

- Share existing practice

- Tell-show-do
- Acclimatisation
- Distraction techniques
- Positive reinforcement and use of descriptive praise
- Yes set
- Counting
- Knee-to-knee/ lap to lap exam
- Use of topical
- Computer assisted anaesthesia system e.g. The Wand®
- Extra-short needles
- Inhalation sedation
- Use of plastic mirrors, toothbrushes, bite props, finger guards
- Adjustments for patients with additional needs - tinted sunglasses, alteration to language used

- Literature

- Paediatric Dentistry in the New Millennium: 2. Behaviour Management - Helping Children to Accept Dentistry (Fayle and Tahmassebi, 2003)
- Local Anaesthesia using Computer Controlled Local Anaesthesia Delivery Systems (Khehra et al., 2018)

- Guidelines

- Behaviour guidance for the paediatric dental patient (American Academy of Paediatric Dentistry, 2021)
- Clinical Guidelines in Paediatric Dentistry: Update of Non-pharmacological behaviour management guideline (BSPD, 2011)
- Prevention and Management of Dental Caries in Children (SDCEP, 2018)
- Delivering Better Oral Health: an evidence-based toolkit for prevention (Department of Health, 2021)
- Conscious Sedation in Dentistry (SDCEP 2017)

- Policy

- Local acceptance policies for referral of paediatric patients to CDS/dental hospital

- Share experiences

- Child anxious, will not sit in chair - how would you manage?
- Child reluctant - how would you manage?
- Child copes well until administration of LA
- Methods to examine - lap-to-lap, modelling of behaviour from parent/sibling, patient and child sat in chair
- Insufficient time booked for examination of nervous child

- Review existing practice in light of discussion

- Am I aware of adjustments that can be made to paediatric exams e.g. lap-to-lap exams, use of finger guards, examining using a toothbrush etc?
- Are extra short needles available?
- Consider use of Computer assisted anaesthesia system e.g. The Wand®
- Do I provide acclimatisation visits prior to referral to secondary services?
- Do I encourage a dental check by 1 years old? (Dental Check by 1 campaign)
- Using child-friendly language
- More nursing support
- Building my confidence

- Identify areas for change

- Quality improvement project - review of referrals to CDS/ Dental hospital: have reasonable adjustments been made to assist in examination prior to referral?
- Quality improvement project - Patient information leaflet: Looking after my child's teeth
- Quality improvement project - Dental Check by 1 Campaign
- Quality Improvement project - Patient information leaflet: Leaflet for Paediatric Patients - our dental practice and what to expect at your check-up

Peer Review Group Meeting: Dental Radiographs in Paediatric Dentistry

1. Introduce topic of discussion - Dental radiographs in paediatric dentistry

2. Group to discuss topic

- Share existing practice

- Types of intra and extra oral radiographs (e.g. bitewings, periapical, upper standard occlusal, orthopantogram, cone beam CT etc.)
- Indications for radiographs
- Doses and risks of radiographs
- Grading of dental radiographs
- Use of parallax technique and indications
- Use of different film sizes
- Radiographs in caries management
- Radiographs in trauma management
- Indications for when radiographs should be repeated
- Patient cooperation
- Compliance with legal requirement for record keeping for radiographs (kV, mA, time)

- Literature

n/a

- Guidelines

- Selection criteria for dental radiographs (College of general dentistry 2018)
- Best clinical practice guidance for prescribing dental radiographs in children and adolescents: an EAPD policy document (Kuhnisch et al., 2020)
- Prescribing dental radiographs for infants, children, adolescents, and individuals with special health care needs (American Academy of Paediatric Dentistry, 2021)
- Ionising Radiation Regulations 2017 (IRR17)
- Ionising Radiation (Medical Exposure) Regulations 2017 (IRMER17)

- Policy

- Recall intervals for dental radiographs
- Grading/ Reporting of dental radiographs
- Indications for dental radiographs

- Share experiences

- 10 year old male requires extraction of two first permanent molars, what radiographs should be recorded?
- 7 year old female unable to tolerate bitewing radiographs, what alternatives are available?
- What is the radiographic recall interval for a 14 year old with a high caries risk?
- A parent is concerned regarding radiation doses of a periapical/OPT

- Review existing practice in light of discussion

- Am I recording radiographs appropriately in paediatric patients?
- Am I reporting radiographs correctly?
- Am I aware of different film sizes available?
- Can I discuss radiation doses in context with parents?
- Am I aware of types/ frequency of radiographs in the management of dental trauma?
- Am I aware of the types of radiographs indicated when managing poor prognosis 6's or unerupted canines/ incisors?

