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BDJ InPractice

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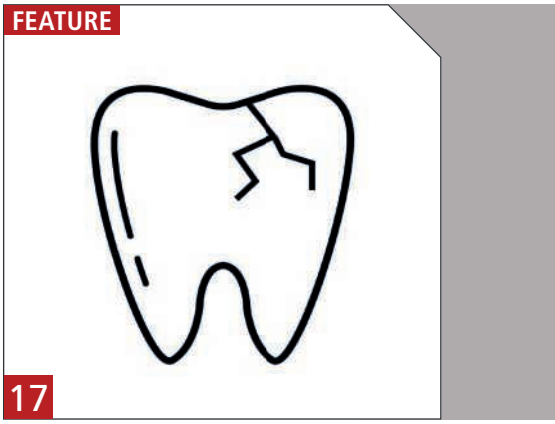
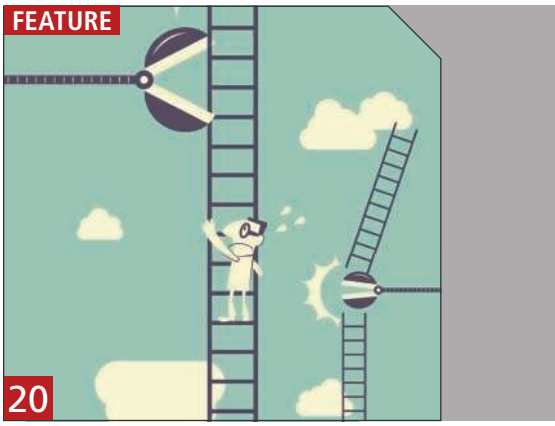




BDA
British Dental Association

# Government now profiting from NHS charges at hundreds of dental practices

As the cost of NHS dentistry in England has once again risen, Ministers are set to turn a profit from NHS charges in hundreds of practices, according to analysis by the British Dental Association.

As 5% increases kick in for the third consecutive year, charge levels now exceed the price dentists are paid to provide services at over 300 practices. Based on current contracts the BDA estimates the government will generate over £40 million in profits by the time of the next general election from an ever growing proportion of NHS practices. A quarter of all NHS dental practices are on track to collect more from patients than government pays them to provide care by 2022.

These charges do not go dentists, and are passed to NHS England. Revenue from patients is now increasing as a proportion of overall dental budget, while contributions from general taxation are in long-term decline. As charges have been rising at an inflation-busting pace, payments to dentists to provide services have increased by an average of just 1% per year since 2010.

Nearly 1 in 5 patients have delayed treatment for reasons of cost according to official statistics. Dentist leaders have called for charge increases to be capped to inflation, and for charge revenue to remain a stable or declining proportion of the total NHS budget, as is the case in devolved nations.

The BDA's Chair of General Dental Practice Henrik Overgaard-Nielsen said: 'When patients put in more towards their care than government pays to provide it, NHS charges cease to be a 'fair contribution' and become a bad joke.

'This absurd situation has been fuelled by inflation-busting increases, and flat-lining budgets. These hikes don't go to dentists, aren't supporting needed investment or improving access. They are becoming a nice little earner for Ministers, which actively discourage the patients who most need our care.

'This funding model reflects Westminster's casual disregard for NHS dentistry. This service requires sustainable funding, not this tax on health.'

Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, added: 'This above inflationary price increase will undoubtedly add to poor patient attendance as it will price more and more people out of being able to access dental services.

'Sadly, it is those most in need, with poorest oral health and higher demand for treatment are those most affected. Continued price rises are a recipe for increasing inequalities and poorer oral health nationwide.

'We have found that more than a quarter of people in Britain see cost as the main barrier to accessing dental services and we fully expect this to grow with this price increase. We need to have adequate funding for the NHS dental services now or face the consequences in the long-term.' ◆

© Credit/Getty Images Plus

# The BDA Member Series

***BDA Chief Executive Peter Ward on listening to members***

Our members are at the heart of what we do. They told us that they wanted fantastic content at venues near them – and we are committed to delivering it.

We know that the pressures on dentists in the modern world are significant. Those pressures come in the shape of keeping up to date clinically, satisfying regulatory requirements and making sure the sums add up in clinical practice.

So, we have designed a series of 24 educational events that are travelling around the UK to 12 different locations, to help our members not just meet those challenges, but to prevail against the competition. We are offering both clinical education and updates on how to make sure you are getting the best return on your clinical activities. Both these elements are central to dentists' well-being wherever they practice in the UK and whether they are practice-owners or associates.

We have secured a team of renowned clinical speakers to give state-of-the-art updates on the really current issues in dentistry ranging from management of tooth wear to periodontal disease management. Dentists attending the clinical lecture days in our member series can be guaranteed to come away with the most up-to-date insights in clinical practice.

We are also aware that financial pressures and regulatory demands make it very challenging for dentists to maintain viability and profitability in their practising lives. So, we have put together a set of complementary lecture days that will provide practical advice on how to make sure you are compliant and that your clinical activity reaps you the best rewards.

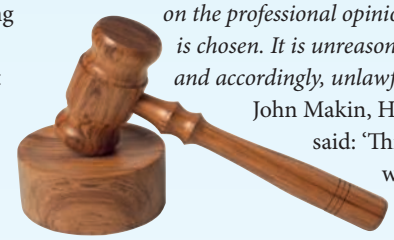
We are offering our Expert and Extra members the first choice for these events and they can attend two free of charge within their membership. But we aren't excluding Essential members – they will be able to buy tickets – or even better to upgrade their membership and get free access alongside the other excellent benefits of the upper tiers of membership.

You can see what's available here https://www.bda.org/events/member-series. All the courses are valid for CPD and will offer at least 5 hours verifiable. ◆

# Ombudsman's decisions must be 'fair and just'

A recent Court of Appeal judgment has criticised the fairness and scope of the former Parliamentary and Health Service Ombudsman's procedure for investigating clinical complaints against healthcare professionals. The GPs in the case were jointly represented by the MDU and another medical defence organisation but the judgment will also have positive implications for dental professionals.

The court considered exactly how the Ombudsman applied her discretion to investigate a complaint. It found an investigation should not begin where a complainant has another legal remedy open to them (other than complaining to the Ombudsman) unless the Ombudsman 'is satisfied' that it was not reasonable to expect the complainant to use the alternative legal remedy. The Ombudsman must obtain and analyse information related to the complainant's particular circumstances and not simply refer to general criteria.



The court also provided welcome clarity on the standard applied by the Ombudsman to determine whether or not the exercise of clinical judgement was reasonable.

The judge commented: *'The standard chosen by the Ombudsman is beguilingly simple but incoherent. It cannot provide clarity or consistency of application to the facts of different cases. There is no yardstick of reasonable or responsible practice, but rather a counsel of perfection that can be arbitrary. It runs the risk of being a lottery dependent on the professional opinion of the advisor that is chosen. It is unreasonable and irrational and accordingly, unlawful.'*

John Makin, Head of the DDU said: 'This judgment will have positive implications for dental professionals. When their clinical judgement is criticised, the Ombudsman can investigate what happened, reach conclusions and make recommendations if service failure is found. It is essential that the standards used by the Ombudsman to judge the clinical care provided to a patient are appropriate. Dental professionals should not be held to unreasonably high standards. It is also important that the Ombudsman stays within its legal powers and does not investigate exactly the same facts as a court would consider as this could present double jeopardy for dental professionals.

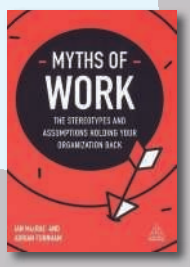
'Those facing an investigation into their clinical practice should have reassurance that the processes being followed by the Ombudsman are fair and just. This judgment is good for healthcare professionals, and will also benefit patients who can be assured that the investigation was properly and fairly carried out.' ◆

BOOK REVIEW

# Myths of work

**The stereotypes and assumptions holding your organisation back**

Ian MacRae and Adrian Furnham
Kogan Page, 2018
ISBN: 978-0-7494-8128-5
£14.99




## In a nutshell

The business world is pervaded by fads and falsehoods that continue to populate an ever-more complex working environment. These myths are often out-of-date assumptions, stereotyped or plagiarised from other businesses and usually well-worn clichés of management speak. Ian MacRae and Adrian Furnham, both experts in the field of industrial psychology, embark here on a treatise to dispel these notions. Some of these misconceptions are well-established and some are strongly-held particularly by some HR departments as though they were written in stone. So these two authors should be praised for this well-argued and very readable iconoclastic paperback. They take aim at many myths including such old saws as employees who work the longest hours are the most valuable people or a computer is going to take over your job.

## Who is it ideal for?

This isn't just a book for employers of staff because there are several myths discussed here that can apply equally to a self-employed, one person business. A good example of this would be the ubiquitous old chestnut that people should retire at 65, despite the fact that from 1 October 2011 it became illegal to force workers to retire due to their age. However, the myth of believing one should retire at 65 is just as pervasive. Living longer and in most cases in good health means that retiring at a notional retirement age is often unnecessary, even undesirable. The authors cite the example of broadcaster Nicholas Parsons, who at 94 (at the time of writing) is the oldest radio game show host. Parsons, who says he loves the job, also discloses that his work keeps him 'sharp, interested and engaged'.

## Why you should read it?

In its twenty seven myth-busting chapters the book systematically eviscerates many long-held beliefs, but crucially, also offers concrete evidence to support these confrontational challenges. One perfect example, damned conclusively by scientific studies, disproves the notion that open plan offices are the best option. In actuality, the studies found that these types of workplaces are damaging to employee satisfaction due to increased noise levels and distractions. The net effect is that employees take more sick leave as a direct result of their working environment. There are many other workplace myths which the authors readily dispel. Millennials, contrary to received wisdom, are not changing the workplace. Annual appraisals are actually not the best way to measure performance. Perfectionists do not necessarily make the best employees. Even the well-established myth that warns of the perils of co-workers forming romantic relationships is summarily dispatched. This book fundamentally changes everything we thought we knew about the workplace. ◆

# Charlotte Waite is new Chair of ECDSC

Charlotte Waite has been elected Chair of the BDA's England Community Dental Services Committee (ECDSC).

Charlotte is a Senior Community Dentist based in Leicestershire, and has served as Vice Chair for the last 3 years.

Charlotte said: 'Financial constraints continue to make a huge impact on salaried dentists, on morale, recruitment and retention. Barriers to care are a daily feature of working in the community dental services. I am determined to confront the barriers facing both practitioners and the patients we serve.

'The next few years will be hugely challenging as we tackle underfunding, digital transformation, and the obstacles facing vulnerable patients accessing the care they are entitled to.

'I will seek to ensure the BDA can provide the policies and the services that reflect the needs of all our members.' ◆

# NI grant scheme 'a much needed boost'

A £1 million grant scheme for GDS dental practices has been welcomed by BDA Northern Ireland.

Utilising underspend in the 2017-18 GDS budget, the Revenue Grant Scheme aims to help dental practices invest in meeting patient care quality and safety standards, as well as modernising practice infrastructure.

Applications for grants should be made by practices to the HSCB, along with the appropriate receipted invoices (dated between 1 April 2017 and 31 March 2018) no later than 30 April 2018.

It is understood eligible items of expenditure range from everyday consumables such as files and gloves, to larger one-off practice investments such as amalgamators, cameras, hand instruments, as well as relevant training courses.

A maximum allowance of 80 pence per Health Service registered patient has been set aside under the scheme. Practices are being written to advising of details of the grant scheme, and with an indication of their maximum practice allowance.

Responding to the launch of the scheme, BDA NI Dental Practice Committee Chair, Richard Graham, said: 'General dental practices have been under unprecedented financial pressure over recent years, and this has directly impacted on their ability to invest in practice. It is right that money earmarked for dentistry within the GDS should be retained within dentistry.

'We have been assured that this scheme has been designed by the Health and Social Care Board with maximum flexibility in mind, and we believe most practices should be able to benefit. 'I encourage every practice owner to contact their local dental advisor, and make claims for the relevant items.'

BDA Northern Ireland representatives have been making the case for retaining any GDS underspend within dentistry. A grant scheme was mooted by BDA in discussions with Department of Health and Health and Social Care Board officials prior to Christmas. ◆

# Why the universities pension strike matters

***BDA Head of Pensions Phil McEvoy on standing together with lecturers***

The cold, late winter days have seen significant levels of industrial unrest in the Higher Education sector, with 14 days of industrial action taken to date. The disputed issue is the proposal to close the defined benefit pension for academics in the Universities Superannuation Scheme (USS). Defined benefit pensions offer individuals an income in retirement, worked out by reference to an individual's earnings during their working life. Crucially a defined benefit pension also comes with a guarantor, typically the employer of the workers who are in the scheme.

In place of this guaranteed pension, the proposal that was tabled suggested that academics and their employers would, in future, pay into a defined contribution pension scheme. The guaranteed pension that has already been earned would be protected, but no more would build up.

In a defined contribution pension scheme there is no guarantee of a future income at all. Individual members shoulder all of the risk associated with pension saving – if investments do badly, then their pension funds are diminished. If life expectancies increase, they have to make their savings stretch further in retirement. There are no guarantees in this form of pension saving.

The BDA is representing members covered by the USS in this matter. However our interest goes even further in seeking to ensure that this group can retain defined benefit pensions. In recent years these forms of pensions have been largely decimated in the private sector. Whilst the public sector, including the NHS Pension Schemes, still provides defined benefit pensions, there may be some in government (the guarantor for the NHS Pension Scheme) who feel that they are out of step with the private sector (even taking account of different earnings levels between the two).

Given that we want good pension provision for dentists; we want to ensure that we are not seen as outliers, and so we hope that quality pension provision can be the norm in other sectors of the economy. That is why BDA has sent messages of support to lecturers who are taking action to protect their pensions and hope a mutually satisfactory resolution can be met. ◆

**BOOK REVIEW**

# The leadership of teams

Mike Brent and
Fiona Elsa Dent
Bloomsbury, 2017
ISBN: 978-1-4729-3587-8
£14.99


## In a nutshell

The two authors of this intriguing paperback are both professors at Ashridge Executive Education, formerly known as Ashridge Business School, and they specialise in team-building and leadership. Their proposition is simply that teams and teamwork are overused and often inadequately used words. Consequently their intention here is to examine the various meanings and manifestations of the team. Does it always need to exist? Does it always work? When and how do teams work and when are they necessary? The authors also examine what characteristics are needed to lead a team and conversely, how to be a fully functioning team member, so this is hardly a one-sided investigation. With the ubiquity of teams found in business, industry, schools, hospitals and government there is a genuine need to determine what makes a successful team and what leaders can do to ensure teams collaborate usefully and are committed to the appropriate goals.

