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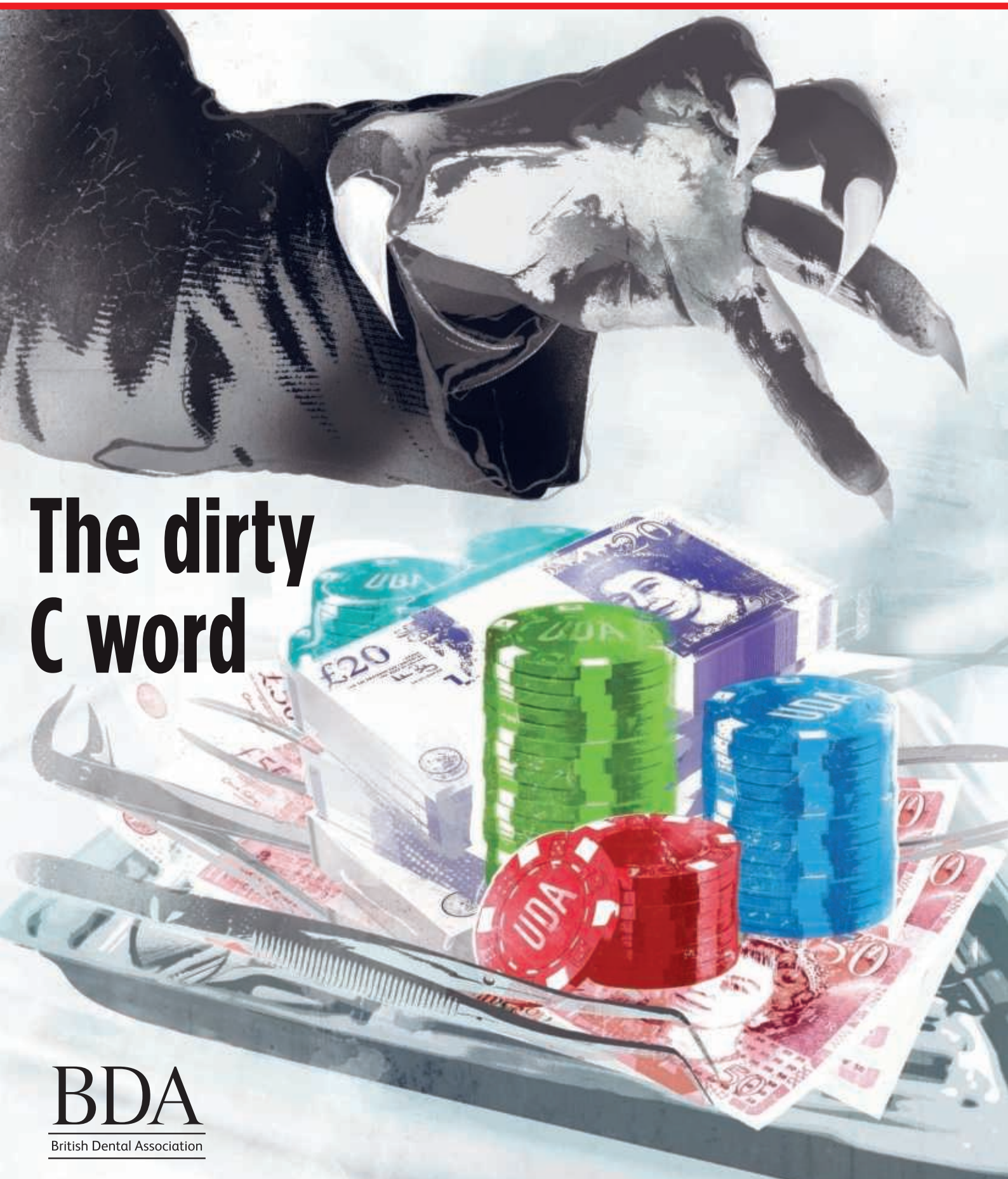

The dirty C word

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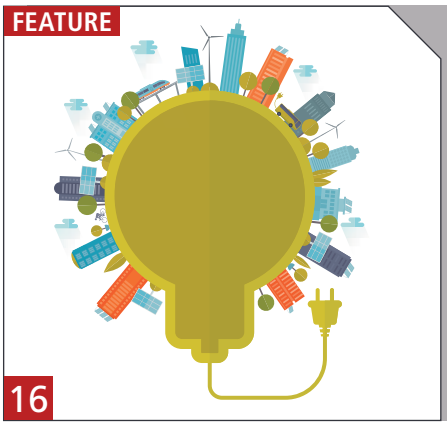

BDA
British Dental Association

JCVI decision on HPV overwhelmingly welcomed by health organisations

The British Dental Association has joined other health organisations in welcoming official confirmation that UK government advisors have finally recommended funding human papillomavirus (HPV) vaccinations for boys – with almost 400,000 across UK set to benefit each year.

Subject to ministers negotiating an effective rate on bulk purchase of the vaccine, advisors have backed extending immunisation to adolescent boys at the same age as adolescent girls (12-13 years).

The BDA has been a leading voice in the call for a gender-neutral approach to the vaccinations, which are currently provided to school age girls as protection from cervical cancer. HPV has emerged as the leading cause of throat cancers, especially among young people, and rates are rising steeply overall. The condition is linked to 5% of all cancers worldwide, including some that affect only men.

Over 30 people in Britain are diagnosed with oral (including mouth and throat) cancers every day. Over the last decade, oral cancer incidence rates have increased by almost a quarter (23%) in the UK, making it one of the fastest rising types of cancer, and has higher incidence among men. Around nine out of 10 oral cancer cases are linked to preventable causes like smoking, alcohol and contracting HPV.

Government advisors at the Joint Committee on Vaccination and Immunisation (JCVI) have delayed recommendations to expand the programme in recent years, and have received widespread criticism for questioning the cost effectiveness of vaccinating boys, based on unpublished, flawed and out of date modelling.

The BDA has urged UK and all devolved governments to press ahead on implementation. 15 countries are already vaccinating boys or plan to do so. These include Australia, Austria, Barbados, Bermuda, Brazil, Canada, Croatia, Czech Republic, Italy, Liechtenstein, New Zealand, Norway, Serbia, Switzerland and the United States of America.

BDA Chair Mick Armstrong said: 'Every year 400,000 boys have been left unprotected from the life-threatening conditions fuelled by HPV. Finally, all our children can benefit from a universal vaccination programme.

'Oral cancer claims more lives than car accidents, and men are twice as likely as women to develop it. Dentists are often the first to see the tell-tale signs, and have fought to see prevention put into practice.

'Too many children have missed out as government advisors have dragged their feet on extending the programme. Further delay will only cost lives. Health professionals expect swift rollout of a national programme.'

In a statement on their website, HPV Action, led by Campaign Director Peter Baker, added their approval.

The statement read: 'HPV Action welcomes today's JCVI statement on HPV vaccination for boys and calls on the Department of Health and Social Care to accept the JCVI's advice and without further delay announce that boys will be included in the national HPV vaccination programme.

'This decision is long overdue. The vaccination programme for girls began in 2008 and the government's vaccination advisory committee (JCVI) began its assessment of whether boys should also be vaccinated in 2013. Decisions were promised for 2015 and then 2017 but postponed until now. In the meantime, about 400,000 more boys each year have been left unprotected against HPV infection and the diseases it can cause.'

Head and neck surgeons have long been lobbying for the change to the vaccination programme, and challenged the JCVI to introduce gender neutrality. The Cancer Services Committee (CSC) of the Royal College of Surgeons of England (senior surgeons drawn from the UK Specialist Surgical Associations that include head and neck cancer surgeons) has disagreed strongly with the concept of 'herd immunity'. The CSC also argued that men who come into contact with unvaccinated women over the age of 23, or who come from non-vaccine countries, or who have sex with men will be exposed to the risk of infection.

As a result, British Association of Oral and Maxillofacial Surgeons Chair Patrick Magennis said: 'The actual cost of annual vaccination is estimated to be a quarter of the cost of treatment of just HPV-driven oropharyngeal cancers (cancers of the tonsil, base of tongue and side of the throat), let alone the cost to individuals who have suffered an HPV-related cancer. The arguments to introduce the vaccination programme are clear.

'Current evidence suggests that vaccination of boys in their teenage years will prevent them from developing HPV-related cancers in middle age. The introduction of male vaccination is both timely and a welcome first step.'

The full report can be found at: www.gov.uk/government/publications/jcvi-statement-extending-the-hpv-vaccination-programme-conclusions ◆

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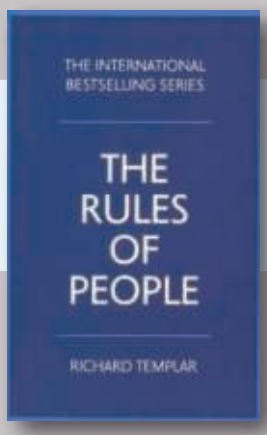
BOOK REVIEW

The rules of people



The rules of people
Richard Templar
Pearson, 2017
ISBN: 978-1-292-191638
£10.99

In a nutshell

Dealing with people, whether in business or in any other context, is fundamental to a trouble-free life or at least a less-troubled one. People have the potential for disruptive behaviour but conversely can also affect things positively. The aim of this book is to influence the way people behave in ways that will be beneficial to them and to everyone else. Author Richard Templar arranges the treatment of his subject methodically and logically. He divides his two-hundred-page paperback into four discrete parts covering, respectively, the following major subject areas: understanding people, helping people, getting them on your side and finally, difficult people. Each section contains around twenty 'rules' spanning two pages and concluding with a boxed epigram summarising the chapter such as 'thoughtlessness is not malicious'.

Who is ideal for?

Templar's book is aimed at everyone, and judging by the ubiquitous presence of his books in leading retail outlets, everyone appears to buy them. The subtitle of this book is 'a personal code for getting the best from everyone', and judging by the section headings, as listed above, readers can take a lot from different areas of the book. Understanding people deals with the psychology of people and helping people may sound altruistic but there are advantages to be gained from these chapters, by managers and leaders willing to determine how their staff tick and how they can be assisted to improve. This similarly applies to the part which covers getting people on your side and the final section on difficult people deals with such a wide range of issues that virtually every reader will be able to benefit from at least some if not all the chapters contained within it.

Why you should read it?

Templar is the author of eight different 'rule' books, including this one and all are bestsellers. The titles range from the rules of management to the rules of work, first published in 2003. Prior to taking up writing full time, Templar spent many years in managerial roles in a diverse range of businesses, from casinos to higher education. The unique selling point of all the titles in his rules series of books, is undoubtedly readability. The titles alone are ambitious enough to induce people into buying them. But Templar excels at hyperbolic chapter titles which again, invite further reading. One great example is the chapter (rule 31) entitled 'some weirdos are great people' (ie, someone who stands out as being different) which ends with the conclusion that 'all these people are doing is being themselves in every situation'. ◆

Patients may request amalgam fillings are replaced as new rules take effect

Dental professionals are being advised by the Dental Defence Union (DDU) that they may be approached by patients wanting mercury amalgam fillings removed, following new rules which have just come into force to restrict the material's use.

Under new EU regulations, from 1 July 2018 dental amalgam should not be used for the treatment of deciduous teeth, children under 15 years and pregnant or breastfeeding women, except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient. There are also further restrictions on the disposal of mercury amalgam due to come into force next year.