- Identify areas for change

- Audit - use of dental radiographs in the paediatric patient cohort
- Audit - grading and reporting of dental radiographs
- Audit - radiographs in the management of dental trauma
- Audit - are recommended guidance for dental radiographs being adhered to?
- Quality improvement project - patient information leaflet - what are dental radiographs and why are they used?
- Quality improvement project: patient information leaflet - how to look after my child's teeth

Peer Review Group Meeting: Recording keeping for Paediatric Dentistry

1. Introduce topic of discussion - paediatric dentistry record keeping

2. Group to discuss topic

- Share existing practice

- Patient attended with
- Reason for attendance
- PCO - as reported by child as well as parent, changes to behaviour etc.
- Trauma history - date of injury, mechanism of injury, emergency treatment sought, head injury, extra oral injuries etc.
- Medical history - include: names of medical teams patient may be under the care of, involvement of additional teams such as Speech & Language Therapists, Dieticians etc.
- Social history
    - Lives with/Legal guardians/Involvement from social services
    - If shared care and split time between residencies, record arrangement if set e.g. weekends with (X)
    - School - name of school
        - Any additional support required e.g. education health care plan, 1-1 classroom support
- Oral hygiene habits
- Diet - food & drinks (if split residencies ascertain if diet/ oral hygiene alters between residencies)
- Contact sports/use of mouth guard?
- Habits e.g. thumb sucking, nail biting, patient non-verbal but displays signs of pain by tapping face
- Occlusal assessment
- Presence/absence of teeth

- Literature

n/a

- Guidelines

- British Dental Association Best practice in record keeping (BDA)
- College of General Dentistry - Clinical Examination and Record-Keeping (CGDent website)

- Policy

- Policy regarding questions to be recorded when carrying out a paediatric assessment

- Share experiences

- Parent complaint that orthodontic referral should have been made years ago, how good are your clinical notes?
- Recording the consent process

- Review existing practice in light of discussion

- Do I modify and tailor my history taking and record keeping when seeing paediatric patients to ensure additional information is recorded?

- Identify areas for change

- Audit - Dental record keeping for Paediatric Patients
- Quality improvement project - Proforma or template of questions to be asked when carrying out a paediatric patient assessment

Peer Review Group Meeting: Complaints Handling

1. Introduce topic of discussion - Complaints handling

2. Group to discuss topic including:

- Method of complaint: Telephone, in-person, via NHS/GDC
- NHS vs. Private

- Share existing practice

- Call the patient
- Write to the patient
- Contact Defence Society/Union
- Issue Refund

- Literature

- Consumer Rights Act 2015
- The Local Authority Social Services and National Health Service Complaints (England) Regulations 2009
- The National Health Services (General Dental Services) (Scotland) Regulations 2010
- The National Health Service (Concerns, Complaints and Redress Arrangements) (Wales) Regulations 2011
- The Health and Social Care Service Northern Ireland (HSCNI) complaints directions
- The Dental complaints service

- Guidelines

- GDC standards for the dental team, standard 5 (2013)
- CQC Regulation 16
- CNSGP Responding to complaints (NHS resolution)
- Complaints handling (bda.org)

- Policy

- Practice/hospital complaints policy
- Practice/hospital data handling policy

- Share experiences

- Case discussions
- Delay in providing treatment
- Faulty procedure
- Failed to attend
- Alternative practitioner
- Referrals
- Request for response from NHS
- Request for information from GDC
- Request for information from Ombudsman

- Review existing practice in light of discussion

- Complaints manager are they appropriately trained?
- Do we encourage the use of our in-house complaints policy enough?
- What do I do if the patient just doesn't accept our response?
- Staff meetings/debrief
- How often do we make a change as a result of the complaint?