## Who is it ideal for?

Despite its hierarchical-sounding title, this book is not aimed exclusively at established or prospective team leaders. Certainly there is much to be learned here in terms of leading a team. However, there is also a fair amount of text focussing on the desired qualities, characteristics and skills of the team member. There is also an emphasis placed on the psychology of the successful team in terms of building trust between team members and engaging the team. In a section entitled 'lessons from an airline', based on an interview with a pilot of aeroplanes owned by a leading UK airline, there's clearly a message imparted of the notion of democratic leadership. The pilot does not dictate to his crew what needs to be done, rather they will ascertain from the crew members what issues are present and the cabin crew are actively encouraged to alert the flight crew to any problems or incidents. This behaviour is essential in order for a team that may change daily, to operate effectively and safely.

## Why you should read it?

Team leaders have a multiplicity of roles to play in the workplace, some of which are not always obvious and others which are often neglected. The authors remind the reader of these adjunctive but important roles in various chapters that deal with subjects such as coaching the team, which involves the essential skills of listening, questioning, observing, reframing, challenging, supporting and giving feedback. Team leaders also must facilitate a team. Facilitate derives from the Latin facilis, to make easy, so leaders are there to make things easier for the team to work together. Engaging the team is always vital and it's here that the authors employ a jazz metaphor where improvisation is a key element of performance and essentially constitutes a dialogue between the players. The skills of improvisation involve empathy, trust and deep listening. Similarly in the engagement of a team, as with a jazz band and especially in an increasingly complex and challenging world, it's imperative to suspend judgement, empower the team members, create a culture of openness and help team members to build on each other's ideas ('yes and rather than yes, but'). As a 'dip in and out' of book, this is crammed with new ideas, tips and techniques for leading or participating in a team. ◆

For more about these books: www.bda.org/booknews

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# So now you're a Principal...

**Heidi Marshall**, secretary at NASDAL, discusses the next steps to consider once you've made the leap to owner


©Kim Kirby/LOOP IMAGES/Getty Images Plus

Phew! The purchase has finally gone through and you're the proud owner of a sparkly new Dental Practice. What happens now and how is your professional life about to change?

## Protection

Moving from an associate to a principal is a big change and all of your current policies are likely to need updating to cover the change. Think professional indemnity, permanent health insurance, sickness cover, life cover etc. If you have a will that may also need looking at. If you don't have a will – why not? It is a fundamental part of life and business planning.

If you've purchased a fully private practice and have previously been part of the NHS then you will have stepped out of the protection 'umbrella' that working within the NHS provides you. As a deferred member you will no longer qualify for death in service benefits, tier 2 pensions (in the event of ill health) or maternity and paternity pay so you will need to make alternative arrangements.

## Cashflow vs profit

We've all heard the age old saying 'turnover is vanity, profit is sanity' but many business owners forget that cash is king. You can make as much profit as you like but if you don't have the cashflow to pay your tax bill and loan repayments then your business just simply won't succeed. I meet so many clients who don't like having debt, so they try to pay it off as quickly as possible and then get themselves in trouble along the way.

The most important bit of advice I can give here is that as a business owner you need to think of debt as being part and parcel of the package, it is not a bad thing to have debt as long as you can comfortably afford to make the repayments so take that HP agreement over a couple more years and give yourself some breathing space. You can always make overpayments of debt if your cash balance starts building up.

## Pension Annual Allowance Charges

The annual allowance (AA) is the maximum amount you can contribute to a pension and obtain tax relief. The AA limit is currently £40,000 although individuals with high earnings (>£150,000) may see this reduced to £10,000.

For those in a defined contribution scheme (e.g. Standard Life) the position is fairly straightforward. It is contributions paid which are compared to the AA limit.

For those in a defined benefit scheme, like the NHS pension scheme, the position is much more complicated. A calculation must be done to establish the increase in value of your pension pot during the tax year. It is this increase in value which is compared to the AA limit. The amount of superannuation contributions made is therefore irrelevant for working out your AA position in this type of scheme.

Many clients who move from being an associate to a principal of an NHS practice will see a spike in their net pensionable earnings which could cause an unexpected annual allowance charge.

## Bookkeeping

Keeping up to date accounting records will help you to plan your finances better. Many are now switching over to 'Cloud' accounting, which is online software that can be accessed anywhere provided you have an internet connection.

The main benefits of using a Cloud package are:

- Automatic bank feeds saves data inputting due to a read only copy of transactions being brought from your bank account which reduces time, duplicates and incorrect entries.
- Real time information can enable accountants to prepare accounts shortly after your year end, if you keep the data up to date. The reporting functionality can reduce the need for excessive spreadsheets.
- Cloud accounting software is deemed easy to use so you will be able to use the system quickly and efficiently in no time. If you can shop online you can use Cloud Accounting!
- You can process your payroll within Cloud Accounting therefore saving time by not running two systems or saving costs by not outsourcing the payroll.
- It can help accountants provide on-going business advice and tax planning due to the data being available in real time, not months after year end.

## Staffing matters

I guarantee that the staff will be one of your biggest headaches. Until you're the boss you never really know what is involved but juggling joiners, leavers, maternity/paternity, disputes, requests for pay-rises and changes in hours will all become part of the day job. It is important to keep yourself (or your practice manager) up to date with the ever changing employment legislation and appoint a good employment lawyer to advise you along the way. ◆

**Heidi Marshall**
Heidi Marshall heads up the dental team at Dodd & Co Chartered Accountants. She is Secretary of NASDAL (The National Association of Specialist Dental Accountants and Lawyers) and acts for clients up and down the country and regularly contributes to the dental press and presents at seminars.

# Whistling a different tune

We can all look in the mirror knowing on at least one occasion, we have turned a blind eye to something. Perhaps it's a beggar on the London Underground, the dark truths a friend has shared with you, or simply something you have overheard in the street. It may be an uncomfortable truth, but it does not change the fact you turned the other way.

Flannery O'Connor, an American writer and essayist, once said the truth does not change according to our ability to stomach it. While she may not have been talking about whistle-blowing, it is a thought that may well encapsulate the taboo subject.

By David Westgarth,
Editor, *BDJ In Practice*

Perhaps it is our tendency to turn the other way and hope someone else will deal with a problem that means whistle-blowing remains a taboo subject. Think of Mark Felt, the FBI source whose codename for many years was 'Deep Throat', who resisted the cover up of the Watergate scandal and fed information to the press. For 30 years his identity remained anonymous, with many still seeing him in a negative light. Without him, would we have ever known about Watergate?

Throw healthcare and patient safety into the mix, and it is little wonder there are still reports of whistle-blowers being unfairly treated. Little wonder then many observers feel whistle-blowers still find themselves in a very lonely place, despite the numerous provisions in place to safeguard them.

Between 2016-2017, there were 390 whistleblowing calls to Public Concern at Work (PCaW) from the health sector, and of these calls, 16% (a total of 64 calls) related to the dental industry. Of these, almost 50 were designated as 'public', or of a whistleblowing nature. Over the last two years, call numbers remain the same, with a slight drop in patient safety (39 calls in 2016 compared to 36 in 2017).

Of the 64 self-identified contacts, 46 were classified as public (or whistleblowing) calls. The most common type of concern (55.2%) related to patient safety. The next most common type of concern (17.9%) related to ethical practices, which include issues such as falsification of records, competence/conduct of staff and conflicts of interest. Almost a quarter (24%) concerned sterilisation of equipment and 6.7% of the patient safety concerns were about infection control.

As Table 1 shows, the largest portion of calls to PCaW (40.5%) came from dentists and 24.3% of calls were from practice management.

**Table 1: whistle-blowing calls to PCaW by position (data from PCaW)**

| | | |
|---|---|---|
| Dentist | 15 | 40.5% |
| Management | 9 | 24.3% |
| Nurse | 6 | 16.2% |

## Guidance for raising concerns

In 2015, Sir Robert Francis QC, Chair of the Freedom to Speak Up Review, recommended a package of measures to ensure in future NHS staff could be free to speak up about patient safety concerns.[1]

His report to Secretary of State for Health, Jeremy Hunt, identified an 'ongoing problem in the NHS', where staff were deterred from speaking up when they had concerns and faced shocking consequences when they did.

In the report Sir Robert found NHS staff wanted to speak up and heard lots of examples of organisations supporting them to do so. But he heard that many staff were put off speaking up because they feared victimisation. Others didn't speak up because they felt their concerns would not be listened to. The review heard stories of staff that have faced isolation, bullying and counter-allegations when they've raised concerns. In some extreme cases when staff have been brave enough to speak up, their lives had been ruined.

Managers told the review that they can find it difficult to identify the people with genuine concerns from those who want to deflect from their own poor performance.

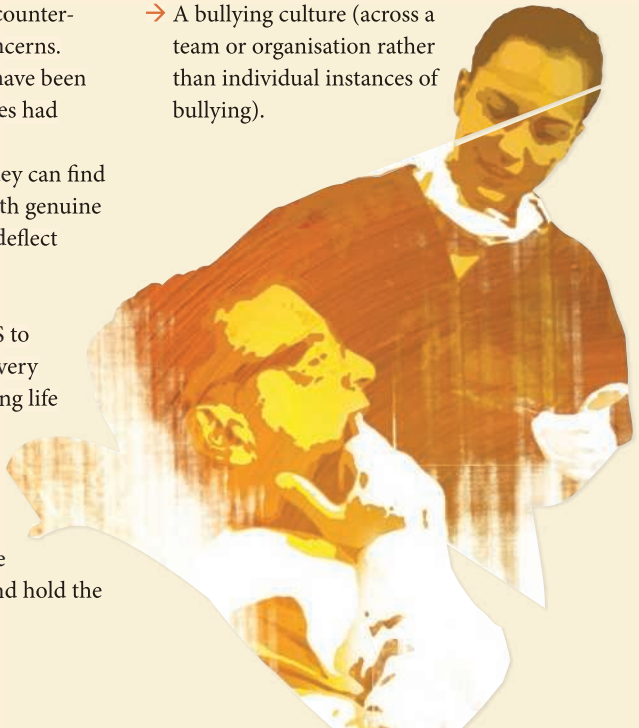
Sir Robert's proposals include:

- Action at every level of the NHS to make raising concerns part of every member of staff's normal working life
- A Freedom to Speak Up Guardian (FSG) in every NHS trust – a named person in every hospital to give independent support and advice to staff who want to speak up and hold the board to account it fails to focus on the patient safety issue.
- A National Independent Officer who can support local Guardians, to intervene when cases are going wrong and identify any failing to address dangers to patient safety, the integrity of the NHS or injustice to staff.
- A new support scheme to help good NHS staff who have found themselves out of a job as a result of raising concerns get back into work.

Based on that report, less than 12 months later the Freedom to speak up: raising concerns policy for the NHS[2] was released, detailing exactly what, how and who to report concerns to.

The standard integrated policy encouraged NHS staff to raise a concern about risk, malpractice or wrongdoing if they thought someone or something was harming the service delivered or commissioned, including:

- Unsafe patient care,
- Unsafe working conditions,
- Inadequate induction or training for staff,
- Lack of, or poor, response to a reported patient safety incident,
- Suspicions of fraud,
- A bullying culture (across a team or organisation rather than individual instances of bullying).



**Standard 8.1**

You must always put patients' safety first

**8.1.1**

You must raise any concern that patients might be at risk due to:

- the health, behaviour or professional performance of a colleague;
- any aspect of the environment where treatment is provided; or
- Someone asking you to do something that you think conflicts with your duties to put patient interests first and act to protect them.

You must raise a concern even if you are not in a position to control or influence your working environment.

Your duty to raise concerns overrides any personal and professional loyalties or concerns you might have (for example, seeming disloyal or being treated differently by your colleagues or managers).

**8.1.2**

You must not enter into any contract or agreement with your employer or contracting body which contains a 'gagging clause' that would prevent you from raising concerns about patient safety or restrict what you could say when raising a concern.

Closer to home, Principle 8 of the GDC's Standards for the Dental Team[3] – raise concerns if patients are at risk – clearly defines what is expected of dental practitioners, what the patient expects and how to act if you feel either of the above have been compromised. But still whistle-blowers are a rare thing.

## Protection for whistle-blowers

On the night of 10 January, 2014, Dr Chris Day raised concerns about critically low staffing ratios during a night-shift on an Intensive Care Unit at the South London hospital where he worked. A protected disclosure was made due to the fact at night the unit routinely did not adhere to national staffing levels as defined in ICU Core Standards. He claimed that after doing so Health Education England (HEE), the body responsible for training and workforce development in the NHS, made false allegations against him and deleted his doctor training number, making it impossible for him to further his career.

More than £140,000 was donated through crowdfunding for Dr Day's case and after taking the issue to court he was told HEE was not subject to whistleblowing law, the ruling judges presiding over the case later challenged, sending it back to tribunal.

So why highlight the plight of a junior doctor, you may ask?

The above scenario faced by Dr Day is not one uncommon in dentistry – albeit not a life nor death situation covered by core standards. But do we hear about an inability to recruit dentists? Do we know dentists are expected to do more for less? Do we know these two factors are high on the list of reasons our profession is considered one of the most stressful?

The simple answer to these is yes, yet they are not considered anything out of the ordinary. In fact, these are working conditions many practitioners have reported. So why would one reasonably expect to be protected for whistle-blowing on conditions everyone faces, particularly if you feel the disclosure is being made in the public interest?

Every practice should have their own policy in place through a Freedom to Speak Up Guardian. Support and protection should be offered to anyone who raises a genuine concern under the policy, regardless of whether you are mistaken or if there is an innocent explanation for your concern.

One such example is that set by Leicestershire & Rutland Local Dental Committee (LDC). On the back of the Freedom to speak up in Primary Care paper published in 2016, it was thought LDC Consultant Advisor Colin Blackler and LDC member Sarah May, could offer the necessary independence integrity and assurance of confidentiality to be a trusted FSG contact for members of practice staff needing to express a concern but unable to do so within their employing practice.

> 'But do we hear about an inability to recruit dentists? Do we know dentists are expected to do more for less? Do we know these two factors are high on the list of reasons our profession is considered one of the most stressful?'

Sarah explained: 'Having raised a concern, practice staff need to have confidence that there will be an effective review or investigation. In most cases, the most obvious level for the matter to then be investigated will be within the practice itself, where the matter can remain confidential to the practice while being properly and robustly addressed. This of course would depend on the apparent seriousness.