David Lauder, DDU dento-legal adviser said: 'More than 80% of the population has at least one filling so it's likely that mercury amalgam will be present in the mouths of most people. The material has been used effectively for more than 150 years, and the new restrictions do not mean amalgam fillings need to be replaced.

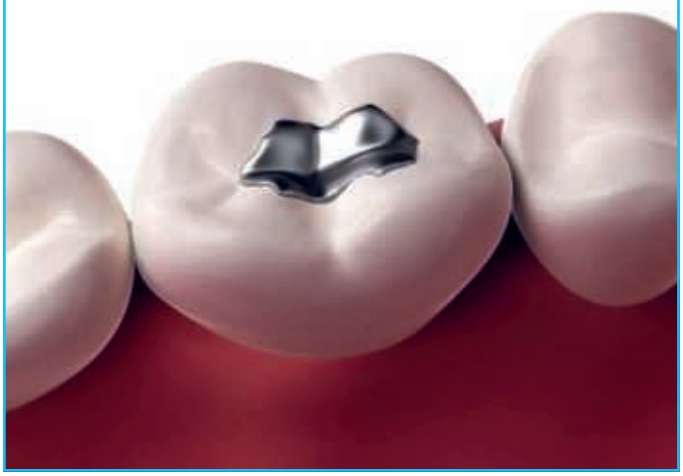
'However, due to the publicity surrounding the new regulations, more patients may ask about the safety of existing amalgam fillings and request they are replaced as a precaution.

'Fortunately there are modern alternatives to dental amalgam readily available but dentists need to consider if replacing old fillings would be in the patient's best interests. As the process of drilling out an old amalgam filling releases more mercury vapour than leaving the filling *in situ*, it may be difficult to argue that the benefits outweigh the risks, unless the filling is already compromised.

'In addition, it is possible that the treatment could itself cause trauma to the tooth and inflame the pulp, leading to pain and the possible need for further treatment or extraction. This in turn could lead to the patient making a complaint or claim for compensation.

'Dentists should try to reassure the patient about the long term safety of dental amalgam and the risks involved in replacing fillings, before making a detailed note of these discussions in the dental records. If necessary, recommend the patient seeks a second opinion.

'All treatment should be in the patient's best interest and in line with current accepted practice and teaching as would be supported by a responsible body of dental opinion.' ◆



A simpler and automated way to switch plan provider

Switching dental plan patients from one provider to another is about to become a whole lot simpler and automated.

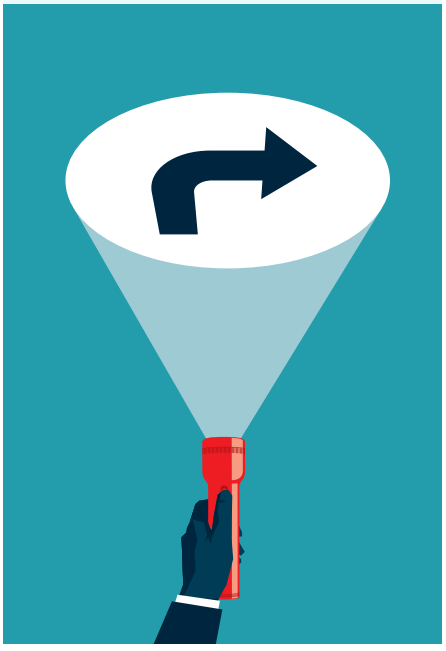
New rules and an accreditation scheme for organisations processing third party Direct Debits, means dental plan providers will soon have to utilise the 'Bulk Change' process if a practice wishes to switch its plan administration from one provider to another.

The Bulk Change process allows for Direct Debits to be transferred automatically 'in the background' from one provider to another, without patients having to sign a new Direct Debit instruction, making life simpler and more convenient for everyone involved.

Patient Plan Direct is the first plan provider to obtain accreditation under the new rules.

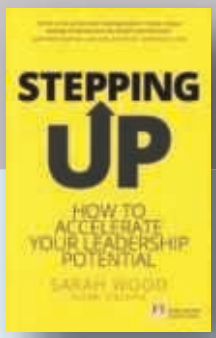
Simon Reynolds, Commercial Director at Patient Plan Direct, comments: 'We welcome these changes, which create a competitively fair market and affords practices the freedom of choice to decide which provider to work with, without being put off by a previously cumbersome switching process.'

For more information visit www.patientplandirect.co.uk/simpleswitch. ◆



BOOK REVIEW

Stepping up – how to accelerate your leadership potential



Stepping up – how to accelerate your leadership potential
Sarah Wood and Niamh O'Keeffe
FT Publishing, 2018
ISBN: 978-1-292-18642-9
£14.99

In a nutshell

Dr Sarah Wood is a technology guru, entrepreneur, a Cambridge University academic and co-founder of her company Unruly. Her co-author, Niamh O'Keefe is a leadership expert and founder of First100 specialising in leadership coaching.
They present here a practical five-point framework outlining how to step up in order to fulfil one's professional ambitions. They have structured their book in five parts to correspond to the five-point framework. Each part is afforded a 'V' word with the five elements comprising vision, values, velocity, votes and victories. These 'V's the authors consider are essential for any aspiring leader to master. They believe that in a changing and volatile world leadership culture needs to adapt too. They contend that it's not the CEOs who will drive innovation but everyday leaders found in all sorts of business contexts and organisations. Crucially, they suggest that opportunities to step up to a leadership role have never been greater than they are today.

Who is ideal for?

Whether it is taking on a new, challenging leadership or management role or changing one's career or leaving employment to start up a single-handed business, the issues faced are common to all and to all of these different circumstances. Alternatively, this book could be equally applicable to those who run their own team but wish to change the way it operates. The advice contained within this paperback isn't specific to any one industry or career type. It is in the words of the authors 'a leadership manifesto and a practical manual designed to help people at all stages in their career and leadership journey'. The lessons they impart here can equally apply to almost any field be it medicine or government, the arts or scientific research and development. Importantly, the authors make no assumptions and thus provide the reader with step-by-step guidance along with helpful tips, 'words of wisdom'.

Why you should read it?

Each of the chapters contained within the five parts of this one-hundred-and-eighty-page book, is written in a concise and digestible manner. Within the 'vision' section, they quote Sir Martin Sorrell's notion of what it takes to lead where he states seven simple qualities: an ambidextrous brain, the ability to argue, an international outlook, early adoption, fast decision-making, no butterflies and finally, the will to win. 'Values' involves establishing a leadership mission and what really matters to you and why you want to lead. In the section covering 'velocity', one chapter suggests developing a leadership 'toolkit'. Examples of this will include facets such as putting people before profit - build your team making them best-in-class, best supported and best recognised. A corollary to this is found in the fourth part, 'votes' where the authors encourage the leader to motivate their team. Talk to them, trust them, empower them and ultimately, champion the team by celebrating the great work they do. The final section deals with 'victory'. By this they recommend being ready to defeat the unexpected challenges that lie ahead. This will include what they refer to as enjoying the 'adrenaline rush' of uncertainty, keeping a perspective and staying purpose-driven. ◆

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

2019 ARF to remain unchanged

The General Dental Council (GDC) have announced that the Annual Retention Fee (ARF) will remain unchanged for 2019. In reaching the decision, the regulator weighed the complex picture of external risk it faces at a time when significant investment is being made for long-term improvement, and concluded the time is not right to make the reduction it had hoped to.

GDC Chief Executive, Ian Brack, said: 'As the GDC's Accounting Officer, it is my responsibility to ensure that the finances and systems of the GDC are robust and to highlight significant risks to Council. We have made some significant progress in terms of real improvements and efficiencies over the last few years but the combination of external risks facing the GDC for the coming year and the short-term cost of internal investment we're making to deliver Shifting the balance and bring further long-term savings led me to advise Council against a reduction in the ARF for the next year.

'Parliament has set the GDC very clear regulatory outcomes that we must achieve, and these focus on protecting the public and maintaining public confidence in Dentistry. This will always be our first priority. We focus heavily on finding new ways to deliver our remit more cost-effectively, but we must achieve this sustainably. Next year we're consulting on our three-year costed corporate strategy, and the activity we propose within that will tell us what the ARF level will need to be to carry out that work. I really hope to hear as many views as possible and look forward to the valuable debate that will undoubtedly bring.'

In response to the announcement, the BDA have slammed the freeze, highlighting the regulator has offered no detailed rationale for the move, offering instead a series of claims on uncertainty and future risk.

Fee levels should be debated and determined in a Council meeting open to the public, linked to a budget and business plan.

The Council has not yet published its evaluation and response to the consultation. The profession's trust in the regulator remains as low as ever due to its approach to fee setting and handling – and continuing lack of transparency.

Fees remain the highest of all the UK health regulators and continue to be used to top-up reserves, well beyond the regulator's own stated requirements.

BDA Chair Mick Armstrong said: 'The £890 ARF symbolises the GDC's cavalier disregard for the profession it regulates, offering new excuses when the old ones have worn thin.

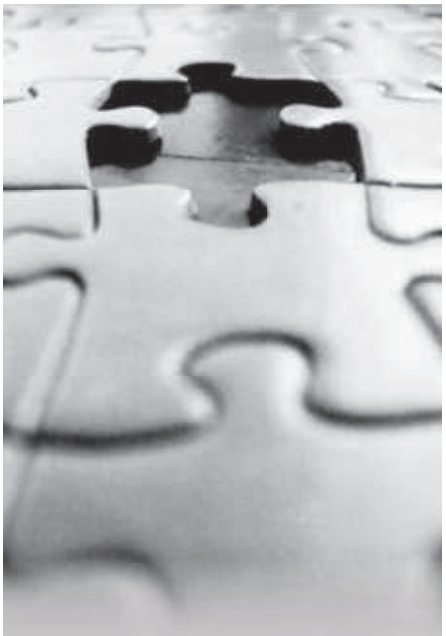
'We require a regulator prepared to live within its means, willing to approach upstreaming and contingency planning with a cool head. Instead we have a body that puts padding out war chests above all else.

'We have long argued that the GDC's approach to its reserves is fundamentally flawed, but even by their own measure, they now exceed their required need. The levels of uncertainty are the same for all the regulators, yet nobody else seems to be arguing in this way.

'The Overseas Registration Exam – and any new approach to registering EU nationals if necessary – should be self-financing. Yes, there may be overheads, but the bottom line is existing registrants should not have to fund registration costs for new registrants. It is simply not a good enough excuse to hoard our cash.

'When the budget for 2019 hasn't even been formally agreed by the Council, it is not a good look for the GDC's Chief Executive to unveil the figures in this manner. The serious concerns about transparency that we keep raising continue and increase. The ARF hasn't changed, and neither has this profession's trust or confidence in its regulator. The case for a significant fee cut remains, a coherent argument for a freeze has not been offered.'

New Secretary of State needs to tackle missing piece in healthcare strategy



The BDA has responded to news that Matt Hancock is to replace Jeremy Hunt as Secretary of State for Health and Social Care.

The Association has recently sought clarity from Mr Hunt, over the place of primary care and prevention within the NHS70 birthday spending pledge. It will be seeking the same assurances from Mr Hancock.

BDA Chair Mick Armstrong said: 'Failure to offer a credible costed plan for oral health is piling pressure across the NHS, most clearly illustrated by tooth decay's status as the number one reason for child hospital admissions.

'We had asked Mr Hunt to clarify if any of the recent spending boost would actually be put to work where it could achieve greatest effect and lasting change through prevention and public health.

'This profession has serious questions, and his successor will have to provide answers on whether dentistry will remain the missing piece in healthcare strategies.'