- Identify areas for change

- Audit of complaints
- Update policy
- Regular training/staff meetings dealing with complaints

Peer Review Group Meeting: Case discussions (When things go wrong OR When things go well)

1. Introduce topic of discussion - Case discussions, either when things go wrong, or when things to well, or both!

2. Group to discuss topic

- Share existing practice

- Groups members to present an interesting case

- Literature

- Refer to literature that supports/does not support your approach
- Refer to literature that supports a change in approach

- Guidelines

- Refer to guidance that supports/does not support your approach
- Refer to guidance that supports a change in approach

- Policy

n/a

- Share experiences

- Receive feedback from peers, what went well, what didn't go so well
- Tips and advice from peers
- Similar experiences shared with peers

- Review existing practice in light of discussion

- Case-dependent

- Identify areas for change

- Case-dependent

Enquiries

All enquiries related to this toolkit should be submitted to:

Hassan-Ali Ismail - Leadership Fellow in Paediatric and Special Care Dentistry	**hassanali.ismail@nhs.net**
N. Tony Ahmed - Chair Local Dental Network	**nadeem.ahmed9@nhs.net**
Sania Ahmed - Administrative Assistant	**sania.ahmed4@nhs.net**

Further help and guidance

Health Education England West Midlands has provided an excellent toolkit for use by dental professionals to help them set up peer review groups. It contains lots of helpful hintsand tips and also provides a number of useful templates. Facilitators may find this information very helpful in setting up and managing peer groups.[7]

Health Education and Improvement Wales (HEIW) has also produced a dental peer review toolkit which aims to guide dental professionals through the process.[8] It also provides templates to assist in running a peer review group. To access to the toolkit please contact **HEIW.DentalQI@wales.nhs.uk**.

References

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5. General Dental Council. *Enhanced CPD guidance* 2018. Available at: **https://www.gdc-uk.org/docs/default-source/enhanced-cpd-scheme-2018/enhanced-cpd-guidance-for-professionals4b2a9cec29bf41faa303a059059ee16d.pdf?sfvrsn=edbe677f_7** (Accessed 22 February 2022).

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7. Health Education England. *Health Education West Midlands Peer Group Toolkit* 2015. Available at: **https://www.westmidlandsdeanery.nhs.uk/Portals/0/Denistry/9Peer%20Group%20Toolkit%20%202015%20Booklet%20Final.pdf?ver=2015-12-22-112440-07** (Accessed 22 February 2022).

8. Health Education and Improvement Wales. *Dental peer group toolkit overview* 2022. Available at: **https://heiw.nhs.wales/education-and-training/dental/quality-improvement/peer-review-group/** (Accessed 22 February 2022).

Appendix 1: PR1 Peer Review Group Application Form

The facilitator is responsible for submitting all relevant documentation for all members ofthe group.
All three sections of this form should be completed by the facilitator once a peer review group has been established.
This form should be returned electronically to **'insert email address'**.
Please note meetings cannot commence until approval has been given by the **'insert organisation'**.
Please note handwritten forms will not be accepted.

Section 1 – Please complete the following:

Facilitator Information

Title	☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Prof ☐Other (please specify below) ……
Forename	
Surname	
Status	☐Dentist ☐DCP If DCP please specify ……
GDC number	
Performer number (if applicable)	
Place of work	
Place of work address	
Place of work contact number	
Email address	
Name of peer review group	
Name of organisation funding this peer review group	
Proposed date of first meeting	

Date of peer review training course attended (if applicable)	
Total number of members in the group	
Number of practices involved in the group (does not apply to CDS, secure settings or secondary care)	

Section 2 – Please provide details of all members in the group (use a separate sheet if needed)

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status		☐Dentist ☐DCP If DCP please specify............................		**GDC number**	
Performer number (if applicable)			**Place of work**		
Place of work address					
Place of work contact number			**Email address**		

Title		**Forename**		**Surname**	
Status		☐Dentist ☐DCP If DCP please specify............................		**GDC number**	
Performer number (if applicable)			**Place of work**		
Place of work address					
Place of work contact number			**Email address**		

Title		**Forename**		**Surname**	
Status		☐Dentist ☐DCP If DCP please specify............................		**GDC number**	
Performer number (if applicable)			**Place of work**		
Place of work address					
Place of work contact number			**Email address**		