'In some cases it may be evident that the matter would be inappropriate for 'internal investigation', in which case liaison with the appropriate NHSE senior manager would probably be the necessary communication. Where the matter is dealt with within the practice, the FSG will need to be satisfied that it is dealt with fully and appropriately. Where this is not the case, the FSG would probably need to refer it to the relevant NHSE contact.'

Colin added: 'As dentists, the LDC saw there could be a potential conflict of interest in practising dentists being aware of concerns relating to other practices, and so Sarah and I were selected as their Freedom to Speak Up Guardians.

'While we know the guidance set out in the Freedom to speak up in Primary Care report is well-known, we thought a local procedure would be a comprehensive way of putting those recommendations into practice. The explanatory flowchart and model policy resulted from that process, and we make it available to all practices.'

Fundamental to any whistle-blowing policy is the understanding that anyone raising concerns will not suffer any adverse consequences or reprisals and will not be at risk of losing their job – protection not offered to Dr Day. Likewise, if colleague A raised a concern about colleague B, colleague B must not subject colleague A to any harassment or bullying, as such conduct may result in disciplinary action being taken.

Given the close-knit nature of a dental practice – a dental nurse wishing to blow the whistle on a dentist may have to see them in communal areas outside the surgery – multiple contacts within the practice – and some externally should be named for raising concerns with.

In many cases, a practice manager may be that guardian. In some cases, they may be the subject of the concern. So how should practice managers straddle that responsibility? ADAM President Lisa Bainham commented: 'The first point I would make is that all GDC registered Practice Managers and Registered Managers should

check the level of indemnity cover that they have. Not all indemnity insurance covers whistle-blowing.

'It can put people in difficult situations where their jobs could potentially be at risk by whistle-blowing. But, if they decide not to whistle blow and it comes to light at a later date, they are then implicated.

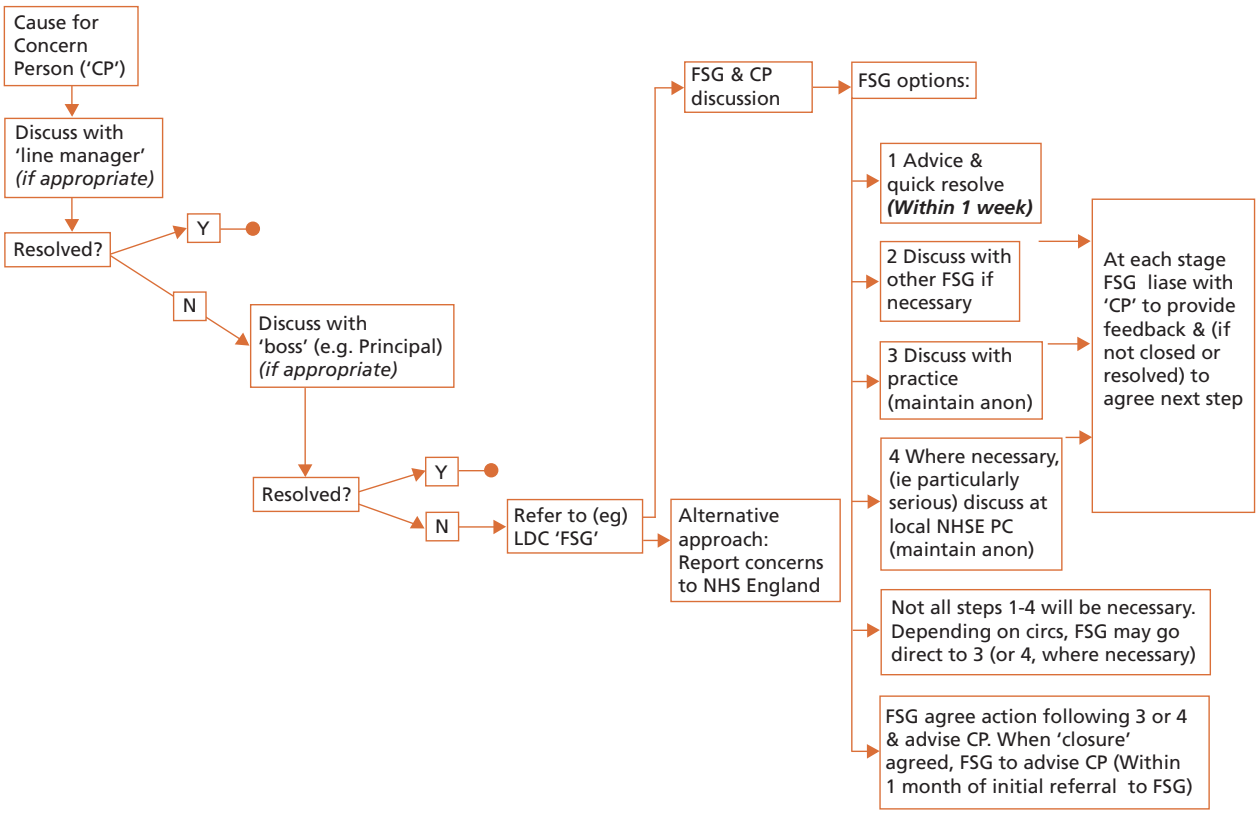
'However, it is also important to remember that not all whistle-blowing is the serious negligence or gross misconduct claims we read about. It's really important for the team to understand that things they may view or question as 'small' issues could be just as important in protecting patient care. For this reason, managers must communicate, demonstrate and earn complete trust, confidentiality and support and practices should encourage an open and honest culture. Whistle-blowing isn't always necessarily a big bad thing, but can also bring positives in helping individuals get the further training, support and guidance they may need.'

## Ethically speaking

Famous whistle-blowers like Felt have been hailed as brave souls who alerted the public to corruption and sought to protect colleagues from an unexpected downfall of a company. In his case, it was the person sitting in the highest office in his country. But are whistle-blowers 'famous' because they are fearful of the consequences?

Research published on the consequences of whistle-blowing suggests it can – and does – lead to improving patient safety.[4] In many respects, it isn't too dissimilar to finding the black box recorder after an air crash, in that you learn from what has

## Leics LDC Flow chart



previous gone on to ensure it doesn't happen again. Likewise, negative consequences include character assassination – something Dr Day claims he was subjected to. Consequences of not whistle-blowing were also recorded, guilt coming high on that particular list.

That could be why – given the conditions they face – almost 58% of the UK's NHS dentists are planning on turning away from NHS dentistry in the next five years – why would one work under a contract that provides poor working conditions and increases stress in an already litigious profession?

Results from a BDA survey[5] highlighted that over half (53%) of young and newly qualified NHS dentists (aged under 35) intend on leaving the NHS in the same period, raising questions about the sustainability of the service.

Nearly 10% of these young NHS dentists state they intend to leave dentistry entirely, with similar numbers stating they intend to move to work overseas. Less than 1 in 6 (16%) of these young dentists estimate they will be able to own a practice within the next 5 years. Practice ownership, once the traditional career path for young NHS dentists has ceased to be an option for many amid a long-term decline in earnings, and the growth of chain 'corporate' dentistry firms.

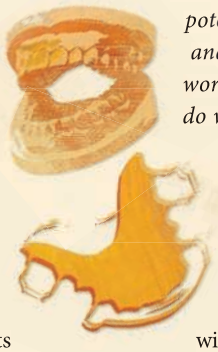
The UK government has failed to honour commitments made since 2010 to offer a decisive break from the discredited 2006 dental contract which sets quotas on patient numbers. Dentists are penalised if they don't hit targets for activity, but are unable to treat extra patients if they want to do more.

Henrik Overgaard-Nielsen, the BDA's Chair of General Dental Practice, called it a 'tragedy' that a 'decade of underfunding and failure to deliver meaningful reform now risk shutting off the pipeline of NHS dentists'.

Earlier this year *BDJ In Practice* told the story of an NHS practitioner who made the jump and left the NHS to focus solely on private work.

In the candid interview, Claire Morley said:

*'Five years in NHS dentistry has shown me that it is no different. The pressures, the stress, the targets. I struggled on a daily basis to be able to provide my patients with the care and attention, the dignity and respect that they deserve. If I were to spend 45 minutes with a nervous lady, holding her hand through the tears because I have just told her she needs a tooth out, that usually she has sedation and I can refer her for that but it will take four months and in the meantime, she will be in pain. To sit and coach her through the appointment and the extraction, to tell her she can do it. To congratulate her and tell her how proud of her I am after I removed the tooth. I would – and do – get behind on targets, which means I will potentially lose my NHS contract and be out of a job. I have so much working against me being able to do what I was trained, what the government spent hundreds of thousands of pounds for me to learn seems to be irrelevant.'*[6]



> 'How can that system not create one where practitioners will consider cutting corners? Little wonder those at the beginning of their careers are already planning their exit strategy.'

How can that system not create one where practitioners will consider cutting corners? Little wonder those at the beginning of their careers are already planning their exit strategy.

## It happens

And cutting corners does happen. Desmond D'Mello prompted a mass blood screening of patients after a whistle-blower exposed the poor levels of cleanliness at his practice.

More than 22,000 patients were recalled after he was secretly filmed breaching clinical standards at the Daybrook Dental Practice in Gedling, Nottinghamshire, over the course of three days in 2014.

A conduct hearing at the GDC found scores of allegations against him, included failing to change gloves between patients and not putting on a new surgical mask for each patient. Dental nurse Caroline Surgey admitted more than 20 allegations which happened when she was working alongside Mr D'Mello.

It was a similar story in Scotland, where Alan Morrison and practice manager Lorraine Kelly were removed from the register. Morrison was found guilty of re-using matrix bands on different patients, not changing surgical gloves between patients, re-using single-use instruments and for not properly ensuring that equipment was sterilised or disinfected before being re-used.

The hearing also found Morrison created false invoices for dental supplies and instruments he didn't buy, in a 'concerted effort to deliberately deceive the health board'. In the same case, dental nurse Dawn Grant, who was initially placed under conditions for 12 months for re-using single-use items, inadequate infection control and dishonestly responding to the investigation by NHS Ayrshire and Arran, was later struck off after an appeal by the Professional Standards Authority (PSA).

The watermark that run through all of those examples – and there are many, many more – was that someone did not turn the other way. Perhaps whistle-blowers will always be considered as 'moles', 'snitches' and 'informants', as the Microsoft Word synonym tool suggests. Maybe they will always be the black sheep of the group. However, like the regrettable black box recorder in aviation, they will always be needed to learn lessons and make improvements. After all, someone has to whistle a different tune. ◆

1. Sir Robert Francis QC. Freedom to Speak Up – A review of whistleblowing in the NHS. Available online at: webarchive.nationalarchives.gov.uk/20150218150512/https://freedomtospeakup.org.uk/wp-content/uploads/2014/07/F2SU_web.pdf (Accessed March 2018).
2. NHS Improvement. Freedom to speak up: whistleblowing policy for the NHS. Available online at: www.improvement.nhs.uk/resources/freedom-to-speak-up-whistleblowing-policy-for-the-nhs/ (Accessed March 2018).
3. General Dental Council. Standards for the Dental Team. Available online at: www.standards.gdc-uk.org/pages/principle8/principle8.aspx (Accessed March 2018).
4. British Dental Association. The Mental Health and Well-being of UK Dentists. A qualitative study. Available online at: www.bda.org/dentists/policy-campaigns/research/workforce-finance/Dentists%20well-being%20and%20work-related%20stress/dmhb (Accessed March 2018).
5. Lim C R, Zhang M W B, Hussain S F, Ho R C M. The Consequences of Whistle-blowing: An Integrative Review. J Patient Saf 2017; doi: 10.1097/PTS.0000000000000396. [Epub ahead of print].
6. Westgarth D. Leaving the NHS. *BDJ In Practice* 2018; **31;** 1.

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# The rise of the millennial

BDA Policy Adviser **Tom King** on the impact millennials are having on dentistry

Millennials, those born somewhere between 1980 and 2000, have been the subject of seemingly endless column inches in recent years. The coverage, much of it derisory, has accused millennials of killing off everything from breakfast cereals to holiday postcards and spending so much on avocados they'll never be able to afford to get onto the property ladder.

Yet, more serious generational analysis has identified shifts in attitudes and behaviours, particularly in how those aged 18 to 38 approach their working lives. In general, the argument goes that millennials are more focused on achieving a good work-life balance, are motivated by career progression and personal development more than financial reward, and are unlikely to work for the same employer throughout their whole career. Millennials are said to seek employers offering flexibility, opportunities for continued learning and that will allow them to get ahead.

But how much of this change is about a generational shift in attitudes, rather than about changes in the economy and the world of work? And what does it all mean for dentistry?

Among the research conducted into how millennials approach the world of work is a PricewaterhouseCooper (PwC) survey that identified international labour market trends.[1] It found that millennials expect to have multiple employers through their career, are willing to make compromises to get a job, place a high value on a good work-life balance, prefer use of technology over face-to-face communication and value opportunities to progress above salaries.

In the future, nearly 40% of millennials expect to work mostly regular hours with some flexible working and around 33% expect to work mainly flexible hours, while only 25% are expecting to work mainly regular office hours.[2]

Meanwhile, the TUC has also conducted research with younger workers with no higher education qualifications working in low paid jobs and found that this group see work as necessary, but without interest or meaning in itself, and as a means to an end. They concluded that this group of millennials, at least, were 'living for the weekend'.[3]

However, it's easy to get ahead of ourselves in claims about generational differences. The research and polling company Ipsos Mori has recently published an in-depth examination of just how different millennials are from the Baby Boomers and Generation X that came before them. The report concluded that, for the most part, the differences between millennials and previous generations in terms of their attitudes towards and behaviours in the workplace are often over-stated and the different age cohorts have a lot more in common than is often thought to be the case. Claims, for example, that millennials are work-shy and lazy aren't true, according to the report. While the working week of a 27 year old millennial is about an hour shorter than that for Generation X when they were the same age, Ipsos Mori cautioned that this is a long-term trend, as working hours decrease with improvements in productivity. In summary, Ipsos Mori say that 'Millennials seem to want more or less the same sort of things from employers as older workers'.[4]

While the younger end of the millennial cohort will only just be heading off to university or the world of work later this year, older millennials have been in the labour market for nearly two decades. The 2008 financial crisis was a significant and formative event in the lives of millennials and, along with the prolonged period of public sector austerity which followed it, coincided with the entry of much of this generation into the workforce. It is thought that this economic downturn has had a scarring impact on millennial's career prospects and their early years in the workforce will have been marked by stagnating pay, relatively high youth unemployment and declining job security. More broadly, the idea of a job-for-life from leaving school to retirement is now a thing of the past and for around the last three decades the economy and labour market have increasingly shifted towards an emphasis on flexibility, de-regulation and competition.