The dirty C word

By David Westgarth,
Editor, *BDJ In Practice*

It's time to talk about the C word.

Some historians and fact-finders have traced the earliest use of the word back to 1230 A.D. By all accounts it was widely-used in Medieval literature and a word that didn't cause great shock, offence or consternation when used.

Today, as soon as you use the word, you're instantly met by an aghast face, an uneasy silence or a plain disgust. And that brings us nicely to the C word I'm actually referring to; clawback.

Having attended a plethora of conferences, exhibitions and seminars over the last 24 months, I get the distinct impression clawback – while it was around in 2006 – rather like the other C word has a completely different connotation attached to it today. It appears to represent the antithesis of what practitioners are there to do. It sounds like it is at the heart of every single issue general dental practitioners face. In reality, it is the glue that bonds the 2006 dental contract with every problem that has manifested from it. And it is getting worse.

The lay of the land

From 2015-16 to 2016-17, the total clawback for under-delivery across all NHS dental contracts in England, as reported by the NHS BSA, increased by 50% from £54.5 million to £81.5 million (fig.1). For standard UDA contracts[1], the clawback total increased from £49.1 million to £74 million (fig2.); a 51% increase in one year. Half of the money for dentists to do dentistry is being taken back. Let that sink in for a minute.

Figures obtained from the Local Government Association (LGA) don't paint a prettier picture. Figures indicate over £500 million has been lost from NHS services in the last five years through the operation of the widely discredited NHS dental contract.

When dentists are unable to hit the tough targets set in their contracts, funding is simply handed back to the treasury, even in the face of high patient demand. Freedom of Information requests undertaken by the BDA indicate that little more than 25% of this 'clawback' is currently being reinvested in care services, while patients across England are increasingly travelling further or facing longer waiting lists to access NHS care.

The BDA has led calls for this money to be put back into frontline services, and for comprehensive investment in preventive programmes to improve health outcomes among children. Tooth decay remains the number one reason for hospital admissions among children aged 5-9, with multiple extractions costing the NHS over £165 million since 2012, so why isn't that being recognised?

Add to this the government's approach to 'recycling' the NHS budgets as cover for their unwillingness to provide fresh investment, and you begin to see why clawback is such an issue. The BDA has described the government's signature policy, *Starting Well* as an 'unfunded gimmick'. The programme, delivery of a manifesto pledge to improve oral health outcomes for 'high risk' children, has no new funding attached, and is so far operating in a handful of wards in 13 local authorities in England.

'The programme, delivery of a manifesto pledge to improve oral health outcomes for 'high risk' children, has no new funding attached, and is so far operating in a handful of wards in 13 local authorities in England.'

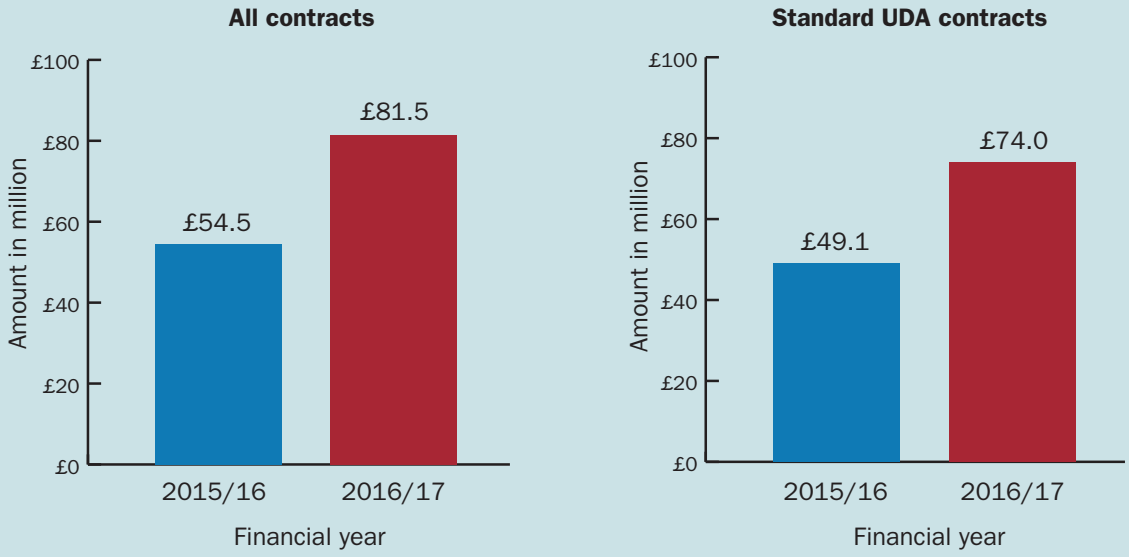
The ugly truth

Nationally, 30% of these contracts had money clawed back in 2016-17, up from 25% the previous year. This means that 1,829 contracts had clawback in 2015-16 and 2,071 in 2016-17. As the data in figure 3 shows, in each of these years, Cumbria and the North East saw the highest proportion of its contracts hit with clawback. Nearly half (47%) of contracts in the area were subject to clawback in 2015-16 and this increased by six percentage points to 53% in 2016-17. In 2015-16, this meant that Cumbria and the North East had the highest total clawback of any NHS local office area, with £6.4 million clawed back.

For GDS contracts, the median amount clawed back from those practices affected increased by 26% from 2015-16 to 2016-17, from £14,701 to £18,458. In each year, the median clawback was 11% of the contract's total value. In total, clawback accounted for 2.2% of the value of all general dental services contracts in 2015-16 and 3.3% in 2016-17.

It is worth noting that over the period the number of contracts for dental services declined. The total number of contracts fell by 6% from 9,537 to 8,927 from 2015-16 to 2016-17. Looking only at those for the provision of general dental services, there was a fall of 4% from 7,260 to 6,961.

I asked Henrik Overgaard-Nielsen, the BDA's Chair of General Dental Practice Committee (GDPC), whether clawback has always been an issue, or whether it has spiralled out of control.



Figures 1and 2: Change in amount clawed-back on NHS dental contracts, England – All contracts and standard UDA contracts

He said: 'Since 2006 NHS England (NHSE) and the Business Services Authority (BSA) have made it more and more difficult to claim UDAs and in a system with many grey areas they have moved the goalposts in the direction of not being able to claim at all. There have been examples of Dental Practice Advisers threatening providers with referral to the GDC unless they pay back large sums of money.

'What that has done is forced dentists to be understandably wary of claiming UDAs, so many colleagues, especially younger ones, have under-claimed to avoid any questions from BSA. Once the seed was sown, it became apparent how much of an issue it was really going to be.'

Chicken and egg

The age old question of which came first still baffles scholars to this very day.

How can you have a chicken without an egg?! *But how can you have an egg without a chicken*?! And so on and so forth.

There are parallels to be drawn between that debate and whether clawback has driven the recruitment crisis, low UDA values, low morale and areas of severe deprivation, or whether it was the other way around.

The BDA's 2017 survey of practice-owners found significant and growing problems with associate recruitment. Of those practice-owners in England that had tried to recruit an associate, two in three had experienced difficulties. This compares to the previous year when half of practice-owners in England attempting to recruit reported experiencing difficulties.

As a result, associate recruitment problems was among the most cited issue that practice-owners stated as having led them to receive a breach notice for under-delivery in 2015-16 in the BDA's 2017 survey, with one in four in England and Wales receiving a breach notice stating it was a factor in their under-delivery.

There were a number of reported factors that were driving recruitment problems, most notably that the NHS was not an attractive working environment and that many younger dentists wanted to work mostly or solely in private dentistry. There were also issues with low UDA values for some practices, but one respondent from an area with high clawback said that practices can't recruit regardless of how much they are willing to pay. Respondents also raised concerns about the impact of Brexit on the willingness of EU dentists to come to and stay in the UK would have in the future.

> 'There are parallels to be drawn between that debate and whether clawback has driven the recruitment crisis, low UDA values, low morale and areas of severe deprivation, or whether it was the other way around.'

Henrik believes this is one of the main contributors to the current crisis faced in recruiting NHS dentists.

'I firmly believe clawback is part of the reason why so many dentists want to work privately', he said. 'The NHS system has become so target driven and it has become increasingly difficult to achieve them. The BDA has just completed research that shows unacceptable levels of stress in the profession. Whilst there are slight differences between age, sex and where in the country you work,

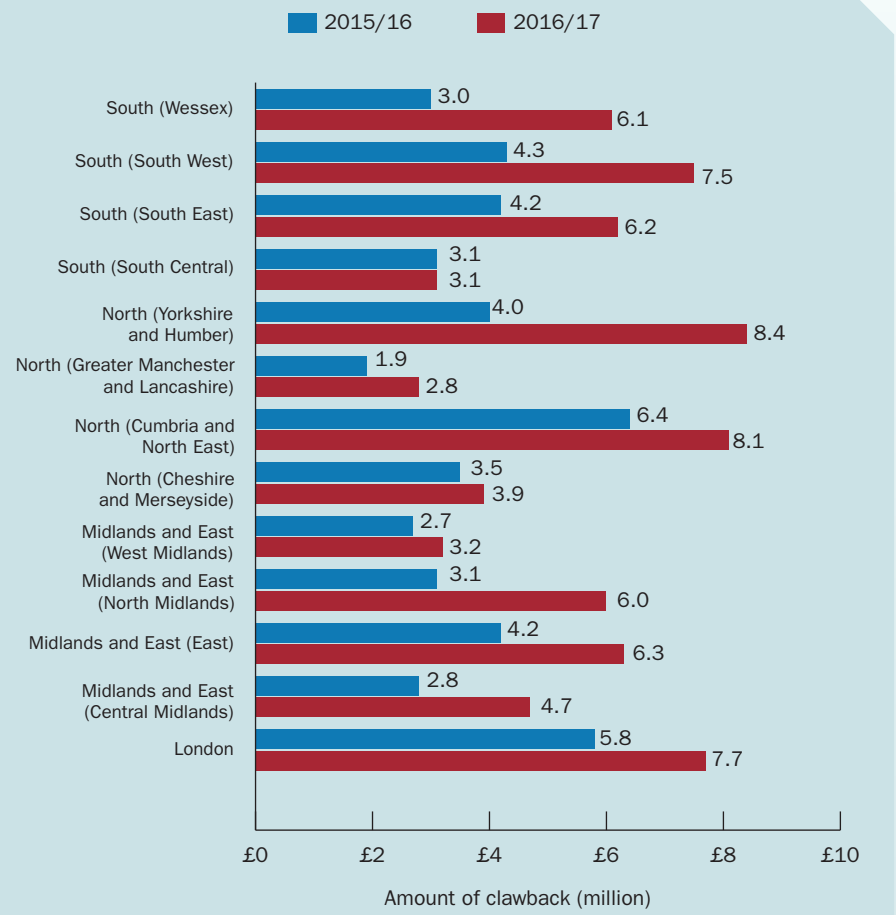


Figure 3: Change in clawback on general dental services contracts by NHS local office from 2015-16 to 2016-17

the main difference in stress levels relate to the amount of NHS work one does. The more NHS work, the more stress. It is frighteningly clear.'

The corporate conundrum

In recent years the emergence of the corporate in England has drastically shaped not only the market, but the whole attitude of the profession and the workforce. Portfolio careers, part time hours and work/life balance over 'a right of passage' are the buzzwords. In theory, corporates have been able to come in, offer bottom dollar UDA rates due to the over-supply of dentists with a 'I you don't like it the next person will' approach, and bring a halt to the traditional independent practice.