Title		**Forename**		**Surname**	
Status		☐Dentist ☐DCP If DCP please specify............................		**GDC number**	
Performer number (if applicable)			**Place of work**		
Place of work address					
Place of work contact number			**Email address**		

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Title		**Forename**		**Surname**	
Status	☐Dentist ☐DCP If DCP please specify…………………………			**GDC number**	
Performer number (if applicable)		**Place of work**			
Place of work address					
Place of work contact number		**Email address**			

Section 3 – Declaration (to be completed by the facilitator)

☐Under guidance issued by the **'insert organisation'**, I confirm that all the information provided above is correct and I agree to provide a report on completion of the peer review cycle.

Full name:	
Date:	

This form, once completed and signed by the facilitator, should be returned electronically to **'insert email address'**.

The facilitator must keep a record of any meeting agendas, minutes, attendance records, meeting evaluations and CPD certificates.

Appendix 2: PR2 Peer Review Group Cycle Completion Form

This form should be completed by the facilitator once a peer review group has completed its cycle of meetings.
All sections of this form should be completed by the facilitator.
The facilitator is responsible for submitting all relevant documentation for all members of the group.
This form should be returned electronically to **'insert email address'**.
Please note meetings cannot commence until approval has been given by the **'insert organisation'**.
Please note handwritten forms will not be accepted.

Section 1 – Please complete the following:

Facilitator Information

Title	☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Prof ☐Other (please specify below) ……
Forename	
Surname	
Status	☐Dentist ☐DCP If DCP please specify ……..
GDC number	
Performer number (if applicable)	
Place of work	
Place of work address	
Place of work contact number	
Email address	
Name of peer review group	
Name of organisation funding this peer review group	

Number of peer review meetings completed in this cycle	
Date of first meeting in this cycle	
Date of last meeting in this cycle	

Section 2 – End of peer review group cycle report. All information should be anonymised. Please continue on a separate sheet if needed.

Meeting 1			
Date		**Venue**	
Number of members in attendance		**Duration**	
List of topics discussed			
What were the learning points from the meeting?			
What improvements will this lead to on the quality of patient care?			
How did the group members benefit from the meeting?			

Meeting 2			
Date		**Venue**	
Number of members in attendance		**Duration**	
List of topics discussed			
What were the learning points from the meeting?			
What improvements will this lead to on the quality of patient care?			
How did the group members benefit from the meeting?			

Meeting 3			
Date		**Venue**	
Number of members in attendance		**Duration**	
List of topics discussed			
What were the learning points from the meeting?			
What improvements will this lead to on the quality of patient care?			
How did the group members benefit from the meeting?			

Meeting 4			
Date		**Venue**	
Number of members in attendance		**Duration**	
List of topics discussed			
What were the learning points from the meeting?			
What improvements will this lead to on the quality of patient care?			
How did the group members benefit from the meeting?			

Meeting 5			
Date		**Venue**	
Number of members in attendance		**Duration**	
List of topics discussed			
What were the learning points from the meeting?			
What improvements will this lead to on the quality of patient care?			
How did the group members benefit from the meeting?			

Section 3 – Declaration (to be completed by the facilitator)

☐I hereby confirm that all the information provided above is correct and that this peer review cycle has not been previously funded or approved by any organisation/ body/ committee/ society in the United Kingdom.

Full name:	
Date:	

This form, once completed and signed by the facilitator, should be returned electronically to **'insert email address'**.

The facilitator must keep a record of any meeting agendas, minutes, attendance records, meeting evaluations and CPD certificates.

Appendix 3: PR3 Peer Review Facilitator Payment Claim Form

This form should be completed by the facilitator once approval of a peer review cycle has been accepted by the **'insert organisation'**.
This form should be returned electronically to **'insert email address'**.
Please note handwritten forms will not be accepted.
A payment of £350 can be claimed by the facilitator for initially recruiting members to the group and holding the first two meetings.
A further payment of £50 per meeting can also be claimed, up to a maximum of £150 for further meetings.
A facilitator can therefore claim for a maximum of £500 for setting up a group and holding five meetings over a period of 12 months.