Millennials are also a generation increasingly burdened with enormous debts before they've even had chance to send out a CV. The BDA estimates that dental students in the first year of their degree now could graduate with more than £76,000 of debt. This creates clear imperatives to get on and get ahead as quickly as possible.

It's difficult to see how these formative experiences wouldn't have altered millennials' outlook on the world and the underlying economic changes have reshaped the working world itself, dramatically shifting the landscape of opportunities available to millennials as they start their careers.

In dentistry, many millennials will never have known anything other than the UDA treadmill and the stress this has caused in general practice. It shouldn't therefore be a surprise if many looked to reduce their exposure to this high-pressure environment. Surveys of dental schools have found a desire to work part-time; with 23% of those surveyed saying they intend to work part-time five years after graduation and only 48% wanting to work full-time fifteen years after graduation.[5] Similarly, the BDA's own research has found associates in all age groups are looking to reduce the number of hours they work, including 30% of those aged 25-34 years old.

This will obviously have implications for workforce planning and the supply of dentists. Although the number of dentists has increased in recent years, it may be the case that the number of full-time dentists does not. The assumption that a given number of dental graduates will be able to provide capacity to deliver a given level of NHS treatment may no longer be the case and this will have consequences for NHS access and the budgets required to teach and train new dentists. This workforce shift may explain the recruitment problems observed across many areas of the country, with practices needing to contract more associates to complete the same number of hours.

There is also anecdotal evidence that some practice owners do not feel that part-time working is a good fit for their practice and it may be that there is a mismatch between older practice owners' expectations of associates and younger dentists' expectations of flexible part-time hours and a good work-life balance.

In its report last year, the pay review body for dentists remarked that the decline in practice ownership among GDPs 'could be connected to the desire for work-life balance, flexibility and fewer responsibilities'.[6] While it may be that changing career aspirations partially explain the trend away from practice-ownership, it is more likely that structural factors within the dental market, not least corporatisation, play a more significant role. The growing gap between the value of dental practices and associates' incomes, which have fallen by more than 30% over the last decade, means that practice-ownership is financially out of reach for an increasing number.

It is also worth noting that dental students remain interested in becoming practice-owners during their careers; with 72% of dental undergraduate students at the University of Bristol aspiring to become a partner after gaining experience as an associate and 7% hoping to find an opportunity for partnership immediately after graduation.[5]

**Table 1. The generations**

| Generation | Cohort |
|---|---|
| Pre-war | Born between 1945 |
| Baby-boomers | Born 1945-1965 |
| Generation X | Born 1966-1979 |
| Millenials | Born 1980-2000 |

Given that career progression is the top priority for millennials, above high salaries, there is potential for young dentists to become frustrated by the lack of opportunities to progress and develop in their careers. It is perhaps to be expected that 71 % of dental students intend to specialise[5], as one of a limited number of routes to develop professionally. As discussed in a previous edition of *BDJ In Practice*, many younger dentists are considering and pursuing portfolio careers; combining multiple part-time roles over the course of the same working week. This trend is of course partly inspired by this desire to develop new skills, take on greater responsibility and gain a degree of career progression. However, it's clear that the UDA system, the fear of the GDC and litigation and the stress these have brought to the working lives of dentists are key motivators in seeking to reduce clinical time and explore options in non-clinical roles or looking outside dentistry altogether.

There are clearly potential challenges for the dental workforce if the observations about millennials do play out over coming years, but the underlying challenges for dentistry – a failed contract in England and Wales and overbearing and costly regulation – cut across generations. The truth is that the recruitment and retention problems faced by NHS general practice are less about generational attitudes towards work and more a symptom of a system in urgent need of reform. ◆

1. PWC, 2012, Millennials at Work: Reshaping the Workplace.
2. Ibid.
3. TUC, 2016, Living for the Weekend? Understanding Britain's Young Core Workers.
4. P.63, Millennial Myths and Realities, Ipsos Mori.
5. Puryer J, Patel A. The career intentions, work-life balance and retirement plans of dental undergraduates at the University of Bristol. *Br Dent J* 2016; **220:** 4.
6. Pg. 109, Forty-Fifth Report 2017, Review Body on Doctors' and Dentists' Remuneration.

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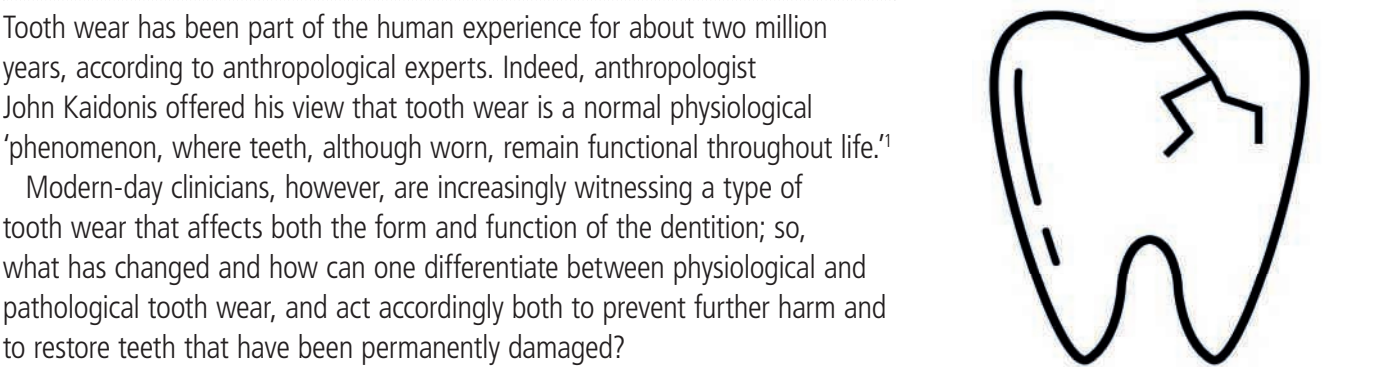
# Tooth wear physiological or pathological?

Tooth wear has been part of the human experience for about two million years, according to anthropological experts. Indeed, anthropologist John Kaidonis offered his view that tooth wear is a normal physiological 'phenomenon, where teeth, although worn, remain functional throughout life.'[1]

Modern-day clinicians, however, are increasingly witnessing a type of tooth wear that affects both the form and function of the dentition; so, what has changed and how can one differentiate between physiological and pathological tooth wear, and act accordingly both to prevent further harm and to restore teeth that have been permanently damaged?



**Professor Andrew Eder** explores the difference between physiological or pathological tooth wear, and considers why being able to differentiate between the two is so important for the long-term care of patients.

## The evolution of wear

The anthropological view of tooth wear is that it is the result of an 'interplay between genes and environment.' Essentially, genetic factors influence tooth morphology and occlusion, and the occlusion and food consistency affect mastication. Mastication results in tooth wear, which then alters the form of the dentition, then the occlusion, bringing this process full circle and ready to start again. Over time, because of attrition, abrasion and adaption, teeth become more worn – resulting in physiological wear.[1]

That is not to say that erosion has not played its part, too, however it does seem to be more of a modern-day problem. Although our ancestors gathered foodstuffs like fruits, exposure to their acids were seasonal, and so their effect short-lived and possibly reparable via remineralisation.

Professor Andrew Eder is a Specialist in Restorative Dentistry and Prosthodontics and Clinical Director of the London Tooth Wear Centre, a specialist referral practice in central London. He is also Professor of Restorative Dentistry and Dental Education and an Honorary Consultant in Restorative Dentistry at the UCL Eastman Dental Institute.



Research has previously identified that: *'tooth wear, or non-carious wear is considered a natural physiological process. However, its intensity can vary. For mild tooth wear, the resulting reduction of occlusal vertical dimension is compensated or adapted through associated structures. However, changes in individual lifestyles and a boom in the consumption of acidic beverages in recent decades have raised concerns on tooth wear. Moreover, symptoms linked to increased stress, including gastroesophageal reflux disease and bruxism, are also potential hazards to teeth. Additionally, increased lifespans make it more challenging for teeth to survive without severe tooth wear.'*[2]

Given all of this, it can be difficult to differentiate between physiological and pathological tooth wear, however, Smith and Knight's definition of the latter may be helpful in this regard: 'The teeth become so worn that they do not function effectively or seriously mar appearance before they are lost through other causes or the patient dies. The distinction between acceptable and pathological tooth wear at a given age is based on the prediction of whether the tooth will survive the rate of wear.'[2]

It has been suggested that different teeth wear at different rates.[3] Merging the available data on physiological wear, previous research shows that over a 60-year period, molars showed 1740 µm of wear, mandibular incisor wear was 1460 µm, maxillary incisors were recorded at 1010 µm and premolars at 900 µm.[4]

## Preventive solutions

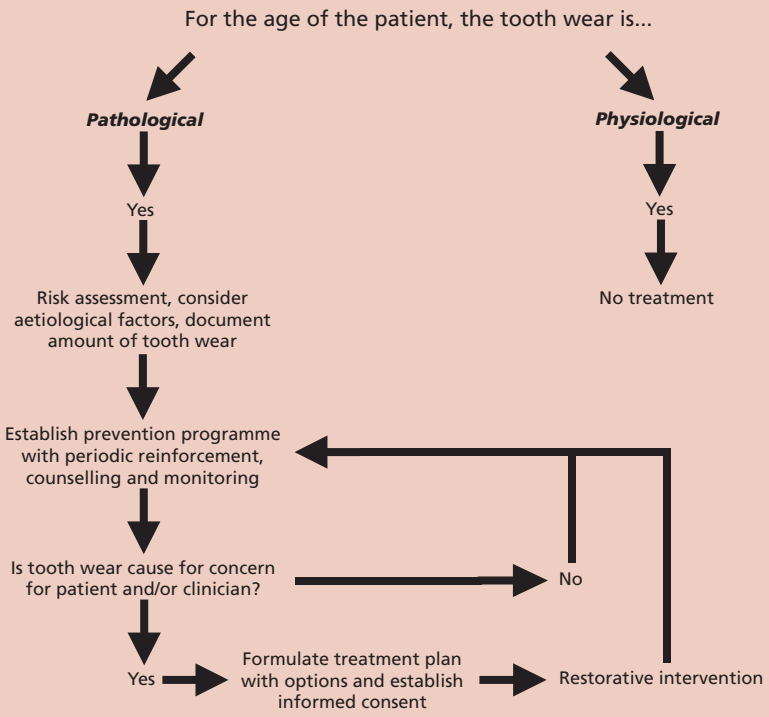
For dental professionals, the signs that indicate pathological tooth wear is occurring and action may be needed include:

- Sensitive teeth
- Discolouration, including yellowing and loss of shine (where some of the outer enamel layer has been lost)
- Sharp or chipped anterior teeth
- Occlusal surfaces wearing flat and taking on a shiny, pitted appearance
- Altered occlusion as vertical height changes
- Restorations standing proud of the teeth
- Abfraction lesions developing cervically
- V-shaped notches or shallower cupping present cervically.

In addition, the report on a recent European consensus statement regarding the management of severe tooth wear, provided a useful flowchart that may help a dentist to decide what form of treatment may be most appropriate.[4] (see overleaf)

Types of tooth wear are rarely seen in isolation, and so the management of a patient with hard tissue wear is likely to be similarly multifactorial. To prevent progression of wear, appropriate measures may include:[5]

## Main types of tooth wear [4]




- Strengthening the enamel via remineralisation, applying fluoride in the form of, for example, toothpaste, mouthwash, or in-practice gels
- Making tooth-friendly food and drink choices, reducing the frequency and contact time of acidic beverages and comestibles. It may also be prudent to use a straw, drink such beverages cold, and to rinse with water, milk or a fluoridated mouthwash following consumption
- Adapt patients' at-home oral health regimen, so that they use a soft-bristled toothbrush and non-abrasive toothpaste and mouthwash. Their tooth brushing technique should also be adapted to ensure over-zealous brushing is not causing problems. In addition, it is important to recommend patients do not brush straight after consuming something acidic, instead rinsing with milk, water or mouthwash, as above
- Addressing hypersensitivity, helping to alleviate the pain using in-practice and/or at-home desensitisers.

### Restorative options

Definitive restorations are inappropriate while the problem is active, as, for example, composites and full veneer crowns do not prevent the process of wear. With this in mind and given our increasingly litigious society, as an aside, it is very important that accurate record keeping is maintained, to include a description of the tooth wear severity, the results of an appropriate measurement index, shared decision-making, actions taken and follow-ups, to ward off any possible suggestion of 'supervised neglect'.[4]

If the dentist and patient agree that the time is right for restorative treatment, despite the lack of high-level scientific evidence, the authors of 'Severe tooth wear: European consensus statement on management guidelines' suggest the following principles:[4]

1. Restorative treatments should be as conservative as possible, involving the minimum number of teeth necessary to achieve a satisfactory clinical outcome
2. Wherever possible, preparations should be restricted to the creation of necessary features, including seats, bevels, or chamfers, to facilitate restoration placement
3. Assuming good oral hygiene maintenance, the selection of materials and technique should consider the expectations, aesthetic demands and risk profile of the patient, operator familiarity and skills, patient availability for recall, and any budgetary constraints.

### Long-term care

Patients suffering with tooth wear may complain about sensitivity, pain, poor aesthetics and/or functional impairment.[6] The physical and psychological effects of these signs and symptoms on patients should not be underestimated. It is therefore key that dentists can differentiate between pathological and physiological tooth wear, so that appropriate, long-term care can be provided. ◆

1. Kaidonis J A. Tooth wear: the view of the anthropologist. *Clin Oral Invest* 2008; **12:** S21–S26.
2. Wu Y-Q *et al.* Attrition-corrosion of human dental enamel: A review. *Biosurface and Biotribology* 2017; https://doi.org/10.1016/j. bsbt.2017.12.001.
3. Sperber G H. Dental wear: attrition, erosion, and abrasion – a palaeo-odontological approach. *Dent J* 2017; **5:** 19-24.
4. Loomans B *et al.* Severe tooth wear: European consensus statement on management guidelines. *J Adhes Dent* 2017; **19:** 111–119.
5. Morozova S Y *et al.* Tooth wear – fundamental mechanisms and diagnosis. *Journal of Dental and Medical Sciences* 2016; **15:** 84-91.
6. Sterenborg B A M M *et al.* The influence of management of tooth wear on oral health-related quality of life. *Clinical Oral Investigations* 2018; https://doi.org/10.1007/s00784-018-2355-8

## Types of wear

**Erosion**

Erosion is tooth wear resulting, for example, from the consumption of acidic food and drinks or stomach acid regurgitation, which is often found to be a result of conditions such as bulimia, pregnancy sickness or hiatus hernia.