As is often the case, theory only gets you so far. In their annual report to bondholders in March of this year, IDH, owner of mydentist, reported 'a challenging trading environment during the year ended 31 March 2018, and their results had been 'adversely impacted by a lower level of UDA delivery in mydentist'. The following exert from the report highlights the complexity and the nature of the issue potentially caused by clawback[1]:

'We have conducted a thorough review of our portfolio of dental practices to identify those which are no longer viable due to structural issues such as, for example, very low UDA contract values and delivery performance or where geographical isolation has made it difficult to recruit dentists. As a result of this review, decisions were taken to close or sell 49 dental practices. By 31 March 2018, the group had sold 13 practices and closed 19 practices, including two which were closed in March 2017, at the end of the previous financial year. The remaining 17 practices are expected to be closed or sold by 30 September 2018. In addition, after the period end, we have taken the decision to close or sell a further 21 practices which we also expect to complete by 30 September 2018.'

Perhaps the most indicative statement made in the report concerns their UDA performance. The company achieved a UDA delivery percentage of 86.1%, after temporary and permanent NHS contract handbacks for the year ending 31 March 2018 compared with 90.4% for the year ending 31 March 2017. Four percentage points may not sound a great deal, but the knock-on effect has consequences.

There are reports of hundreds of long-standing appointments for serious procedures such as root canal, crowns and extraction being cancelled without warning by dentists across the south coast.

Patients in Plymouth, Torquay, Worthing, Brighton, Sheffield, Nottingham, Oldham and dozens of others have reported problems getting appointments with mydentist. To compound issues, there are further reports of those dentists able to see patients writing repeat prescriptions for antibiotics to treat infections – which flies in the face of national guidelines – because they do not have time to carry out full treatment.

As if a self-fulfilling perpetual cycle of misery, this forces patients into one of two things – self-medication, or A&E. Neither are suitable. Both place enormous strain on an already crippled system. And neither place prevention at the heart of what dentistry is supposed to be about.

Previous research has pointed to sizeable numbers of patients unable to access care risking paracetamol overdose in accident and emergency departments.[2]

The study at Queen's Medical Centre Nottingham's A&E unit, identified self-medication for dental pain with paracetamol as a significant cause of accidental overdose and potential liver failure.

Over a two-year period researchers found 436 cases presented to the emergency department with accidental paracetamol overdose, 164 of which were a direct result of dental pain. It revealed that lack of access to emergency dental care was a contributory factor to paracetamol overdose.

The BDA has estimated that around 135,000 dental patients attend A&E per year at an annual cost of nearly £18 million – with over 95,000 cases of toothache coming in at £12.5 million – while a further 600,000 patients a year seek treatment from GPs. Neither are equipped to treat dental pain. Dental pain requires specialised and time-consuming surgical intervention by a dentist, whereas GPs and A&Es can only provide temporary pain relief or inappropriate antibiotics.

As always with a problem like self-medication, it's not a problem that exists in isolation. Access is one side of the coin, and you will often find deprivation, and in particular the affordability of dental patient charges, on the other.

With the recent above-inflation increases in patient charge for consecutive years, it is little wonder patients that perhaps struggle to afford dental care simply choose to self-medicate. 'DIY dentistry' isn't limited to the homeless. Those increases in patient charges mean patients

might be inclined to wait until they require multiple fillings, for example, before seeking treatment rather than paying for regular check-ups, impacting on the number of UDAs the dentist would be able to claim for completing this treatment.

The magical money tree?

While the Prime Minister has struggled to find her now infamous 'magical money tree' while simultaneously financing deals to keep her government afloat, the NHS has looked on like Oliver asking 'please sir, can I have some more?' And yet £500m over five years has been lost. How sustainable is that? And just exactly where is the money going?

> 'With no new agreement on how best to develop the prototypes, let alone a new NHS dental contract that has been delayed more often than a Thameslink rail service, the profession will continue with the status quo.'

That's a question Henrik believes we will not get an answer to anytime soon.

He said: 'NHSE doesn't seem to be bothered about the effects of clawback on dentists. In fact there are local areas where they factor in a set amount that commissioners are targeted to claw back. The money they get back is then used in other parts of the NHS, so from the finance directors' perspective, the more clawback the better.'

The BDA has received data from all area teams in England setting out the extent to which money clawed back from dental providers is reinvested in dentistry. The results show a wide variation in approaches across area teams, with some not reinvesting any money, some reinvesting the majority and others saying they only reallocate clawback funds on non-recurrent in-year activity. The sporadic nature of the approach suggests there is little coherent strategy from above.

The difference in approach by area is further underscored by the notes of Local Dental Network (LDNs) meetings in 2016-17 that were released to the BDA under a Freedom of Information request. While some areas state that 'Dentistry monies are not ring-fenced, so clawback is subsumed into the overall financial system', or that 'clawback received from contractors doesn't sit within the dental budget', others are engaged in detailed discussions as to how clawback money can be reinvested in primary care dentistry or related activities.

Right now, the Government appears to be in no great rush to bring forward long-awaited and much needed contract reform, and meanwhile, successive years of above-inflation increases in NHS patient charges means that with each passing year, a greater proportion of the financial burden shifts from the state to charge-paying patients. Practitioners and dental practices are left to deal with the ensuing patient dissatisfaction.

So what's the answer?

Advice on how to contest the decision ranges from simply not paying up without doing further research to taking advice from someone who has dealt with many claw back situations. With some careful research and thoughtful negotiation, the amount being claimed may be reduced or even eliminated. It's not a one-size-fits-all process, so find out if your data is correct. You need to check with both BSA Dental Services and your Local Area Team that your data has been collated accurately.

Check to see if it is not a full year of activity, whether computer glitches have caused data to be lost, or lost in the post if not computerised, and not all your FP17s recorded or accepted. It is also possible that the clawback amount has been rolled forward over one or more years and that the figures for earlier years are incorrect.

No sign of abating

What we currently have is a failing dental service where clinicians are banging their heads against a brick wall. Targets and their resulting pressures do not allow for a focus on spending adequate time on giving individual, preventive advice. They are overwhelmed by sheer patient numbers and overburdened by regulation - NHS England, NHS BA, GDC, rising indemnity fees. The list goes on.

And that's even before we start to discuss and assess the impact clawback has on practitioners. 'Can you treat more patients with less money please and fewer UDAs?' Henrik believes the problem is only likely to worsen, given we have seen clawback grow over the last three years, both in the amount of money and the number of practices it affects.

So for how much longer can practitioners be expected to do more for less?

'I think we are heading for a perfect storm', he added. 'There is a huge recruitment crisis in NHS practices and even NHSE admits that dentists are only a couple of years behind the GPs in the recruitment stalemate.

'We see many contracts being handed back to NHSE and there are councils with 9,000 patients on waiting lists to see a dentist.

'The fewer dentists there are the more we will vote with our feet, if NHS work is just a question of fulfilling tick boxes and targets while being paid less and less then more and more colleagues will go private. And patients will then have to pay privately as fewer patients will be able to make an NHS appointment. NHSE and the Government will have to do something about this, it is not going to go away by itself.

'I have tried to explain to politicians that you don't win an election on dentistry – but you might lose one. Another queue in Scarborough and they will probably start caring.'

With no new agreement on how best to develop the prototypes, let alone a new NHS dental contract that has been delayed more often than a Thameslink rail service, the profession will continue with the status quo. Many have no other option. And in the meantime we will continue to see a drain of talent, of resources, and of dentists willing to work under such circumstances. And in the meantime patients wanting NHS dentistry will increase, leading to widening access problems, self-medication and DIY dentistry. And NHS England will continue to prevaricate over a new contract fit for purpose.

Remind me again which C word we're talking about? ◆

Footnote

1. *Excluding those that include the provision of Units of Orthodontic Activity or are for sedation or domiciliary services.*

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The mercury has risen

BDA President and Dentolegal Adviser, Dental Protection, **Susie Sanderson** on what the new regulations mean for in practice

Even if you missed the news that that The Control of Mercury (Enforcement) Regulations 2017 came in to force on 1 January 2018, you will be aware that there are now restrictions on the use of dental amalgam in some patient groups. This issue does not only relate to NHS patients in general practice. All providers of dental care must be compliant with the regulations and there are civil penalty notices as well as criminal sanctions for breach of the Regulations.

Article 10 of (EU) Regulations 2017/852 applies to dentistry and the full provisions are discussed more extensively on the BDA's webpages[1,2] along with the background to the Minamata Treaty, BDA representatives' involvement in negotiations and some FAQs. Further restrictions in due course are possibly heralded by the requirements in EU law for the UK to develop a national plan by 1 July 2019 to phase down the use of amalgam and the EU Commission to conduct a study by 2020 to examine the feasibility of a phase out of dental amalgam by 2030.

A key provision, Article 10(2) came into force on 1 July 2018 and needs the attention of all dental professionals throughout the four countries of the UK. It says:

'From 1 July 2018, dental amalgam shall not be used for dental treatment of deciduous teeth, of children under 15 years and of pregnant or breastfeeding women, except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient.'

The Scottish Dental Clinical Effectiveness Programme (SDCEP) advice on implementing the restrictions[3] provides assistance for practitioners in all UK countries in relation to Article 10(2) and is endorsed by the four UK Chief Dental Officers and several other bodies. The BDA recommends that all members of dental teams take the time to read the SDCEP advice in detail and do not rely on second-hand information. SDCEP has specifically avoided providing a comprehensive list of medical or dental needs, instead leaving it to the clinical discretion of the dentist.

For practitioners who routinely place restorative materials other than dental amalgam in line with the regulations, few issues arise. For others, undoubtedly, the restrictions of the use of dental amalgam in certain patient groups raises many questions and potentially introduce risks for the unwary. In this article, we will explore some recommendations to help to manage those risks.

Discussing the regulations with patients

Dental amalgam has been used safely for 150 years to sustained effect. We can intuitively expect that the new restrictions will raise concerns for some patients about health risks of new or existing amalgam restorations. Although it is clearly not the profession's responsibility to justify the regulations, it will make our consenting processes easier if we are able to explain clearly to our patients that the regulations are in place to help to reduce the amount of dental amalgam entering the environmental cycle. The mercury in dental amalgam only becomes an (indirect) health risk once it does so but that risk is global and to be taken seriously. For some patients, it may not be enough simply to describe that the regulations are environmentally driven but further explanation might help. Patients can be reassured that current evidence does not preclude the use of dental amalgam as a restorative material[4] but that the regulation supports the reduction of the global mercury environmental burden.

Patients who ask for their existing sound dental amalgam restorations to be removed will need to know that, in the majority of cases, to do so is in neither their best interests nor the environment's. If there is a genuine concern that a patient might have an allergy to components of dental materials, they should be offered a referral to a reputable dermatology clinic for testing.