Facilitator Information

Title	☐Mr ☐Mrs ☐Miss ☐Ms ☐Dr ☐Prof ☐Other (please specify below) ……
Forename	
Surname	
Status	☐Dentist ☐DCP If DCP please specify ……
GDC number	
Performer number (if applicable)	
Place of work	
Place of work address	
Place of work contact number	
Email address	
Name of peer review group	
Name of organisation funding this peer review group	
Number of meetings held	
Dates of all meetings	
Total amount claimed (£)	
☐	I certify that I am the facilitator of the above named peer review group and claim payment from the **'insert organisation'** on completion of a peer review cycle as defined by the guidance provided by the **'insert organisation'**
☐	I understand that I am liable to declare payments to the Inland Revenue and that Income Tax and National Insurance payments will NOT be deducted on my behalf from the payment that is being claimed

All payments will be made by BACS. Please provide your bank details:

Name of Bank Account	
Account Number	
Sort Code	

Appendix 4: Meeting Agenda

Name of Peer Review Group
Meeting Title (main topic of discussion)
Meeting Agenda

Date:

Time:

Venue:

Meeting facilitator:

Aim(s):

Objective(s):

1. Discuss key points arising from previous meeting and any changes made to practice
2. Introduce topic of discussion
3. Group to discuss topic
- Share existing practice
- Literature
- Guidelines
- Policy
- Share experiences
- Review existing practice in light of discussion
- Identify areas for change

4. Plan next meeting
- Topic, Date and Time, Location, Meeting Facilitator

5. AOB
6. Summary of meeting

Task List
Individual member tasks after the meeting:
1. Complete individual reflection learning log

Facilitator tasks after the meeting:
1. Record minutes
2. Complete PR2 **for this meeting only (for funded groups)**
3. Complete attendance register
4. Issue CPD certificates

Facilitator tasks after cycle of 5 meetings completed (for funded groups):
1. Ensure PR2 has been completed for all meetings
2. PR3 - payment claim form

Appendix 5: Attendance Register

Name of Peer Review Group
Meeting Title
Attendance Register

Date:

Time:

Venue:

Meeting facilitator:

Name	GDC Number	Present at Meeting
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐
		☐

Apologies

Name	Name

Appendix 6: Peer Review Individual Reflective Learning Log

Name of peer review group:
Date:
Venue:
Meeting facilitator:

Title of meeting:
Main discussion points:

Reflection is an important part of CPD and peer review, and should form part of your personal development plan. Please use thisspace to reflect on what you have learnt, your experience and how it applies to your role.

What did you learn?

What will you do more as a result of this?

What will you keep doing as a result of this?

What will you do less of as a result of this?

How can you demonstrate you have implemented changes as a result of this?

Please share any other comments, thoughts or feelings.

Appendix 7: Peer Review Meeting Evaluation

Name of peer review group:
Date:
Venue:
Meeting facilitator:
Meeting title:

I enjoyed this meeting

The meeting was well organised

The meeting met my educational needs

The meeting was relevant to me

There was sufficient time available for discussion

The facilitator communicated with a clear voice

The facilitator made the meeting interesting

What specific changes would you like to make, if any, to your practice as a result of what you have learnt?

What do you think was the most successful and/or useful aspect of the meeting?

What, if anything, was the least successful and/or useful aspect of the meeting?

Please share any comments, thoughts or feelings.

Appendix 8: Verifiable CPD Certificate

Insert Organisation (if non-funded insert name of peer group)

This is to certify that
Insert Name
GDC no: Insert GDC no.

Attended and participated in the following peer review group meeting on
Insert Title of Meeting

Insert venue e.g. online on Zoom
On **Insert date e.g. Monday 17 January 2022**

Accredited by **Insert organisation or name of peer review group if non-funded**
This CPD is subject to quality assurance by

Signed……

Insert facilitator name here and signature above
I confirm that the information provided on this certificate is full and accurate

This activity represents **X hour(s)** of verifiable CPD awarded by the **Insert organisation or name of peer review group if non-funded**

Aim:
Insert aim

Objectives:
Insert objective
Insert objective
Insert objective
Insert objective
Insert objective

GDC Domains: This CPD course meets the criteria for the GDC's development outcomes:
Insert GDC outcomes A, B, C, D