**Attrition**

Attrition is where there is contact between the teeth over and above what we would consider 'normal' use. In healthy people, wear of the enamel as a result of attrition alone is considered non-pathological. Patients exhibiting pathological attrition generally suffer from bruxism, which is often linked to a stressful lifestyle. It is worth noting that for patients with severe bruxism, the occlusal load can be 2 to 10 times higher than non-sufferers. [2]

**Abrasion**

This is where excessive rubbing damages the enamel and dentine, for example over-zealous tooth brushing, porcelain crowns rubbing against the natural dentition, bad habits such as chewing pencils or biting of nails, or the consumption of a rough diet.

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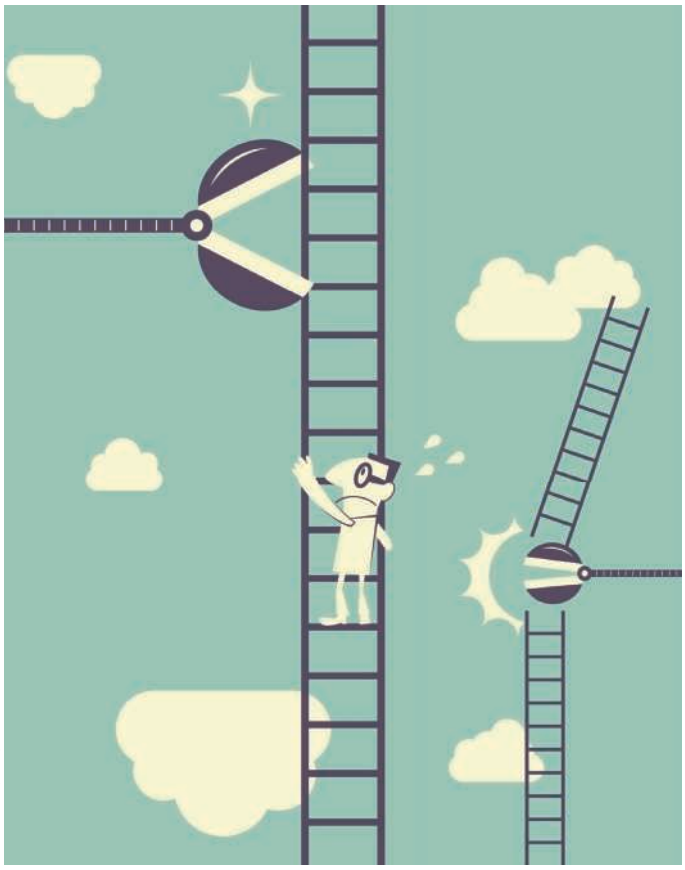

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# A dental student's journey to joining a profession which is failing the very people it cares for

Last November, the ICE Postgraduate Institute and Dental Hospital in Manchester hosted a presentation from GDC Executive Director Matthew Hill on Fitness to Practise. In an open Q&A, Mr Hill fielded many questions about the GDC's previous and well-documented shortcomings, but one particular question stood out.

**Mohammad Ghafraan Hussain**, a newly qualified dentist, told *BDJ In Practice* how he felt the GDC are not equipping student dentists and those fresh from university on the challenges ahead.

Defensive dentistry is real and being practised across the country, which is far from ideal. Practising in this manner highlights the fear amongst the professionals, fear which affects decision-making in treatment planning and career choice. The fear is nothing more than the risk of being stripped naked by the GDC leaving you with a memory of a license to practise dentistry. Why is litigation in dentistry increasing? It is clear the GDC links the increase in registration fees to increase in litigation. As reflective individuals we point the finger to ourselves and ask what am I or what could I do wrong? Dentists are working in the best interest of the patient giving the best advice and carrying out clinical dentistry to the best of their capabilities. The doors are open to the public making a mountain of a molehill and I believe this is advocated by the GDC.

Dentists are humans carrying out highly-skilled procedures within the confined beauty of the oral cavity and yes mistakes are made. To point the finger at the dentist and make him/her to feel incompetent is wrong. The procedures carried out will never be risk-free, so if there is an unintentional complication of a procedure why should it be pinned on the dentist? Why is the dentist being held accountable? Why are we not educating the public and promoting a practitioner-patient relationship in which the public understands that the dentist is always working in your best interest and this principle is present from the beginning of their careers to retirement?

There are many unprecedented shortcomings which may explain the current climate of dentistry, shortcomings so profound that we cannot let them continue as they are affecting the public – the very people we wake up and go to work for. Of these shortcomings, we as professionals, supported by the BDA, need to explore the various factors exacerbating this climate of increasing litigation and put appropriate measures into place to limit this unhealthy practice.

> 'Why are we not educating the public and promoting a practitioner-patient relationship in which the public understands that the dentist is always working in your best interest and this principle is present from the beginning of their careers to retirement?'

Of the many factors which contribute to increased litigation and defensive dentistry, I would like to turn your focus to the genesis of dentists. We as a nation have a responsibility to deliver highly-skilled professionals to carry out the art of dental surgery. Dentists take time and investment to produce. The GDC are responsible for the training of undergraduate dental students and for this reason I hold them accountable to explain why clinical training standards have fallen so sharply over the last century.

Not so long ago newly-qualified dentists had undertaken vast numbers of clinical procedures during their years as an undergraduate. If anyone speaks to their seniors who are retired or close to retiring, you will find that they had gained experience far beyond our generation's graduates. Speaking to undergraduates in their final year many have done less than 3 crowns, less than 3 dentures, less than 10 restorations. A paper published in the *BDJ* highlighted only 5% of dental foundation (DF1) trainees felt confident with complete denture construction.[1]

This is truly shocking and a major

shortfall in the dental education system, particularly when 90% of graduates will go on to work as GDPs who are expected to carry out general dentistry, which includes the very procedures they lack confidence and competence in. With such minimal experience, how can we or the GDC confidently say to the public we have adequately trained dentists who will now take care of your oral health? I speak on behalf of young dentists who have been so unfortunate to gain such little experience. Each university has its own requirements for students to progress and there is no national standard.[2,3] Each student has their own potential which nurtured appropriately will lead to the development of confident and competent dentists. The British education system is failing our young, keen undergraduates who are paying vast amounts of money mostly via loans. There is no shortage of people who are in need of dental care, thus we would expect a robust system in place to route many more people who consent to dental treatment by undergraduates under close supervision.

The failing in training undergraduate dental students adequately is showing itself in many ways. A more devastating fact is the journey the student takes from dental school. The majority are being assigned to a foundation trainer within a primary care setting. Within this setting, a qualified dentist of at least 4 years is assigned a foundation trainee for a generous sum of money but unfortunately the voice of the students across the nation speaks of inadequate support. This comes as no shock because how much support can a trainer give when they have fully booked diaries themselves? On the contrary foundation trainers have concerns that graduates lack essential skills such as diagnosing and treatment planning and 51% of trainers report the standard of graduates entering foundation training is unsatisfactory.[4] Overall it appears the money needed to train DF1 trainees is being spent unwisely at the expense of vulnerable graduates. Keeping in mind the main victims of this education system are the public. Upon 'satisfactory' completion of foundation training dentists are given permission to work on people. After 6 years of training and at least £150,000 being spent per student, our public deserves a dentist who feels confident and competent not scared of being stripped of their license.

Had our students not been overwhelmed with fear, the student feedback would be much louder. They would ask for further support. It is difficult to expect students to speak out when they fear they may be judged as inadequate. They have been studying hard all their young lives and now they unfortunately have no choice but to keep quiet and keep moving forward. When an inappropriate level of fear clouds a professional it does not lead to them giving their best or producing their best. Too much fear can leave individuals feeling bullied and all alone. I believe the failing standards of dental graduates defines why many dentists are shying away from roles as a GDP or working within an NHS dental practice.

Working within an NHS dental practice means thorough understanding of the NHS regulations. This is such an important component of practicing NHS dentistry yet we don't see this included in the undergraduate training curriculum. Dare I ask who has read the National Health Service (General Dental Services Contracts) regulations 2005?[5] To claim or not to claim, to provide or not to provide? I am merely highlighting a leak in the pipework which allows fear to creep in. Fear of making unintentional mistakes.

> 'I did not set off on a journey to be faced with such hideous conditions to practise dentistry in. Neither did I realise as a student that I will have to practise defensively.'

One must take a moment to ponder why our GDC annual retention fees have almost doubled. Surely the main reason is litigation. Litigation claiming poor dentistry, which allows the innocent public to claim compensation. I am sure there are cases of criminals practising dentistry but correct me if I am wrong, the majority save a few are honest, hardworking, conscientious professionals. So why is there so much money being made by lawyers and the GDC, could it be their inability to resolve cases efficiently? On one hand we accept to pay large sums to indemnify ourselves in the patient's interest, but then when an unintentional mistake is made the annual indemnity fee could be doubled or tripled or registration revoked. Why are dentists as a whole being made to pay such high registration fees to the GDC to cover for the few? We are treated and punished as if we are a single body. It is time we speak up united. The financial burden of paying extraordinary amounts for registration and indemnity needs to be regulated by appropriate leadership.

The public always have and always will carry an unpredictable level of fear when visiting the dentist. This coupled with the media's portrayal of dentists as greedy injury causing individuals does not increase the public's confidence in British dentistry. We have seen large increases in the NHS charges which patients pay but they do not see an improved dental service in return, rather they find less and less access to NHS dentistry. I fear the future of dentistry is failing the British people. It is not rising to the needs of the population.

Dentists need to feel supported by the GDC not bullied. Defensive dentistry is being practiced and this is not in the dentists' or the patients' best interests. We should be nurturing an environment of quality dentistry which people would be proud of, not one where they feel they are being robbed and harmed.

The law governing in the interest of running a harmonious society needs to open its' eyes to the downtrodden professionals and public. If there is no change in the near future we can only expect more unhappy dentists, unsatisfied patients and increased GDC and indemnity fees. This change will only arise from a united voice challenging our profession to evolve in everyone's best interest.

I did not set off on a journey to be faced with such hideous conditions to practise dentistry in. Neither did I realise as a student that I will have to practise defensively, and nor did I realise I would receive flyers in my post-box advertising medico-legal negligence as if it is a route to make quick tax-free cash. Something has to change. ◆

1. Wieder M, Faigenblum M, Eder A, Louca C. An investigation of complete denture teaching in the UK: part 2. The DF1 experience. *Br Dent J* 2013; **215:** 229-236.
2. Youngson C C, Molyneux L E, Fox K, Boyle E L, Preston A J. Undergraduate requirements in restorative dentistry in the UK and Ireland. *Br Dent J* 2007; **203:** 9-14.
3. Derringer K A. Undergraduate orthodontic teaching in UK dental schools. *Br Dent J* 2005; **199:** 224-232.
4. Oxley C J, Dennick R, Batchelor P. The standard of newly qualified dental graduates-foundation trainer perceptions. *Br Dent J* 2017; **222:** 391-395.
5. The National Health Service (General Dental Services Contracts) Regulations 2005. www.legislation.gov.uk/uksi/2005/3361/pdfs/uksi_20053361_en.pdf (Accessed March 2018).

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# Please sir, we're British

We British are a funny bunch. Our traditional stiff upper lip and furrowed brows are legendary outside of this tiny island in the North Sea. We do sarcasm terribly well, not to mention are fine purveyors of cups of tea. But there is one thing we don't do terribly well, and that's talk about sex.

A quick Google on 'British approach to talking about sex education' throws up some interesting results. NHS Choices has some guidance for parents, carers, healthcare practitioners and educators on how to approach the subject. There are many, many references to how uptight British people appear to be about the topic. Previous research has suggested patients aren't too forthcoming about talking to their dentist about it either.[1]

Perhaps then it's unsurprising that the profession isn't geared up to have such awkward conversations too. Last month the *BDJ* reported that only 14% of students were prepared to talk to patients about HPV-related scenarios.[2] HPV-related oral cancers are on the increase, and are expected to overtake alcohol consumption and tobacco use as the leading cause of oral cancer within the decade. *BDJ In Practice* asked Dr Rhona Eskander and Dr Richard Leck about whether they would forego their stiff upper lip and ask patients about their sexual history.

*Do you think dentists should ask patients about their sexual habits?*

**RL** In an ideal world, yes we probably should. If we are to care for our patients in a truly holistic manner then we should identify all risk factors to oral health in order to deliver the relevant preventative advice. In a climate of increased litigation where so much emphasis is placed on recording patients' smoking status and alcohol intake, should a patient develop a health concern failing to include sexual habits in our histories may be deemed as neglectful. It's an interesting thought.

**RE** I'd go the other way Richard. I don't see this question as being fitting for dental professionals and their patients. Patients do not view dentists in the same way as they do their GP, for example. Therefore some questions may be deemed as intrusive. Perhaps leaflets in the practice educating the patient may prompt them to open the question to us.

*If you already do ask, how do you approach it? If not, how do you think you would approach it?*

**RL** Currently, I do not ask any questions regarding a patient's sexual history. If I were to start, I expect patients would need 'easing in' to the idea of the discussing the subject with their dentist – remember to many patients we just fill teeth, right?!

Perhaps one method of approaching it would be to include questions on the confidential medical history form which patients complete in the waiting room prior to the consultation. This section of the form could be preceded by a tick box – 'I do/do not wish to discuss my sexual habits with my dentist today' in order that the patient has the choice to opt out.

**RE** I'm with you on this. I don't ask, and I think that would be a really good way to go about it. Having it as part of my medical history form and asking them to tick a box expressing their awareness of sexual aspects of their life and health gives the patient freedom and a bit more control. Another box would also be present requiring them to tell me if they want to talk about things.

### *Do you think it is ethical to ask about sexual history?*

**RE** Ethics is seen to be the moral principles that govern a person's behaviour or the conducting of an activity. If we are asking as caring health care professionals, then yes, this is certainly ethical. However, I still struggle to see how relevant it would be in comparison to a GP asking.