Consent

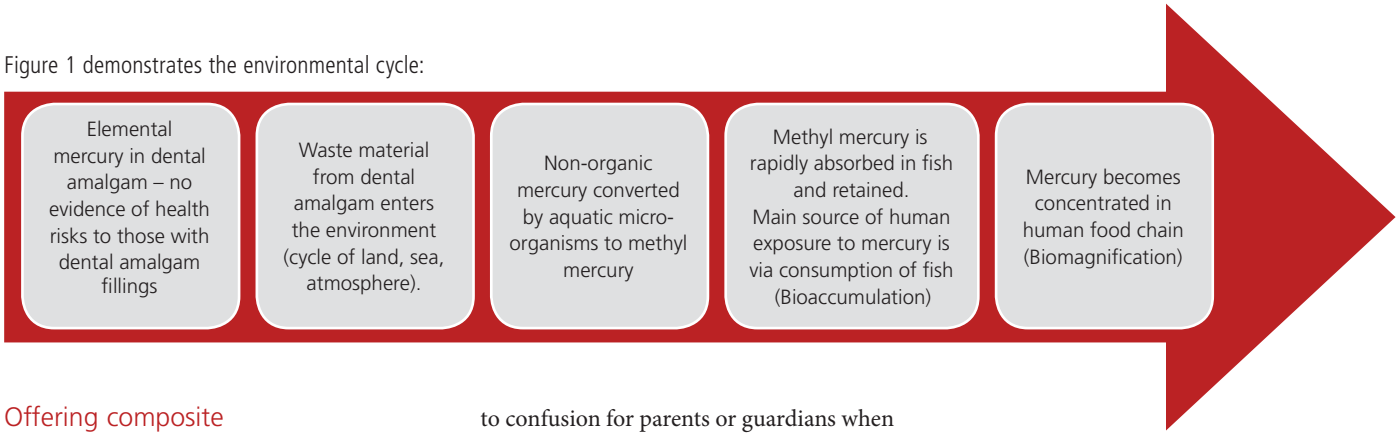
The Control of Mercury (Enforcement) Regulations 2017 introduce a potential tension between professional and ethical duties to act in the patient's best interests. The flexibility provided by the exceptions in Article 10(2), however, help to manage the tensions. Practitioners will, nevertheless, need to consider the following:

- Compliance with the regulations
- The appropriateness of the choice of material for the clinical situation
- The evidence for and against the use of each restorative material
- The implications for the environment associated with the material of choice.

If a practitioner considers that dental amalgam is the material of choice for a tooth of a child under 15 years old or for a pregnant or breastfeeding woman, the valid consent of the patient or the person who has parental responsibility for them must be obtained in order to provide that treatment. For the consent to be valid, the practitioner must be able to justify that the decision is in the patient's best interest and provide information about the material risks and benefits of using dental amalgam in that particular situation to the patient or person who has parental responsibility.

This also applies for alternative materials which you do not believe are suitable and the reasons why in their specific case. Consent should be a shared decision with the patient and all the issues that arise from the Montgomery case will be relevant.[5] For example, these include what the particular patient (or parent/guardian) needs to know and to what they might attach significance. As with all treatment planning situations, they should be given the opportunity and time to ask questions about the proposed care.

Figure 1 demonstrates the environmental cycle:



Offering composite restorations privately

The three restricted groups are all exempt from NHS charges so questions might arise in relation to whether composite restorations can be provided privately under the NHS mixing regulations. The UK legislation requires that dental amalgam is not used in these specific patient categories except when deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient. The implication is, consequently, that restorations completed with appropriate alternative materials must be available to the restricted categories of patients on the NHS.

This does not prevent a patient or parent/guardian choosing to have private treatment under NHS mixing regulations but, in the discussions leading to the patient/parent/guardian making that choice, the clinician must be honest about the regulatory situation and must not mislead patients/parents/guardians about the treatment, materials or the quality of treatment available to them under NHS contract.

Dental practices should, if necessary, review their policy on offering private alternative options for restricted group NHS patients and any revisions should be understood and followed by the whole dental team. The reliance on guidance that treatment that is cosmetic is not available on the NHS will not apply. Each dental registrant has their own obligations to comply with the legislation irrespective of any practice wide policy. Agreeing a compliant policy in advance will prevent any misleading communications with patients and perhaps avoid time-consuming and stressful complaints.

Siblings who fall within and outside the regulatory restrictions

The restriction on dental amalgam use in young people under 15 years old is a legal requirement in UK law. This is likely to lead to confusion for parents or guardians when they are asked to consent to specific dental treatment that differs between their children of different ages. Legally defined age limits are, however, implemented in many other contexts including in healthcare. It might be helpful to reassure parents/guardians that the restrictions are not based on any health concerns other than the reduction of the environmental burden of dental amalgam. The situation where a child is approaching 15 years of age needs to be carefully managed so that, if a third party were to investigate a complaint, there is no perception that treatment has been deliberately delayed. In this transitional phase there may be patients in these restricted categories who have been treatment planned for amalgam or private composite restorations before 1 July 2018 with appointment after that date. When they attend they will need to be made aware of the regulations which may result in a revision of their treatment plan.

Record keeping

The justification for placing dental amalgam in one of the groups listed in Article 10(2) should be recorded clearly in the clinical records along with the discussions leading to valid consent with the patient or patient's guardian about the options, risks, benefits and costs. Because the discussions and consent process will be different and particular for each individual patient, the use of template narrative should be avoided.

If a parent/guardian refuses your recommended treatment, even if it would be in the child's best interest, and insists on another restorative material, the risks of using the parent's choice of material in the particular situation and child should be explained and the discussion noted in the clinical records as part of valid consent.

SDCEP has provided information leaflets for parents or carers of patients under 15 years old and for pregnant or breast-feeding patients for use in the practice setting. If information leaflets are given, this should be recorded in the notes.

Contemporary caries management

It is considered by many that the phasing down of dental amalgam provides an opportunity for the contemporary management of caries to be more constructively engaged. Notwithstanding the contractual reform that will be necessary to facilitate this throughout the UK, for some practitioners and others involved in the regulation of the profession, it will involve further postgraduate training so that the implications and transfer of risk to patients are properly understood. Valid consent and full, clear and useful records will again be essential to prevent a practitioner becoming vulnerable to criticism when things do not go to plan.

It is inevitable that some practitioners will, from now on, be providing restorations using materials the use of which is unfamiliar to them, particularly in under 15s. With a view to being in a position to 'do it once, do it well', planning some continuing professional development in this area would be an interesting and perhaps worthwhile investment. ◆

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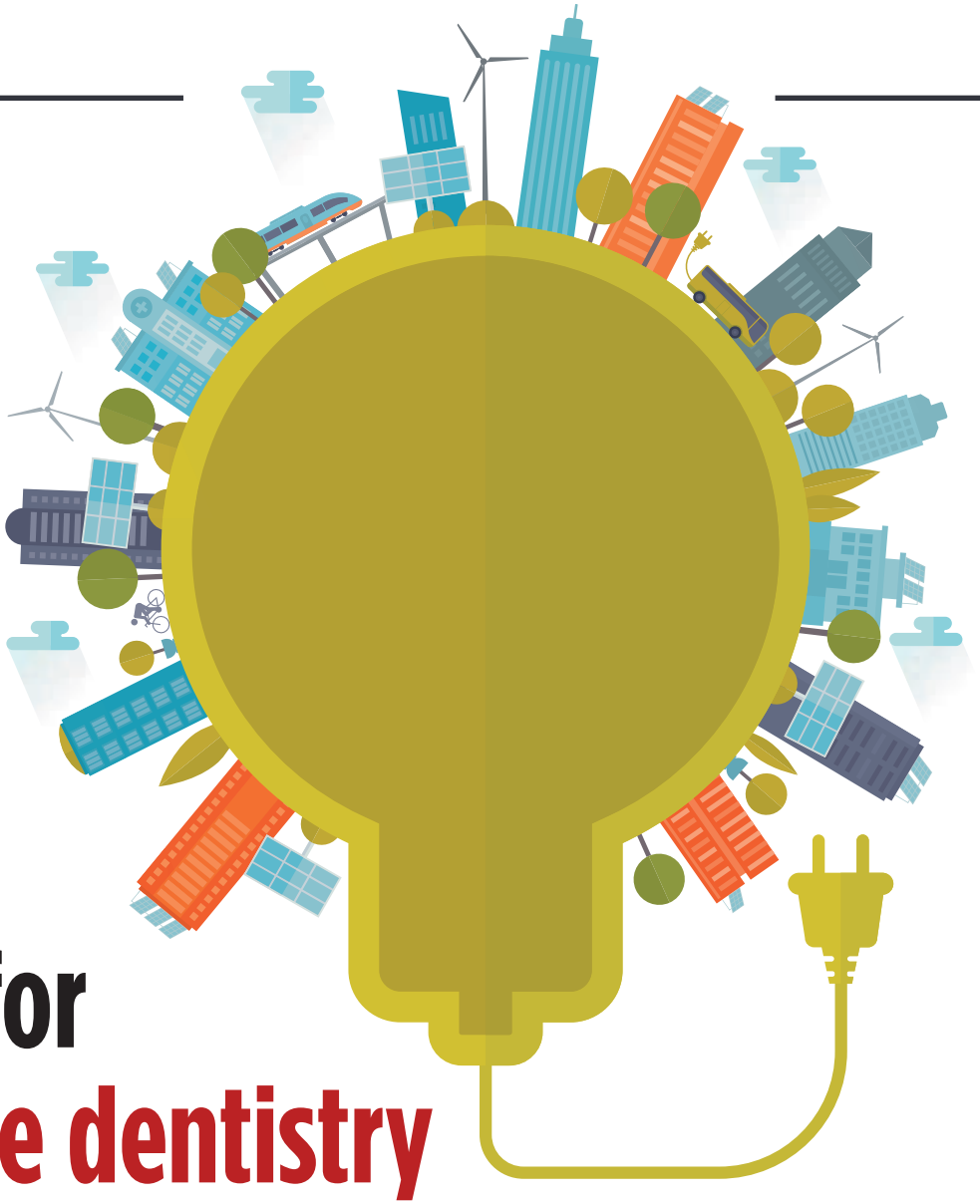

The need for sustainable dentistry

Jane Phillipson from Birmingham Dental Hospital discusses how practices can make substantial financial savings and promote sustainable dentistry at the same time

Jane Phillipson
Birmingham Dental Hospital

Climate change is the biggest global health threat of the 21st century causing extreme weather and negatively affecting the population's physical and mental wellbeing.[1,2] Dentistry is highly energy and resource-intensive which is unsustainable and environmentally harmful.[3] Sustainability is meeting the needs of the present without compromising future generations' ability to meet their own needs and has two main principles: resource use efficiency and eliminating/minimising pollution.[3,4] Due to the use of finite materials and NHS England being legally required to reduce greenhouse gas emissions, sustainability in dentistry needs to be addressed.[1,3,5] Sources with high carbon emissions include: biomaterials, energy, travel and waste. Targeting these sources and promoting sustainable practice will lead to significant reductions in the dental carbon footprint and financial savings.[2,3]

Waste

Dentistry creates vast amounts of waste with the average UK dental practice producing over 1600kg of clinical waste per year.[6,7] The NHS produces more waste (5.5kg per patient per day) compared to countries such as Germany (0.4kg).[8] Materials used in dentistry such as polymers and metals are finite, non-biodegradable resources, which upon landfill disposal may leach harmful by-products

that can contaminate drinking water.[3,9] If not properly separated, toxic materials such as mercury can pollute water and harm wildlife.[10] Furthermore, incinerating clinical waste releases greenhouse gases such as carbon dioxide and noxious air pollutants contributing to 1% of Europe's toxic emissions.[3,7,9,11]

However, healthcare waste is a low priority topic with a lack of awareness, especially in dentistry where there is little information, evidence or studies on sustainable practices.[2,3,9,12] Several barriers to improvement exist including inadequate training and disposal systems, financial and safety concerns, insufficient resources and a lack of leadership.[3,6,9,13] Legal barriers also exist with HTM 01-05 having a detrimental effect on environmental sustainability by encouraging single use items and increasing sterile wrapping incorrectly entering clinical waste.[2,7,13,14]

Sustainable waste management could target all tiers of the waste hierarchy (Fig.1) produced by the World Health Organisation which ranks waste management methods from most to least desirable in terms of: impact on environment, public health protection, financial affordability and social acceptability.[4]

Prevent and reduce

Minimising waste can be achieved by using fewer materials, bulk ordering, preventing expired waste, minimising packaging by negotiating with manufacturers and material elimination such as the EU phase down of dental amalgam driven by its environmental impact and digital radiography preventing fixer and lead foil use.[2-4,8,14,15]

Reduce and reuse

In Germany, phasing out single-use products and reusing bottles and suction systems has led to environmental and financial benefits.[16,17] This was observed in Bonn where several items such as aspirator tips and metal instruments were sterilised and reused and tap water used in dental chairs. Unfortunately, HTM 01-05 and other guidelines prevent similar actions being taken in the UK advising against reusing several instruments and suggesting water should be distilled or reverse osmosis in self-contained water bottles leading to increased clinical waste.[5,18,19,20] Using disposable

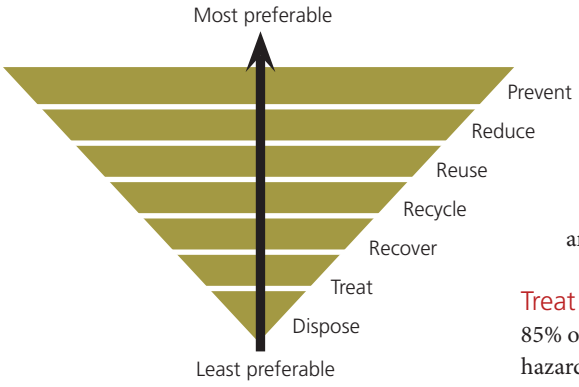

Figure 1 The waste-management hierchy[4]

examination instruments at Birmingham Dental Hospital has increased sharps waste and so reusable instruments should be used where possible. Reducing the number of plastic sharps containers incinerated is possible. 'Bio Systems' reusable sharp containers can be reused up to 600 times preventing hundreds of plastic containers being made and incinerated as well as saving 10-20% in total costs.[21]

Recycle

Although recycling is less energy efficient than reducing or reusing, recycling plastics and glass will reduce the demand for oil and quarrying raw materials.[8] More healthcare waste could be recycled, with an audit at the Royal Sussex County Hospital revealing that 40% of all waste was recyclable.[8] In dentistry, the most frequently disposed items are tissues (33%), gloves (26%) and sterile wrapping (11%) yet tissues and sterile wrapping could both be recycled if uncontaminated.[3,6,7] Regular training in waste management and segregation will aid in increasing recycling rates.[6,15,22,23] An environmental team or 'Green Champion' would help staff query issues and allow targeted improvements in waste management to be made.[2,4] Financial savings are achieved as clinical waste costs more to dispose of than general waste and recycling, with training NHS personnel reducing costs by a third.[11,13] Training could be provided on site or from resources such as Centre for Sustainable Healthcare which has relevant e-learning modules counting towards CPD.[18] Training should be relevant and simple using flowcharts and colour coded bins and could include targets or incentives to help encourage employees.[2,4]

Recover

Waste recovery involves recycling waste into new products or energy.[4,19] Recovery is used at BDH with sharp bins incinerated at a waste-to-energy plant and the incineration products then recycled and reused.[21]

Treat and dispose

85% of total healthcare waste is non-hazardous yet is incorrectly disposed of alongside hazardous waste due to a lack of information and clear guidance.[2,9] This leads to an unnecessary increase in waste volume and incineration at high financial and environmental costs.[7] Waste incineration has serious environmental concerns due to noxious emissions but alternative techniques such as heat disinfection used by BDH can reduce this impact.[3,4,21] Finally, as landfill disposal is undesirable and increasingly expensive, disposal companies that recycle and recover waste should be selected.[2,4]

Procurement

The procurement of goods and services represents 72% of healthcare's carbon footprint being the second highest contributor to total greenhouse gas emissions in NHS dentistry and accounting for 19% of total emissions.[1,3]

Environmentally Preferable Procurement is purchasing the least environmentally damaging product and green procurement refers to purchasing minimally packaged goods that are easy to recycle; both of which reduce the impact on human health and the environment.[2-4,15] For example, sustainable forestry practice or using recycled paper will reduce deforestation and subsequent habitat destruction and global warming.[3] Currently in the UK there are very few green products despite the British Dental Industry Association requiring companies to have an environmental policy.[3,13] However, they do exist elsewhere, such as the American Eco-Dentistry Association green product guide.[24] With £40 billion per year spent on procurement by the NHS, healthcare systems have a great impetus to ask for more sustainable practices.[3] A demand from dentists could spur manufacturers to design and supply more green products as well as adopting measures such as reduced packaging.[2-4,13,15] Finally, sustainable procurement could reduce the environmental impact associated with increased single use

instruments and sterile wrapping caused by HTM 01-05 by using sustainable materials which are less environmentally damaging upon disposal.

Travel

Travel and transport form 13% of healthcare's carbon footprint and the highest proportion (64.5%) of dental care emissions.[1,3] To reduce travel, patients and staff should be encouraged to use active travel, public transport and car sharing.[1,3,17] Providing cycling facilities, public travel information and discounted tickets, and commissioning services in locations close to public transit systems could all help minimise travel.[1,3] 'Teledentistry' such as video conferences would reduce staff travel saving working hours and costs.[3,11] Preventative dentistry, combining procedures and the longest suitable NICE recall should all be used to minimise patient travel, material use and CO_2 emissions.[1] Lastly, using digital medium and local manufacturers and disposal services also reduces transport requirments.[2,3]

Energy

Energy usage contributes to 15% of healthcare's carbon footprint.[1,3] Dentistry is highly energy intensive so reducing unnecessary use, increasing energy efficiency and using low carbon energy should be considered.[3] Lighting energy use can be reduced by installing motion-activated sensors and LED bulbs.[3,13,17] LEDs last 15 times longer and use 70-90% less energy than standard bulbs saving energy and costs.[5,13] Equipment is becoming more energy-efficient and this should be considered when purchasing new equipment.[5,17] Electricity providers that use renewable or low carbon energy sources such as Ecotricity and OVO Energy who supply 100% green energy, should be utilised.[1,3,13] Energy auditing and monitoring allows identification of high energy use areas and waste which an action plan can then target producing financial savings with low/no cost initiatives.[3,11,17] Staff motivation is required to reduce energy use. Barts and the London NHS Trust found that energy usage alone was not motivating staff, so combined reducing energy usage with improving patient care to change staff behaviour, for example switching lights off to promote sleep, leading to financial savings with the programme paying for itself in under a year.[11]

Conclusion

It seems there is a desire for healthcare to be more sustainable with the majority of those working/attending Bonn and BDH being aware of environmental issues and preferring a more environmentally friendly hospital. Several barriers to sustainability exist including a lack of information, attitudinal issues and perceptions that it is costly.[3] In fact costs are reduced by improving waste management and energy efficiency, sound procurement strengthens economy and using green energy minimises effects of fluctuating global oil prices.[3] Implementing sustainable practices through the methods discussed not only has financial and environmental benefits but also benefits society by increasing individual productivity of those working in a sustainably designed environment and improving general health from efficiency savings and remediating the environment.[3,7,20] As mentioned, staff behaviour is important in implementing sustainable practice. To change behaviour, individuals need to be motivated and in a culture that enables change.[2] The workplace should make waste segregation easier, develop an action plan involving staff consultation and provide evidence based training.[3,4] Training would increase awareness of the environmental impact of dentistry which could help increase demand for green products and sustainable practices. At a time when introduction of green policies to prevent further damage to the environment is more crucial than ever, the responsibility of the dental industry and the benefits of sustainable practice should not be overlooked. ◆

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Be careful what you wish for

Part Three

In his final instalment, Mike discusses how and why things can go wrong

Mike Young
Author of *Managing a Dental Practice the Genghis Khan Way*

A word of caution – things don't always go as smoothly and serenely as you would like. Here are a few cautionary tales. First, though, I think it's worth saying that having anyone working at your practice, especially a clinician, who is not on the same wavelength as you and your team when it comes to patient care, is very unsettling for everyone. Employees become anxious because they hear or see things being done that they know shouldn't be done, for example, the way the specialist talks to staff and patients. Patients become anxious for the same reason. You risk losing good employees and patients. The interview and induction processes are crucial for all potential new employees and clinical staff alike, but are particularly important when it is someone on whom you are relying to play such a key role in the development of the practice.

The first example involves a very well-qualified and experienced specialist who started working in a well-managed, clinically-sound practice. They were very confident and a touch arrogant about their ability. Things started to go wrong almost from the outset when this person walked out of one of their induction sessions, stating that, 'They were too busy and too important to bother with this!' They then began a campaign of 'divide and rule' among the staff. After months of anguish and grief for the practice owners, the specialist finally left and moved on to another practice not a million miles away, but not before they had downloaded the patient list and poached employees. The practice owners learnt a great deal from this experience. This is maybe an extreme example but it does show the risk a practice runs if it lets the wrong personality through its doors.

Another example comes from a friend who rented a surgery to a specialist and who subsequently caused havoc in their practice.

The specialist came with all the necessary qualifications, but when it came to customer care they really couldn't have cared less. They ran over time all the time, keeping patients waiting without any explanation or apology. The receptionist was forever having to make excuses. The worst bit was that the patients who had been referred from other practices thought that this was the way my friend's practice dealt with all of its patients. Having an excellent clinician working as a specialist in your practice is not always the same as having someone who really cares about their patients.

Specialists (like anyone else) can come with a toxic mix of unreliability and a maverick attitude to practice rules. Couple these with an exaggerated sense of their own importance (one practitioner described this as Prima donna-itis) and a disregard for customer care, and you are looking at someone who could quite easily undo your years of hard work in the blink of an eye. I know of such a case, the specialist had all of the above traits and who eventually took total control of their appointment book, cancelling sessions at short notice, making business planning extremely difficult for the practice. Problems with specialists can often arise because of their exaggerated sense of specialness.

> 'Having an excellent clinician working as a specialist in your practice is not always the same as having someone who really cares about their patients'

How do you deal with a problematic specialist in your practice? First, treat them as you would any other employer: hold meetings to discuss the problem(s) and its underlying cause(s). Try to see their point of view, which can sometimes be overlooked by the practice. If you want to retain them then adjustments might have to be made, but be careful you don't give away too much. Often problems arise through misunderstanding, with both sides seeing things in a different way. Changing how you see a thing changes how you think about it.

If you are reading this and thinking that I have been negative about the role specialists can play in a general practice, I will try to redress the balance. Their role is about more than the enhanced clinical skills they bring with them, although it is obviously a big part. A good, or preferably an excellent, specialist coming into a general practice environment should ideally have a general practice background, in contrast to someone who has only ever worked in a hospital setting. I say this not out of any bias, but because I think it will give them greater insight into how a general practice functions. Finding such a specialist might not always be easy, but if the best candidate happens to have a hospital background you will need to invest time in helping them adjust to working in a practice environment. Your specialist could and should make a significant contribution to your business aims and objectives, and some of them do, I am sure. Sharing their knowledge with others in the practice is going to increase overall clinical standards in the practice, but they should also be prepared to take on board information coming the other way. Specialists need to be excellent communicators, not only with their patients, but also with the rest of their co-workers.