**RL** This is where the ideal world separates from reality. I see several issues emerging. For example, at what age would your history taking start to include questions about sexual habits? At what age would it stop? How would the consultation be chaperoned? Would patients want to have this conversation with their dentist with a nurse standing a few feet away? What if a patient preferred to undertake the consultation without the nurse present, how does the dentist feel about that? How would the consultation work with family appointments? There are so many different strands to the question that would need to be ironed out.

### *Do you have the time to ask about it? It's a sensitive/taboo subject!*

**RE** Time limits in my private practice are not as pressing as the NHS practice I work for; however I still consider this a subject to be dealt with very carefully. As dentists do not regularly ask these questions we need to ensure that patients are not alarmed so gauging their feelings via a medical history form may be best.

**RL** Questions already take up a significant portion of an examination appointment, and time is at a premium. Would it be appropriate to try and squeeze-in a quick inquiry into sexual habits without explaining the reasoning behind the questions? How many patients have we offended by starting a consultation by discussing their alcohol intake, or asking about recreational drugs? How would these 'new' questions come across to patients if they weren't handled tactfully?


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> 'As dentists do not regularly ask these questions we need to ensure that patients are not alarmed so gauging their feelings via a medical history form may be best.'

### *But there is a preventive message relating to alcohol, drug use and tobacco use. How realistic would messages of HPV-prevention – using protection when engaging in oral sex – be to pass on to patients?*

**RL** I like the idea of reinforcing a preventive 'micro-message' similar to eat five fresh fruit and vegetables a day, or spit don't rinse, for example. I do think this could be achieved in surgery if adequately supported by a national health awareness campaign. It would be unrealistic to expect dentists to start delivering a message like 'use protection whilst engaging in oral sex' without the background of a significant existing health message which patients had read about, or seen on TV.

**RE** I think that educating the patient can never be a bad thing however I still think that the public view dentists differently to doctors or GPs. Information around your waiting room and promotional material regarding to your matter reading 'ask your dentist for more' can always work in your favour.

### *Should this be taken out of your hands by offering boys the HPV jab?*

**RE** My understanding regarding boys is that they are not included in the school-based vaccination programme. This is because the HPV vaccination programme, which began in the UK in 2008, was introduced to specifically help protect women against cervical cancer, as high-risk HPV causes 99.7% of all cervical cancer cases. For the other cancers, including those that affect men, far fewer cases are linked to high-risk HPV, so vaccination does not provide as much protection as it does from cervical cancer.

Further to that, the vaccination of girls/young women does not directly protect boys and men, but it does offer them 'herd protection'. Non-heterosexual males do not benefit from this.

Ultimately I think before dentists can attempt to treat anyone the stigmas and public's perception need to be broken down. The power of the media is invaluable in this case.

**RL** My understanding of the current strategy is that vaccinations are offered to girls only. As Rhona has previously mentioned boys are expected to benefit from 'herd immunity'.

With HPV having emerged as the leading cause of oropharyngeal cancers, encouraging dentists to deliver a safe sex message as part of their consultation may sound an attractive option to the Department of Health, but I cannot imagine it would be as effective as offering boys the vaccination. Unfortunately it does seem that priorities are focused more on saving money than on saving lives. For me the idea of herd immunity is complicated ever further as some girls don't receive both doses of the vaccine, and women from outside the UK may have not benefited from a vaccination programme at all, whilst men who have sex with men are left altogether unprotected from HPV. Presumably the reason for the 'girls only' programme is cost. It always is. ◆

1. Mouth Cancer Action Month
2. Walker T W M, Fleming C, Kerai A, Hall S, Rakhra D, Horwood J P, Waylen A E, Thomas S J. Are dental students well-equipped to deal with difficult communication situations? *Br Dent J* 2018; **224:** 163-168.

**Biographies**

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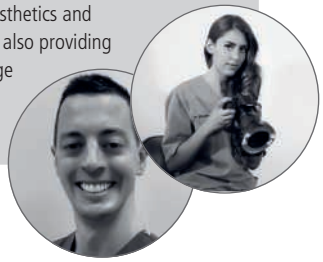

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# Contracts with suppliers: checking the terms of agreements

By Claire Bennett
Claire is a practice management consultant in the BDA Practice Support Team and advises general dental practitioners on associate contracts and a wide range of employment and other law.

Be it for the removal of clinical waste, provision of IT software and support or the leasing of equipment, most dental practices will enter into contracts with suppliers at some point. The commercial success of a practice can, to a large extent, depend on finding and contracting with reliable and competitively priced suppliers. It is therefore essential that practice owners take the time to review and consider contractual terms, including any service level agreements (SLAs), before confirming acceptance of them in writing.

## Written agreements

Generally, it will be the supplier who produces and provides the initial written agreement. In most cases, these agreements will represent the supplier's standard terms and conditions and there may be little room for negotiation. Nevertheless, you should still consider the contract carefully and try to negotiate more favourable terms if there is something you want, for example, a better price or the ability to terminate more easily.

## Terms to look for

In a busy practice, it can be difficult to find the time to read every piece of paperwork that lands on your desk, especially contractual small print. There are some terms and conditions, however, it will always prudent to check before entering into a supply contract.

## Parties

The contract should correctly identify the names of the parties, including their addresses. If you trade as a partnership or limited company and are contracting on that basis, the correct corporate entity should be identified.

## Term and automatic renewal

The duration of the contract should be confirmed. You should note whether it is for a fixed term or will continue until terminated in accordance with other termination provisions contained in the agreement.

Some contracts, like those with utility suppliers, renew themselves automatically after the initial contract term. This can mean that the contract 'rolls over' on less favourable terms. You should check for any clauses dealing with automatic renewal. Do you have to give notice if you do not want to renew? Are there penalties if you do not give notice in a particular way? Will the contract renew on the same or less favourable terms? Will there be any price increases? If you miss a renewal date, and fail to provide a supplier with notice of termination, you may find that you are tied to that supplier for another significant period of time, which may not be desirable if you have been experiencing problems with the quality of their services or product provision.

## Obligations of the parties

You should ensure that the contract accurately sets your obligations and the obligations of the other party. For instance, a contract with a cleaning company may mean that it supplies you with cleaners, but not the cleaning products and materials to do the job.

Obligations of the parties are often set out in a SLA, 'built in' or appended to the contract. SLAs set out standards of performance for individual aspects of service, which, in addition to the respective responsibilities of the parties, can include: the timetable for delivery; provisions for legal and regulatory compliance; service monitoring and reporting mechanisms; and payment terms.


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You should ensure that the services to be provided meet all the main elements of your needs. If suppliers fail to meet agreed levels of service, SLAs usually provide for compensation, usually in the form of rebates of service charges.

## Pricing and payment terms

You should check that pricing and payment terms are properly defined. Will there be an upfront payment? How will payment work thereafter? Does the contract provide for price increases? Will those increases be linked to a suitable index?

## Indemnification provisions

When you agree to indemnify someone, you are agreeing to protect them from liability or loss that may arise as a consequence of the agreement. If you must indemnify the supplier, you should seek to limit the indemnity as much as possible and/or negotiate the same indemnity for yourself.

## Limitation of liability

Some provisions may limit the benefits you are expecting and may also limit your ability to protect yourself or take action against the other party in the event that the other party does not fulfil their contractual obligations. You should check for such provisions and seek to re-negotiate the terms if necessary. Ultimately, if you feel your expectations are unlikely to be met or the agreement exposes you to too much risk, and you are unable to negotiate more favourable terms, you may have to 'walk away' and find a supplier better able to meet your needs.

## Termination

You should ensure you understand the circumstances in which the contract may be terminated. The contract may allow you to terminate at any time, provided you give due notice in a particular way, for example, in writing and by first class post. It may provide for penalty payments on early termination; the effect of which may be to 'lock' you into the contract for its full term. ◆


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# Leases and rent review – what you need to know

By Juliet Mellor
Juliet is Head of Operations for Advisory Services co-ordinating the BDA's teams that deal with associateships, partnerships, employment law and NHS dental regulations and agreements

If you are a landlord or tenant of a dental practice, the likelihood is that at some point you will have to deal with rent reviews.

Rent reviews allow the rent on a commercial property to be adjusted in line with the current market level. As a landlord you will want to review the rents on your properties as set out in the lease to increase your rental income.

As a tenant you will want to minimise your liability and so proper negotiation and representation at rent review will be important to you.

Rent reviews typically occur every three to five years. The exact interval between commercial rent reviews can be negotiated and agreed between the landlord and tenant. The period should be stated in the rent review clause of the lease.

The rent review clause should also outline when a notice, usually in writing, can be served by the landlord and/or tenant. It should also state when a response must be served by, what happens if an agreement can't be reached and may also outline if the notice needs to be in a particular format.

Unless the lease states otherwise, the date when the valuation takes place is the same as the date from which the new rent becomes payable.

The rules by which the rent can be changed should be specified and understandable in the lease agreement.

The new rent is usually the 'open market rental value' of the premises at the date of the rent review. Some leases link the new rent to the increase in the Retail Price Index instead.

## What is open market rental value?

The open market rental value is the rent the landlord could reasonably expect to receive if the premises were leased to a third party, on similar lease terms.

Rent reviews need to take into account local 'comparables' and 'open market' rents – i.e. other rents being charged on similar properties in similar areas and the best rate the property could receive. Normally, both parties appoint their own property surveyors to help manage the process and negotiations.

It is possible for rents to decrease as well as increase, but typically they go up due to inflation. It is therefore an accepted practice for leases to include 'upward only' rent review provisions. This means the rent can never be reviewed lower.

There are usually 'assumptions and disregards' outlined in leases which need to be considered.

For example, the use of the property may be 'assumed'. This means it may have originally been used for one purpose (e.g. as dental practice) but is now used for another. In this case, on the review the assumption will be that it is a dental practice.

## How should rent review negotiation be conducted?

Many businesses use a surveyor to compile evidence on what the rent should be, and to handle initial negotiations. If necessary solicitors can be involved if the negotiations become acrimonious or legalistic.

## Can a rent review include a change to the terms of the lease?

A rent review does not include any changes to the terms of the lease. However, the terms of the lease can be changed by negotiation at any stage.

What if we can't agree on the new rent?

If both parties can't agree on a rate, there are established dispute resolution processes and arbitrations systems in place. Most leases make provision for alternative dispute resolution in rent reviews, meaning a third party can be appointed to assess and impose the new rent. Another option would be to go to court and let a county court judge decide on the new rent.

It is in both parties' interest to negotiate a new rent and resolve any dispute early on. It can end up being a long, expensive process.

The rent review clause in the lease might include time limits or deadlines. If either party misses these then they have broken the agreement and it could have serious consequences for them.

The rent continues to be paid at the old rate until a new figure has been agreed. Once the new amount is agreed, it can be back dated to the review date, meaning an additional lump sum making up the difference may be owed by the tenant to the landlord, and interest can also be charged.

## What should I, as Tenant, do if I can't afford the new level of rent?

The lease may allow some way of exiting. For example:

- The lease might include a 'break clause', allowing you to surrender it to the landlord
- You might be able to sell the lease to someone else, or sublet part of the premises.

Even where there is no solution like this, it may be possible to negotiate a compromise with the landlord. This is often preferable to the prospect of chasing for payment, taking legal action, finding new tenants and the possibility of being unable to recover money owed if the tenant becomes insolvent. ◆

# Securing a dental practice


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By Sabina Mirza
Sabina is a practice management consultant in the BDA's Practice Support team. Sabina advises general dental practitioners on associate contracts and all aspects of employment law.

With the new General Data Protection Regulation ('GDPR') set to come into force on 25 May 2018, now is a good time to review the security measures in your dental practice to ensure future compliance. GDPR places a greater emphasis on data security, by giving individuals better control over their personal data and significantly increasing the penalties for those who fail to protect data and imposing a mandatory requirement to report the breach to the Information Commissioner's Office ('ICO') within 72 hours. This means it is more important than ever that you have adequate security measures in place to protect your patient data.

Your dental practice could face a penalty, even if the data breach is done inadvertently, such as by sending an email to the wrong patient, forgetting to file away a consent form which is then picked up by an office cleaner or leaving a laptop containing unencrypted data on the train. In deciding what action to take the ICO must take account of many factors, including the nature, gravity and duration of the breach. That said, any breach of a patient's health record has the potential to result in serious consequences for your practice including patient distress, loss of trust and confidence, increased insurance premiums and a possible investigation by the ICO. Undertaking a risk analysis now will help you to select the appropriate security measures you need to protect your dental practice from security breaches in the future. You should assess the risk to all of your practice processes which collect, store, use and dispose of patient data including both manual and electronic records, dental equipment e.g. images from dental X-rays and video footage from CCTV.

Below are some helpful suggestions you should consider as part of your risk assessment.

## Control access to information

- Restrict access to patient data by authorised staff only. Set up file access permissions to give designated staff access only to the information which they need to undertake their duties. This will prevent access to a patient record for personal curiosity. Check data logs regularly to identify any misuse.
- Provide staff with their own username and a reminder to use strong passwords. Also, implement password changes on a regular basis, the use of screen lock when computers are left unattended and forbid any password sharing.
- Set up your system to limit the number of failed login attempts and cancel password access when the staff member leaves the dental practice. An employee stealing patient information is one of the leading causes of security breaches.

## Malware protection, firewalls and online security

- Ensure data are encrypted on disks and computer files to prevent unauthorised access. In the event of a security breach, the encrypted data would ensure accessed information does not reveal patient identity.
- Install up to date anti-virus and anti-malware products that regularly scan your network to prevent or detect any spyware and/or viruses affecting your computerised system. Set up automatic software updates and to receive alerts.
- Train staff to spot phishing scams and suspicious links in emails. Ensure they know not to conduct dental business on public Wifi or access websites or online services that present a threat.
- Implement guidelines on use of social media including risks involved in posting and sharing information about patients or which could identify a patient or someone close to them. Be clear that staff must not use publicly accessible social media to discuss individual patients or their care with those patients or anyone else.

## Back up of digital data

- Analyse how often your practice performs digital data backups. It is important that not only all the data is correctly captured, but your back-up data can be quickly accessed off-site.
- Be aware that if you operate any CCTV system you need strict controls in place and policies on capture, use, storage and disclosure of those images and to undertake a privacy impact assessment to assess the CCTV use.

## Physical security of paper files, digital data and equipment storing data

- Secure all paper files in locked cabinets and/or in a locked room. Assign designated keyholders to restrict access to or removal of documents from secured area.
- Ensure mobile devices containing personal data are stored or transported securely when off-site as many data breaches arise from the theft or loss of a device (e.g. laptop, mobile phone or USB drive) during a break in or in transit whilst away from the practice.
- Consider installing a remote disable or wipe facility on mobile devices. This allows you to send a signal to a lost or stolen device to locate it and, if necessary, securely delete all data.