Practice owners with an appetite for practice improvement, and dentists with specialist skills have obviously identified an opportunity for both parties to offer patients a number of in-house specialist treatments. This trend, or Zeitgeist, looks set to continue. What we are witnessing might be the passing of practices that are inhabited by generalists, dentists who are a jack of all trades, masters of none. Clinical standards in general practices are hopefully being driven upwards in part by the introduction of specialists. Is it the standard of the specialist in practice that is now the new expected standard? Patient expectations will undoubtedly rise as they are exposed to more and more specialist treatments, and this too could be a driver in general practices having to look at introducing specialists.

As I have pointed out, introducing a specialist into your practice takes very careful planning, supported by a very good business case. No aspect of the process should be overlooked, whether it be the practicalities or the human aspect. The risks to the practice of not getting it right from the outset are the same as for any other appointment. The specialist shouldn't be given specialist consideration just because of who or what they are, the relationship must be based on mutual respect for each other's skills and talents, as well as a desire to build something that works for everyone. ◆

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Achieving positive outcomes from complaints

Effective complaints handling is crucial in a dental practice and where a complaint is handled well, then the loyalty of that patient is often strengthened. However good a dentist and their team are, they will occasionally receive complaints. Dr Philip Johnstone, Dentolegal Adviser at Dental Protection, examines what dental teams need to do to learn lessons from complaints and how to deal with them effectively.

Dr Philip Johnstone
Dentolegal Adviser at Dental Protection

Like any service, whether that is in retail, entertainment or indeed healthcare, there is always the possibility that the customer may not be entirely satisfied. In a dental practice setting, when a complaint is directed to an individual or a team member it could potentially have a demoralising effect. The individuals concerned may feel undervalued and underappreciated and in turn, this may affect confidence levels and even lead to a questioning of decision-making.

Dental treatment is obviously a very personal service, based on the needs of the individual patient. When complaints arise, they can be down to either predisposing or precipitating factors.

Predisposing factors include events which, when considered individually, may be of little consequence to a patient's satisfaction. Collectively however, they may influence a patient's decision when something goes wrong or is perceived to have gone wrong. This includes events such as rudeness, miscommunication, inattentiveness or minor system errors.

Precipitating factors are the factors that can trigger a patient's final decision to complain, and more often than not relate to more serious issues such as adverse outcomes or major system errors.

Formal complaints process

A complaint may be defined as:

Any oral or written expression of dissatisfaction, whether justified or not, from, or on behalf of, a person about the provision of, or failure to provide, a service.[1]

All dental practices are required to provide a formal complaints process but a recent YouGov survey carried out on behalf of Dental Protection[2] showed that 65% of the public are not aware of this. When Dental Protection asked members if they think patients are aware that dentists are required to provide a formal process for managing complaints which arise, 40% said they did not think the public would be aware of this.

This difference in awareness of the complaints procedure between the public and dentists shows that there is still the need for dental professionals and their teams to make all patients aware of the process to follow in the event of a complaint.

The need for a complaints process is not just good practice but is mandated by the General Dental Council (GDC), which stipulates that practices should 'have a clear and effective complaints procedure.' As per the GDC Standards for the Dental Team Principle 5, Standard 5.1.53:

'You should make sure that your complaints procedure:

→ Is displayed where patients can see it- patients should not have to ask for a copy.

It is important that every team member takes responsibility and ownership for complaints management and is trained and confident to identify, capture and act on any signs of patient dissatisfaction. A problem intercepted in the right way can diffuse a potential complaint and act as a practice builder. This demonstrates team members and the practice as a whole is listening, cares and are doing the right thing. Although it may appear counter intuitive, patients should be offered a copy of the in-house complaints procedure for their information at the earliest opportunity.

Standard 5.3.1 of the Standards for the Dental Team states[3]:

'You should give the patient a copy of the complaints procedure when you acknowledge their complaint so that they understand the stages involved and the timescales'.

Although a GDC requirement after receipt of the complaint, the information provided to support the patient may represent the first stage in early resolution of the issues before a complaint has arisen. It may be useful to see when the complaints procedure was last reviewed to ensure it is compliant, current and facilitates patients in seeking early resolution with the practice.

Resolving complaints effectively

If a dental team receives a complaint from a patient, they should view this as an opportunity to learn and improve their service.

Patients are all able to recognise good and poor customer service first hand. Many judgement calls are made, particularly when using a service for the first time, so it may be worth taking a step back to observe your work place with a dispassionate eye to see what level of customer service is being delivered on the ground.

In order to ensure you deliver good customer service to your patients, you need to ask a few questions of your team and your practice: Is your practice a responsive[4] (services meet people's needs) and caring[4] (services involve and treat people with compassion, kindness, dignity and respect) environment for patients and can this be demonstrated?

Given that it costs five times as much to attract a new customer than it does to keep an old one there is a powerful business case for empowering patients to speak up, when they are dissatisfied.

According to the YouGov survey, if a patient's treatment did not go as expected, 74% of the public would expect the dentist to offer further treatment to fix the problem/complication at no additional charge, while 50% would expect an apology. In comparison, 31% of Dental Protection members believed patients would expect further treatment, and 27% believed that patients would expect an apology.[5]

While treatment may not go as expected, an apology by the dental professional can demonstrate to the patient a level of sympathy, while offering to fix the problem with further treatment can help to restore trust.

The YouGov survey demonstrated that 57% of the public would complain directly to the surgery about any treatment they received, while 36% would complain to the specific dentist that carried out their treatment. Positively, only 16% would complain to the GDC.

While a patient directly addressing a complaint to you may be unnerving, dental professionals and their teams should see this as an opportunity to resolve any issues locally, rather than face the even more daunting challenge from the regulator.

Learn from complaints

Mistakes and system failures will occur from time to time. The important issue is to be open to the learning from these situations. Complaints provide the opportunity to reflect on current practise and look for improvements. The learning from a complaint or adverse event should be added to the individual's Personal Development Plan. This will allow targeted reflection and can inform future learning. A no blame culture in the work place allows individual team members to share errors in a supported environment and negate the negative consequences a complaint. ◆

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A conscious benefit

David Craig

Carole Boyle

It's estimated around one in four patients suffer from some degree of dental anxiety. For some, the anxiety is deep-rooted in a previous unpleasant experience. For some, it's the sights, sounds and smells of the dental practice. For many it's a long standing and profound fear of needles and injections.

So what options are available to practitioners to help solve this access barrier? One technique is conscious sedation, and *BDJ In Practice* spoke to **David Craig** and **Carole Boyle**, Consultants in Special Care Dentistry at Guy's Hospital in London, about why it's such a benefit to patients and practitioner alike.

Why is conscious sedation (CS) an integral part of controlling pain and anxiety?

DC Many patients are phobic of even simple dental procedures and so do not attend a dentist until they are in pain. Others who are undergoing long or unpleasant procedures (for example, surgical extractions or implants) or who have disabilities, including medical conditions, may also benefit. CS not only makes dental treatment more acceptable, but may reduce the possibility of subsequent dental phobia. CS must be combined with effective local anaesthetic. Together they have the potential to control the so called 'pain-anxiety' cycle.

CB It's common for patients to describe a previous unpleasant experience as the reason behind their anxiety. Often we hear that procedure – although clinically and surgically successful – was rather unsympathetically managed - often when the patient showed signs of anxiety. The patient's attitude and expectations of dental treatment may then have been affected, resulting in – as David suggests – them simply not attending for future treatment or even check-ups.

DC When describing the advantages of treatment under CS, phrases such as 'conscious sedation is like a light general anaesthetic' are unhelpful. A better explanation is that CS will 'detach' the patient from their fears whilst leaving them able to communicate with the dental team. Many patients are fearful of being unable to say how they are feeling.

So in theory could CS be a tool for re-engaging patients who fit this profile with dentistry?

CB While it is not the philosophy adopted at Guy's, there is a line of thinking that suggests you tell patients you are going to treat them under conscious sedation and then gradually tail it off until they can be treated without. This may have some merit, but, in our opinion, it's not best practice. Better to take the lead from the patient and wait for them to suggest that they may be able to cope with LA alone. With sensitive and caring management many patients become less anxious over time,

particularly when they get to know and trust the dental team.

What methods of CS are available, and which would you recommend practitioners adopt?

DC Nitrous oxide/oxygen (RA) and midazolam (IV, oral and intranasal) are generally suitable for ASA I/II (fit and healthy) patients in a primary care setting. The wider the range of CS techniques on offer, the greater the opportunity to manage each individual appropriately and safely at each visit. Whichever CS technique is chosen by the patient and dentist all sedation practitioners must comply with the IACSD Standards (2015).

CB Training is very important. If practitioners have the appropriate training they will be able to deliver safe and effective CS for a wide range of patients and procedures. Sedation providers should also be aware of the difference between sedation need and demand – making the right judgement doesn't necessarily come as second nature. We both stress the importance of following current clinical and commissioning recommendations.

But is this simply another area of dentistry where practitioners are burdened with over-regulation that doesn't necessarily work in the patient's best interest?

DC No. The use of 'procedural' CS is increasing rapidly across a wide range of medical specialties, not just dentistry. There are overarching National guidelines (AoMRC, 2013) and also those individual specialties. The IACSD Standards (2015) cover CS for dental treatment in the UK.

These Standards provide clear and definitive guidance for dentally and medically qualified practitioners providing CS for dentistry). There is no evidence to suggest that these clinical guidelines work against the patient's best interest – quite the contrary.

Is CS compatible with the time general dental practitioners have?

CB Providing treatment under CS generally takes no more time than treatment under LA alone once practitioners have acquired the knowledge, skills and clinical experience. 'Teamworking' is the key to success! Again it's about training. Practitioners who are not able to offer CS themselves should consider referring patients to hospital or community services.

DC Unfortunately, the funding arrangements for CS under NHS regulations are currently less than satisfactory. Unless a practitioner has a contract to provide CS, they will not be paid. This is probably why so many patients needing treatment under CS are being referred to hospital. Most ASA I and II patents can receive their treatment in a primary care setting and, as many sedation practices have found, this can also be a great practice builder!

Can you really get informed consent from a patient, knowing they're in pain or severely anxious?

DC Yes, but care must be taken to ensure that the patient properly understands the proposed treatment, any alternatives, and the risks and benefits of each. The IACSD Standards recommend that consent is best obtained at a previous assessment appointment as this allows a 'cooling off' period but, if the patient needs immediate treatment, this may not always be possible.

CB It is very rare to see someone so paralysed by anxiety of the dentist that they are unable to provide valid consent. At Guy's if we know a patient is struggling, we would involve one of our health psychologists to help the patient understand the treatment, explain the proposed dental treatment, and ultimately to obtain consent.

Is there any profile of patient CS is potentially not suitable for?

DC CS is suitable for most patients but it is important to consider 'who does what to whom and where'. In a non-specialist setting (e.g. primary dental care) only ASA I and II patients should normally be treated but in a specialist setting (e.g. an NHS Acute Trust) sedation for a severely medically compromised (ASA II/IV) patient might be the safest option. However, this would be managed by either a very experienced sedationist or an anaesthetist in a theatre environment.

CB This is why careful, individual, patient assessment is crucial. Some patients still require GA. Generally speaking these are patients needing very large amounts of treatment or individuals with severe or multiple disabilities. There are also some social circumstances where CS is contra-indicated e.g. no escort.