## Minimise your data

Don't keep data that you no longer need. Ensure your patient data are regularly destroyed in line with legal requirements and your record retention policy. Consider moving data retained for archive purposes to a more secure location off-site.

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## Style meets functionality

Tavom Alnair Mito cabinets from RPA Dental are some of the most stylish and elegant units used in dental practices.

With simple lines and contemporary design features, Alnair Mito cabinetry is a perfect addition to any surgery, whether they are used as a centrepiece or finishing touch. There are a number of galvanised steel base unit compositions available (both elevated and wall-mounted), with the option to have either corian or glass worktops and electronic or push drawer slides.

As well as being aesthetically pleasing, the range is HTM 01-05 compliant, easy to clean and maintain and is impervious to wear – the functionality of Tavom cabinets really is like no other.

Choosing cabinetry that is durable and hard wearing yet stylish and elegant can be a challenge, but when you source your equipment from RPA Dental, there doesn't have to be a compromise.

To find out more about the extensive Alnair Mito range, contact RPA Dental on 08000 933 975 or visit the website www.dental-equipment.co.uk.

## The crowning glory of modern restorations

Eliminate the need for traditional dental impressions with MyCrown – the fully integrated system that has been innovatively engineered to build sophisticated restorations chair-side.

MyCrown offers an acquisition unit with both 2D and 3D capabilities, advanced software, and a milling unit that allows you to fabricate common restorations such as crowns, inlays and veneers quickly and easily. With its intuitive intraoral scanner, MyCrown can design and produce restorations with precision to ensure a supreme fit for every patient.

The state-of-the-art MyCrown software allows you to export detailed designs and share them among multiple clinics, or save them for your own personal reference.

With MyCrown, you are not limited by specific manufacturers or materials so you can select restoration blocks according to your preference.

The efficiency of MyCrown means that restorations can be processed and completed in a single appointment, saving time for both you and your patient.

For more information, visit www.my-crown.co.uk or call 03339 873007.

## A diamond finish

There's no point working hard on a restoration if you haven't got the tools to finish it properly. With the Sof-Lex diamond polishing system from 3M Oral Care, however, you'll be able to get great results every time.

Sof-Lex diamond polishing system is comprised of two separate spiral systems:

- Pre-polishing spiral – to prepare restorations for final glossing
- Diamond-impregnated polishing spiral – to finish off restorations with a beautiful paste-like gloss.[1]

Thanks to its innovative design, the Sof-Lex diamond system will also adapt to any tooth surface[2] – and, what's more, this product is very cost-effective, due to the fact that it is entirely reusable.[3]

Fast and easy to use[4], the Sof-Lex diamond polishing system from 3M Oral Care will help you achieve a diamond finish.

For more information, call 0845 602 5094 or visit www.3m.co.uk/oralcare.

1. 3M Oral Care Internal Data: Imparts a paste-like gloss. Claim 6549 (2015).
2. 3M Oral Care Internal Data: Reusable. Claim 6485 (2015).
3. 3M Oral Care Internal Data: Adapts to all surfaces. Claim 6524 (2015).
4. 3M Oral Care Internal Data: Efficiently achieves highly aesthetic results. Claim 6521 (2015).

## Be You!

Curaprox's mission has always been to help patients express themselves whilst improving their oral health and brightening their smile. This has led to the development of many innovative products, including the popular Black Is White range – and now Curaprox is delighted to announce a brand new creation.

Available in six unique flavours and colours, the exciting Be You range of exclusive whitening toothpastes will be launched at the upcoming British Dental Conference and Dentistry Show 2018. The new toothpastes are: rising star, pure happiness, candy lover, challenger, daydreamer and explorer – one to suit every mood and personality of each patient!

The original formula includes everything your patient will need to experience oral freshness and beauty like never before with the added benefit of enzymatic whitening, including 950-ppm fast-acting fluoride, hydroxylapatite, glucose oxidase, xylitol, Echinacea, devil's claw and pennywort.

For more information please call 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.

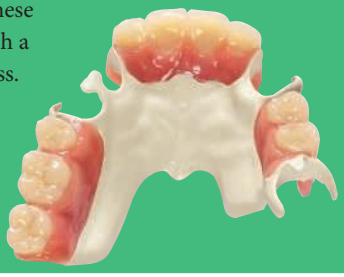

## No more metal mouth

Whether they are worried about dental toxicity, have an allergy or think they may be hypersensitive to metal – an increasing number of patients are reluctant to accept metal dental materials.

For removable partial denture (RPD) frames, Solvay Dental 360 has the answer. Ultaire AKP is a brand new biocompatible material that has been custom-designed for RPD application.

RPD frames fabricated from Ultaire AKP are not harmful to natural tissue and provide a viable option for patients that are susceptible to allergies or to those that would simply prefer not have metal in the mouth.

Ultaire AKP is thin and lightweight and has bone-like properties that provide both the elasticity and flexural strength to withstand loading. These frames are tooth supported, comfortable and stable with a superior overall fit that could even limit future bone loss.



As well as this, your partial wearing patients will be delighted with the aesthetically superior results that can be achieved with Ultaire AKP.

To find out more about this high performance, metal-free material, visit www.solvaydental360.com.

## Busting the corporate myth

This is a time of immense change for the dental profession but, for forward-thinking practices, there are still many opportunities to grow and thrive.

If you are thinking about selling, speak to Rodericks Dental.

Rodericks Dental specialises in the acquisition of new dental practices, expanding its group and further establishing its brand. The company believes that dental services – either private or NHS – should be consistently first-class and patients have the right to expect the highest standards of care every time they visit.

Rodericks Dental is also an inspiring place for any forward-thinking practitioner to work. For talented and committed staff, there is clinical and managerial support as well as opportunities for professional development that are second-to-none. Rodericks practices are also far from generic and all maintain their own unique qualities.

To find out more about what Rodericks Dental does, and how the team can work with you and for you, visit www.sellyourdentalpractice.net or contact Rebecca Bird at acquisitions@rodericksdental.co.uk or on 01604 602491 (option 5).

## Achieving HTM 01-05 and L8 compliance

Yet another recent report recommends that reservoir water bottles in dental chairs be filled with freshly-produced Reverse Osmosis (RO) or distilled water, as they are less likely to contain Nontuberculous Mycobacteria and Pseudomonads found in potable water.[1]

This advice supports the technical guidance of HSG274 (part 3) of the L8 Approved Code of Practice, as well as section 6.84 of the industry bible – HTM 01-05 (2013).

CleanCert's RO water filter is a fast, easy and cost-effective system for providing as much purified water as the dental practice needs, on tap. The fast 'tool-free' cartridge connections are one reason why CleanCert RO is increasingly recognised as the no. 1 choice by dental professionals.

For further information, please visit cleancert.co.uk, email sales@cleancert.co.uk or call 08443 511115.

1. Pankhurst CL *et al.* Dental unit water lines and their disinfection and management. Dental Update 2017; 44: 284-292.

## No scrubs


Do your patients know that over-zealous cleaning can damage enamel?

Scrubbing at the teeth can be a cause of tooth wear. Tooth wear is no longer only associated with old age but can affect people at any age. In fact, the statistics show that more young adults than ever are experiencing a worrying loss of enamel.

TANDEX has a range of high-quality oral health products that can offer an efficient and gentle clean and can actually support and strengthen the enamel.


The brushes are all latex-free, yet soft and pliable. The range includes interdental brushes such as the FLEXI, which has a flexible design and extra-long filaments for efficient plaque removal.

The interdental brushes can be used with PREVENT GEL, which is also non-abrasive. Finally, dental professionals can recommend the new, premium mouthwash from TANDEX, WASH & PREVENT, which can actively strengthen the enamel, too.

For more information on Tandex's range of products, visit www.tandex.dk.

## Making implants easier

BioHorizons is delighted to be bringing Camlog's iSy implant system to the UK & Ireland dental markets.

iSy, 'The Intelligent System', is a complete, fully streamlined implant system, with high primary stability and the capability to provide fully digitised restorations. This intelligent approach to workflow gives dentists superior time and cost efficiencies.

Everything needed for single implant surgery is contained within the all-in set, including single-patient form drill, iSy implant with pre-mounted base, two multifunctional caps, cover cap and gingiva former.

The implant's innovative design offers dentists improved performance:

- 2+2 cutting groove design gives perfect tapping performance
- Fast osseointegration and stable bone apposition long-term thanks to the proven Promote® Surface
- Pre-mounted implant base promotes transgingival healing
- One prosthetic platform – a standardised connection for all implants and prosthetics
- Click mechanism and matched components lead to time-savings

For more information on the iSy implant system visit www.camlog.co.uk or contact the exclusive UK & Ireland distributor BioHorizons.


## A scent solution

The odours found in dental practices can evoke negative connotations causing anxiety, stress and even fear in many patients. As dental businesses increasingly strive to become more commercially focused by enhancing the patient care and experience that they deliver, the use of fragrance can be used for a more positive outcome.

The Premium Scenting Cube from Initial Medical is a device that can be easily and discreetly integrated into a dental surgery waiting room. The fragrances released neutralise odours without leaving unsightly deposits on work surfaces, and are safe to have within a surgery setting.

Fragrance is evenly dispersed throughout the entire room, and there are four scents to choose from. These are: 'Refreshing Lavender' for a calming effect, 'Fresh Clean' for an uplifting feeling, 'Fresh Cotton' for happiness and increased mental energy, and even 'Chocolate Chip Cookie' which could trigger warm, homely and comforting memories.

For further information please visit www.initial.co.uk/medical or Tel: 0870 850 4045.

## Level 7 accreditation achieved

Now in its 25th year, Ucer Education is delighted to announce that its Multi-system Certificate Course has achieved EduQual Level 7 accreditation, as a formal Postgraduate Certificate in Implant Dentistry.

Lead by course leader, Professor Cemal Ucer BDS, MSc, PhD, Oral Surgeon, a highly-regarded authority on implant education and a contributor to the GDC/FGDP's Training Standards in Implant Dentistry (2016), the training is held at the impressive ICE Postgraduate Dental Institute and Hospital. It is now a vocationally-related qualification, accredited and awarded by EduQual, an established UK awarding body which offers a range of qualifications that are credit-rated for the Scottish Credit and Qualifications Framework (SCQF) by the Scottish Qualifications Authority (SQA).

Commencing 21 November 2018, the 12-day (one day-a-month) Postgraduate Certificate in Implant Dentistry programme will focus on academic teaching with practical preclinical skills development. To achieve the required clinical competence for independent clinical practice of implant dentistry, the academic education is followed by clinical skills development on live patients provided by the centre preparing the trainees to meet the GDC/FGDP's Training Standards in Implant Dentistry (2016).

To start your career in implant dentistry, book your place onto Ucer Education's next Postagraduate Certificate (PGCert) in Implant Dentistry starting November 2018 visit www.ucer.education or call 0161 237 1842.

# Dentist to Dentist

For when you want to refer a patient to a local colleague

## Scotland

### BLACKHILLS SPECIALIST REFERRAL CLINIC
www.blackhillsclinic.com

5 Maidenplain Place, Aberuthven Perthshire PH3 1EL
**Tel:** 01764 664446
**Email:** info@blackhillsclinic.com
Cone beam CT scanning
**Mr Paul Stone BDS (Hons) Lpool, FDS RCSEd, FDS RCPS (Glasg)**
**Interests:** Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts.
**On Specialist List:** Yes, Oral surgery (60534)
**Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond**
**Interests:** Fixed & removable prosthodontics, dental implants
**On Specialist List:** Yes, Prosthodontics (66211)
**Dr Marilou Ciantar BChD (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel**
**Interests:** Oral surgery, implant surgery, tissue regeneration, periodontology, conscious sedation
**On Specialist List:** Yes, Oral Surgery and Periodontics (84070)
**Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA**
**Interests:** Fixed and removable prosthodontics, endodontics and dental implants
**On Specialist List:** Yes, Restorative Dentistry and Endodontics (77605)
**Mr Graeme Lillywhite BDS Edin, MFDS, MSc, MRD, FDS RCSEd**
**Interests:** Restorative Dentistry, fixed prosthodontics, dental implants
**On Specialist List:** Yes, Restorative Dentistry and Prosthodontics (68916)
**Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd**
**Interests:** Endodontics
**On Specialist List:** Yes, Endodontics (79246)
**Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR**
**Interests:** Cone beam CT imaging
**On Specialist List:** Yes, Dental and Maxillofacial Radiology (70079)

266979



## East Anglia

### J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

J Smallridge Dentalcare
**Childrens Dentistry**
82 Berners Street, Ipswich, Suffolk, IP1 3LU
**Tel:** 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Consultant Orthodontist
Clinical Psychologist
Specialist Prosthodontist for adults
Endodontist

289511

### DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

2 Queen Edith's Way, Cambridge CB1 7PN
**Tel:** 01223 245266
**Email:** enquiries@devonshirehousedental.co.uk

**Specialist Referral and Education Centre**

**Interests:** Prosthodontics, Implants, Endodontics, Periodontics and Orthodontics, Dental Education and Mentoring.

**Specialist Prosthodontists:**
**Julian Martin**
**Kevin Esplin**
**Ian Pearson**
**Wail Girgis**
**Cyrus Nikkhah**
**Nick Williams**
**Philip Taylor**
**Assad Khan**

**Interests:** Restorative Dentistry, Dental Implants, All-on-4®, Aesthetic Dentistry, CT Scanner, OPG Service and Dental Education

**Specialist Endodontists:**
**Elisabeth Smallwood** and **Julian Martin**

**Specialist Periodontists:**
**Trisha Whitehead** and **Puneet Patel**

**Specialist Orthodontist:**
**Dirk Bister**

296176

## North

### SPECIALIST DENTAL CARE
www.specialistdentalcare.com

**Mr Martin F. W-Y. Chan**
**BDS, MDSc, FDS (Rest Dent) RCPS (Glasg), DRD, MRD, RCSEd.**
29 The Grove, Ilkley, W. Yorks, LS29 9NQ
**Tel:** 01943 608090
**Email:** info@specialistdentalcare.com
**Interests:** Restorative and Implant Dentistry, Prosthodontics, Periodontics, Endodontics
**On Specialist List:** Yes, as above

261782

## South East

### AYUB ENDODONTICS
www.ayub-endo.com

**Dr Asim Ayub BDS MFDSRCS MClinDent MRDRCS**
2 Salisbury Road,
Wimbledon,
London SW19 4EZ
**Tel:** 0208 247 3777
**Email:** info@ayub-endo.com
**Interests:** Endodontics
**On Specialist List:** Yes

270171

## MOOR PARK SPECIALIST DENTAL CENTRE
www.moorparkdental.com

10 Main Avenue, Moor Park,
Northwood, Middlesex, HA6 2HJ
**Tel**: 01923 823 504
**Email:** info@moorparkdental.com

**Dr Joe Bhat BDS FDS RCS MClinDent MRD RCSEd**
Specialist in Oral Surgery and Prosthodontics

**Dr Lydia Hopkins BDS MSc Ahea**
Specialist in Periodontics

**Dr Nick Vyas BDS MSc FDSRCS Cert. Implantology**
Specialist in Periodontics

**Dr Norman Gluckman BDS Rand**
Specialist in Endodontics

**Dr Neeta Patel BDS FDS RCS**
Specialist in Oral Surgery

**Dr Sheetal Patel BDS MFDS RCS MSC Morth**
Specialist in Orthodontics

**Professsor Raman Bedi BDS MSc DDS honDSc DHL FDSRCS(Edin) FDRCS(Eng) honFDSRCS(Glas) FGDP FFPH**
Specialist in Paediatric Dentistry

**Dr Amanda Reynolds DDS LDS DDPH(Eng) MSc DPH Dip Endo, Cert Sed & Pain Management, CILT**
Specialist in Special Care Dentistry

294230

## DENTAL SPECIALISTS ST ALBANS
www.thedentalspecialists.co.uk

96 Victoria Street, St Albans, Herts AL1 3TG
**Tel:** 0172 7845706
**Email:** admin@thedentalspecialists.co.uk

**Interests:** Periodontics with a special interest in Peri-Implantitis and hard and soft tissue Regeneration, Orthodontics, Implants, Full Mouth Rehabilitation, Anti-Snoring Devices, Non-Surgical Management of TMJ problems

Specialists in Periodontics: **Dr Adetoun Soyombo, Dr Olanrewaju Onabolu and Dr Carol Subadan**
Specialist in Orthodontics: **Dr Ayodele Soyombo**
Special Interest in Orthodontics: **Dr Juanita Levenstein**
Special Interest in Prosthodontics: **Dr Richard Craxford**

239826

## TOOTHBEARY RICHMOND
www.toothbeary.co.uk

**Dr Nicole Sturzenbaum**
Toothbeary Practice Richmond
358a Richmond Road,
East Twickenham TW1 2DU
**Tel:** 0208 831 6870
**Email:** info@toothbeary.co.uk
**Interests:** Children

258051

## BOSTON HOUSE DENTAL CLINIC
www.bhddc.com

### SPECIALIST REFERRAL CENTRE IN THE CITY OF LONDON

82 London Wall, City of London EC2M 5ND
**Tel**: 0207 6284869
**Email:** info@bhddc.com

Interests: Prosthodontics, Restorative & Implant Dentistry, Implant complications, Endodontics, Periodontics, Orthodontics, Oral Surgery, Oral medicine, Sleep Medicine & Sleep Apnoea, Mentoring.

### Specialist services:

| | |
|---|---|
| **Farid Fahid** | Specialist in Prosthodontics |
| **Farid Monibi** | Specialist in Prosthodontics |
| **Hatem Algraffee** | Specialist in Periodontics |
| **Natasha Wright** | Consultant and Specialist in Orthodontics |
| **Anish Shah** | Consultant and Specialist in Oral Surgery/ Special Interest in Oral Medicine |
| **Robert Crawford** | Consultant in Restorative Dentistry, Specialist in Prosthodontics, Endodontics & Periodontics |

### Special Interests services:

| | |
|---|---|
| **Kostas Papadopoulos** | Aesthetic and Implant Dentistry |
| **Aditi Desai** | Sleep Medicine & Sleep Apnoea (President of British Society of Dental Sleep) |

295045

## PERIO & IMPLANT DENTAL REFERRAL CENTRE
www.perionimplant.com

351 Richmond Road, Upper Ground Floor, East Twickenham, TW1 2ER
**Tel:** 020 8912 1346 **Email:** info@perionimplant.com
**DR CHONG LIM - GDC No. 70007**
**BDS (National University of Singapore)**
**MSc in Periodontics (Eastman Dental Institute, UCL)**
**MSc (Distinction) in Dental Implantology (University of Bristol)**
**Specialist in Periodontics**
**Interests:** Periodontics and Dental Implants
**On Specialist List:** Yes - Periodontics

293125

## DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
**Tel:** 01908 630169 **Email:** admin@dentalspecialistmk.com
**Interests:** Orthodontics, Periodontics, Implants, Peri-implantitis, Full Mouth Rehabilitation, Prosthodontics, Endodontics, Oral Surgery including TMJ , Restorative Surgery, Sedation and Snoring.
CT scanner and Zeiss microscope on site
**On Specialist List:** Yes, Orthodontics Dr Ayodele Soyombo, Dr Patel
**Special Interest in Orthodontics:** Dr Juanita Levenstein
**Specialists in Periodontics:** Dr Adetoun Soyombo, Dr Carol Subadan and Dr Olanrewaju Onabolu
**Specialist in Prosthodontics:** Dr Peter Yerbury and Dr Ulpee Darbar,
**Specialist in Restorative Dentistry:** Dr Ulpee Darbar
**Specialist in Endodontics:** Dr Neil Kramer
**Specialist in Oral Surgery:** Dr Tamer Theodossey, Dr Wale Towolawi and Dr Yinka Lesi

209440

## ROOT CANAL DENTAL REFERRAL CENTRE

www.rootcanalcentre.co.uk

351 Richmond Road, Upper Ground Floor, East Twickenham TW1 2ER
**Tel:** 020 8050 0351 **Email:** info@rootcanalcentre.co.uk
**Dr Nicolai Orsteen**
**DDS Oslo 2002**
**Specialist in Endodontics**
**GDC No. 175404**
**Interests:** Endodontics
**On Specialist List:** Yes

293124

## Midlands

## DENTAL SPECIALISTS MM

www.dentalspecialistsmm.co.uk

20 Park Road, Melton Mowbray, Leicestershire LE13 1TT
**Tel:** 01664 568811
**Email:** info@parkroaddentalpractice.co.uk

**Interests:** Periodontics, Orthodontics, Peri-implantitis

**Dr Ayodele Soyombo** **On Specialist List:** Yes, Orthodontics
**Dr Bola Soyombo** **On Specialist List:** Yes, Periodontics
**Dr Richard Craxford** **On Specialist List:** No

209439

## THE PRIORS DENTAL PRACTICE LTD

www.thepriorsdentalpractice.co.uk

Pinfold Lane, Penkridge, Stafford, Staffordshire ST19 5AP
**Tel:** 01785 712388
**Email:** info@thepriorsdentalpractice.co.uk

**Dr Mark Emms L.D.S.R.C.S (Edin) MSc (UCL)**
**Interests:** Dental Implants, Fixed and Removable Prosthodontics, Bone Grafts, Sinus Lifts, Full Mouth Reconstructions, Periodontics, Occlusion, Restorative and Cosmetic Dentistry, Implant Mentoring

**Mr John Scholey BDS, FDS, RCS (Edin), FDS (Orth) RCS (Edin) MOrth RCS (Eng), MDentSci**
**Interests:** Specialist Orthodontics, Mini-Screw, Lingual Braces
**On Specialist List:** Yes

**Dr Lukas Javorskis MSc Endodontology (Kaunas, Lithuania)**
**Interests:** Endodontics (including Instrument Removal), Use of on-site Microscope

CT Scanner and dedicated implant suite on-site.

236739

## North West

## ST GEORGE'S DENTAL PRACTICE

www.stgeorgesdentalpractice.co.uk

19-21 St George's Street,
Chorley,
Lancashire PR7 2AA
**Tel:** 01257 262545
**Email:** info@stgeorgesdentalpractice.co.uk
**Interests:** Dental Implants, Oral Surgery, Orthodontic Specialist, Endodontic Specialist, Paediatric Dentistry, Sedation, Restorative and Cosmetic Dentistry.
**On Specialist List: Yes, Endodontics and Orthodontics**

261006

# Practice management CPD

**Q1:** Why should you check for any clauses dealing with automatic renewal?

**A** You may have to give notice if you do not wish to renew

**B** There may be a penalty if you do not give sufficient notice

**C** There may be a price increase built in

**D** All of the above

**Q2:** What is considered a typical timeframe for rent reviews?

**A** Every one to three years

**B** Every two to four years

**C** Every three to five years

**D** Every four to six years

**Q3:** When should you report a breach of data to the Information Commissioner's Office?

**A** Within 24 hours

**B** Within 36 hours

**C** Within 48 hours

**D** Within 72 hours

**Q4:** What is a leading cause of security breaches?

**A** Patient's seeing other records

**B** Employees stealing patient information

**C** Unauthorised use of images on social media

**D** Data stolen by hackers

WELCOME ONCE AGAIN to the *BDJ In Practice* continuing professional development (CPD) programme.

To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists keep up with the latest developments in the profession.

All the questions relate to articles in this issue of *BDJ In Practice*. By completing the answers online, you can earn one hour's verifiable CPD. Do so in every issue of *BDJ In Practice* and you can earn 12 hours' verifiable CPD in a year.

This programme is free to members. A record of the CPD you have earned from *BDJ In Practice* CPD is available to view and print at our CPD Hub. Responses must be completed within six months of the publication date because we need to ensure our questions serve their purpose in helping you keep up to date with current issues.

Log onto **cpd.bda.org** now to earn one hour's CPD.

## Need help?

To access *BDJ In Practice* CPD online:

Either visit **www.bda.org** and select 'CPD' from the main menu, or type **cpd.bda.org** directly in the long white box at the top of your web-browser screen. When prompted, log into the BDA CPD Hub using your BDA website login email and password details.

**First-time user:** select *BDJ In Practice* CPD on the front page of the CPD Hub and enrol for the service. You will automatically be taken to the *BDJ In Practice* CPD page.

**Registered user:** Log into the BDA CPD Hub and select *BDJ In Practice* CPD to see the available CPD opportunities.

Select an issue and answer the questions. When finished, you will be prompted to view your CPD Record where you can see your result.

For support use: cpd.hub@bda.org

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SPRINGER NATURE

*Google Analytics data 1 Jan–30 June 2017 and BDJ Jobs Data. **Ts&Cs apply

BDA
British Dental Association

# The impact of modern diets and lifestyle on dentition

At the end of 2017 GSK hosted a panel webinar on the topic of enamel wear with a particular focus on younger people and practical advice for patients. The panel was chaired by Dr Rupert Austin, specialist in prosthodontics at King's College London Dental Institute and he was joined by Dr Manrina Rhoda, cosmetic dental surgeon, Ali Lowe, dental hygienist and Amit Rai, general dental practitioner.

## The importance of early detection

Dr Austin shared an image of a man in his mid 30's with extensive tooth wear to highlight the importance of early steps for prevention. It was agreed that signs of tooth wear in children's deciduous teeth are a good predictor for tooth wear in adult life and should not be ignored.

The results for the last two Adult Dental Health Surveys[1,2] have highlighted increasing levels of tooth wear amongst younger age groups. And the important thing to reinforce to patients is that enamel will not grow back, making prevention critical.

## Healthy lifestyle risk factors

The panel identified the impact of patients' desires for a healthy lifestyle as a possible factor in the increasing prevalence of tooth wear. Habits such as drinking hot water with lemon or snacking throughout the day on fruit, juices and vegetables can all play a part. In addition Manrina commented that, in her London practice, the stresses of modern life often result in more signs of bruxism and tooth grinding.

## Tooth wear as a key aspect of measuring dental disease

With a consensus that tooth wear is increasing in prevalence, it was agreed that it is likely to be an important factor for dental professionals in the future. Amit highlighted the increased level of engagement amongst Foundation Dentists around the condition, particularly those working in the NHS where tooth wear forms part of the four domains of dental disease in the Primary Care Pathway. In addition, the prevention of erosion forms a chapter of the Delivering Better Oral Health toolkit, developed by Public Health England.[3]

## Measuring and monitoring acidic tooth wear

The panel recommended the use of the BEWE examination as an ideal way to measure tooth wear and record it in patient notes for future reference. In addition, some DHCPs use intraoral pictures to help monitor the significance of tooth wear and the progression. The role of study models was also discussed alongside measurements to aid monitoring. These can be shown to the patient and discussed during the appointment for maximum impact. It was agreed that monitoring and recording is an important part of condition management.

## New online resource – erosivetoothwear.co.uk

Sponsored by a range of stakeholders, this new site has been developed to provide information and education on the topic of erosive tooth wear for healthcare professionals and was highlighted as a useful resource.

## Advice and tips for patients

1. Try to reduce the frequency of acidic food and drink intake.
2. Consider the potential impact of acidic medication or conditions such as acid reflux – ask your GP or pharmacist for advice.
3. Consider the manner in which you are eating food – eat acidic items in one go, ideally with meals rather than to spread out and 'graze'. Avoid habits such as swilling drinks or sucking on orange segments.
4. Use a straw when consuming acidic drinks such as fruit juices or fizzy drinks.
5. Consider the use of a diet diary for discussion with your dental professional.
6. Avoid brushing your teeth straight after consumption of acidic food or drinks.
7. Use a toothpaste with an optimised fluoride formulation such as Pronamel toothpaste – fluoride plays an important role in the prevention of demineralisation.
8. Consider the use of a fluoride mouthrinse with a neutral pH, such as Pronamel mouthrinse, at a different time to brushing.
9. You can access the full webinar footage and gain CPD online at https://digital.vevent.com/rt/gskpronamel~webinar.


1. Adult Dental Health Survey, 2009. Office for National Statistics. Social Survey Division. Accessed 18/01/18
2. Adult Dental Health Survey, 1998. Office for National Statistics. Social Survey Division. Accessed 18/01/18
3. Delivering Better Oral Health: an evidence-based toolkit for prevention. Third Edition. Public Health England, London. Accessed 18/01/18

# ARCHIVE


2010 ARCHIVE


2011 ARCHIVE


2012 ARCHIVE


2013 ARCHIVE


2014 ARCHIVE


2015 ARCHIVE


2016 ARCHIVE


2017 ARCHIVE


JANUARY 2018


FEBRUARY 2018


MARCH 2018