What complications could arise from CS, and how do you spot them?

DC When carried out in accordance with the IACSD Standards, CS is very safe and there are few serious potential complications. In the UK, CS for dental treatment has an excellent safety record. Midazolam (administered by any route) is associated with mild-moderate respiratory depression and so careful monitoring (using pulse oximetry), and prompt management are essential. ◆

David Craig MBE FDS RCSEd
Consultant, Honorary Senior Lecturer, Head of Sedation & Special Care Dentistry at Guy's & St Thomas' NHS Foundation Trust, King's College London Dental Institute and Visiting Professor at the University of Portsmouth. David has over 30 years' experience teaching conscious sedation techniques to undergraduate students, dental and medical practitioners and has served on dental and multidisciplinary groups preparing guidelines for safe sedation practice. He has held substantive appointments in oral surgery, anaesthesia and primary dental care.

Carole Boyle FDS RCSEng FDS RCSEd
Consultant and Honorary Senior Lecturer in Special Care Dentistry at Guy's & St Thomas' NHS Foundation Trust, King's College London Dental Institute. Carole has extensive clinical experience treating special care patients using both conscious sedation and general anaesthesia and in teaching sedation and special care dentistry to undergraduate and postgraduate students and DCPs.

Conscious sedation – An update for the dental team is a BDA Training Event coming up on Friday 9 November. To find out more, or to book a place, please visit **www.bda.org/events/sedation-update**

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Business Services Authority Dental Services claim and prescribing reviews

By Trevor Homewood

Trevor is a practice management consultant in the BDA's Business team. Trevor advises members on all aspects of NHS general dental regulations and agreements

We get many calls from members normally who are in a bit of a panic as out of the blue they have received a letter and review from either the Business Services Authority Dental Services (BSADS) or their local area team (LAT).

The BSADS continually monitor all contracts and the claims the providers and their performers submit. They continually review the provider's prescribing profile against other providers in the area and across England and Wales, and, when there appears to be an issue which might show high or low treatment prescribing figures, will write to seek clarification.

However, just because you are an outlier doesn't mean you are doing anything wrong, but you do need to know why you are different to the other providers in the area.

It's important that you start reviewing and auditing patients' notes and records. Often the issue becomes apparent very quickly and sometimes it's because someone isn't entering the codes correctly for the treatment they have provided. In the case of items like fissure sealant or fluoride varnish, it might be that the performer isn't doing it for some reason. Often it might be a software issue and the codes for the treatment you have provided are not listed on the treatment data set which is sent to the BSADS. It could be for a number of reasons including not claiming correctly or maybe seeing patients too frequently.

The secret it not to panic, but to begin an audit and review of your claiming profile. If it becomes clear you have unwittingly been claiming inappropriately, we would advise to own up and be honest – we all know the NHS rules and regulations are not very clear in some areas. Strictly speaking there are no codes for treatment under this contract. However, for ease of completing the patient's record and claims, software systems use the coding system from the pre-2006 contract for items of treatment which may often conflict with what you have actually done.

I often find that members can tell me why they claimed the way they did and when I ask if that reason is stated in the records they say no. The answer often given is that they don't have time. We encourage all members to find the time to complete full and comprehensive notes, as it could potentially be the difference between an investigation or not.

The situation presents a good time to review yours and your performer's knowledge of the NHS regulations and record-keeping. If you feel there is an issue in either area, we would suggest you put yourself or performers through formal training. This helps to demonstrate that you are being proactive and taking the concerns seriously.

The BSADS produce statistical information (vital signs) usually every three months which you can access on COMPAS. We would advise you to regularly review this to help identify any potential issues the system is presenting, such as a software glitch, lack of training or a performer not entering details correctly.

There are other reviews that the BSADS carry out such as 28-day review but the process you need to go through is much the same.

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You can read the BDA's NHS BSA Dental Activity Review advice sheet at: www.bda.org/dentists/advice/ba/Documents/NHS%20BSA%20Dental%20Activity%20Review.pdf

For further advice please contact the NHS and Business team for advice and guidance.

How PPE helps control infection in dental practice

By Harriet Purdie
Harriet is a practice management consultant in the BDA's Compliance team, helping members on all aspects of health and safety law, infection control requirements, practice inspections and compliance with professional regulations

Gloves? Check! Mask? Check! Eye protection? Check! Our donning of personal protective equipment (PPE) is often automatic, having been drummed into us early on in our training. However, as with all activities it is important to understand the reasons behind carrying out these everyday practices. At times, the regulatory burden can seem heavy but the dental practice does carry a real risk of the transfer of infections and strict adherence to PPE use is vital.

Employers have a duty to provide appropriate PPE for all team members and also to ensure it is being used correctly. Training on PPE should be included as part of regular infection control training and the requirement for its use should form part of all team members' employment contracts.

Infections can be transmitted by various routes, ranging from direct contact with blood or saliva to flying debris produced during procedures such as drilling and scaling.

The process by which cross-infection occurs involves:

- An adequate number of pathogens
- A source
- A mode of transmission, e.g. aerosol
- A method of entry, e.g. nasal passages
- A susceptible host.

Gloves

Hand contact is one of the main routes of cross-infection. A new pair of gloves must be used on each patient and disposed of as clinical waste after use. Gloves play an important role in protecting workers from exposure to blood borne viruses, especially where there is risk of an injury, such as a puncture wound with a contaminated sharp. In addition, they offer protection against infections passed by skin contact such as herpetic whitlow which is caused by Herpes Simplex Virus type 1 (HSV-1) and which may manifest in a patient by, for example, a cold sore or gingivostomatitis. This may be transferred to the fingers of the operator if gloves are not worn. The effects of a herpetic whitlow can be painful and debilitating and can last for several weeks.

Dental team members should be aware of the potential for cross infection if surfaces or non-clinical items are touched during and between treatments when wearing contaminated gloves. A 'no-touch' policy should be observed as far as is practicable, especially regarding touching equipment that is difficult to clean.

Eye protection

Eye protection is vital to protect against foreign bodies, splatter and aerosol. It should be worn by all patients in addition to team members carrying out clinical and decontamination duties. Eye infections can be caused by bacterial, viral and fungal agents. Infections can affect any part of the eyes, from the eyelids to the cornea, and even the retina at the back of the eye. As mentioned above, the Herpes Simplex Virus, presenting as a cold sore on a patient can be aerosolised during various treatments and, if this reaches the eyes of a team member can result in Herpes Simplex infection of the eye. If treated appropriately, most symptoms are self-limiting, however one in five cases go on to become more serious, which may include scarring of the cornea or permanent loss of vision. It is also important that eye protection is suitable and protects the eyes from debris or aerosol that may enter from the side, hence side shields should be present. Some patients prefer to wear their own eyewear. Often, this is not protective enough and patients should not be treated until full protection is obtained.

Masks

Masks have a bad reputation for quickly losing their efficiency when they become moist through the breathing of the wearer. Clinical staff sometimes report reluctance in wearing one due to the claustrophobic feeling it may give or the idea that it hinders effective communication with the patient. Is there any truth to the statements about their inefficacy? Well, yes and no! Most masks produce a poor facial seal and therefore do not protect the wearer effectively from aerosol inhalation however they do provide a barrier protection against splatter. The bottom line is that a mask is only as good as it fits. Therefore, they should be sealed well around the nose and tied or looped, so the mask remains as close to the face as possible. Masks do become less effective the damper they become. They should be changed after every patient and removed by touching only the ties or loops.

Additional methods

Whilst the above-mentioned PPE provides the most common forms of protection and reduction in infection transmission, there are some other ways of reducing risk further. The use of high volume aspiration can help to reduce the bacterial load in any generated aerosol. Further infection control protection may be gained by use of rubber dam. By isolating the tooth from the patient's saliva, the quantity of particles and pathogens entering the air in the first place will be reduced.

In order to prevent the spread of infection, all patients should be treated with universal precautions. This involves the understanding that every patient may be carrying an infectious disease.

Extra and Expert members can find out more about infection control by contacting the BDA's Health and Safety Team on 02075634572 or **advice.enquiries@bda.org**

The curse of overperformance

By Victoria Michell
Victoria is a practice management consultant in the BDA Practice Support Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and on practice and associate contracts

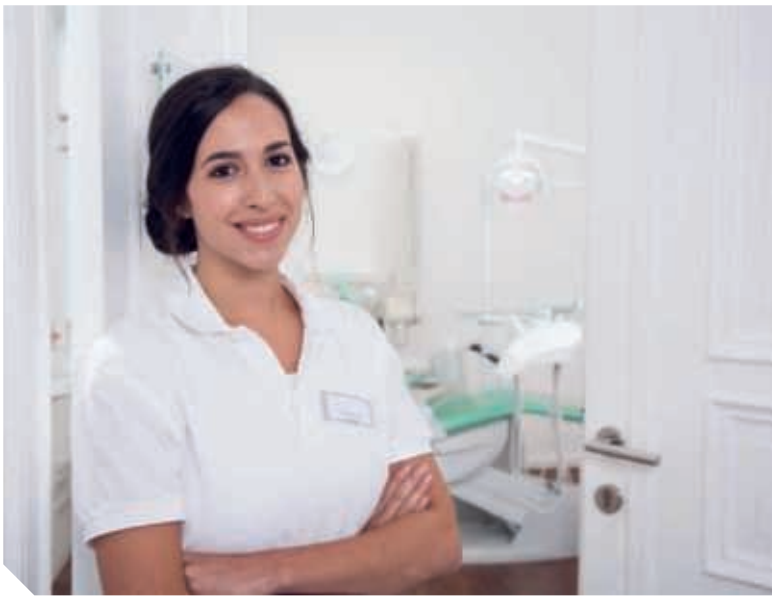
Each year June sees the publication of performance statistics for NHS practices in England and Wales by the BSA. A practice may have hit target, underperformed or overperformed and if it is either under or over performance then the local area team are likely to be in touch.

Overperformance does not carry the contractual sanction that underperformance can carry if the shortfall exceeds the permitted tolerance level. However, practices will not normally be paid for overperformance. In England overperformance of up to 2% of a practice's contractual target will be allowed to be carried over to offset against next year's UDAs, whereas in Wales this is 4% of a practice's contractual target.

NHS obligations

There is no contractual requirement to manage a practice's activity to ensure equal provision of services throughout the year however it is considered best practice. It is also the preference of NHS England to ensure they can meet the needs of the local population as they arise throughout the year. In addition to this, under clause 42 of the standard GDS contract practices are required to complete courses of treatment in a timely fashion and to treat urgent patients under clause 75. It is impossible to predict what treatment a patient will need before they come in for a check-up or how many urgent appointments a practice may fill each day. Therefore, the best a practice can muster is educated guess work as to both of these.

Practices do need to remember that they are under no obligation to work for free so where a practice runs out of activity it is not obliged to continue to treat patients other than those in a course of treatment. If a practice overperforms against their contract they will not get paid for this without explicit agreement in advance of the over-performance from their local NHS team, and therefore will effectively have been working for free where the overperformance exceeds 2% (or 4% in Wales).



Ideas for management

If a practice has overperformed against last year's contract, here are some ideas to help prevent this reoccurring this year.

Split the contract value into 12 and allocate the number of UDAs to each calendar month. If a practice knows that some periods may be busier than others, small adjustments can be made to reflect this. From this monthly allocation a practice can anticipate how many UDAs it should perform per day and from this how many NHS appointments it should offer each day. A small allowance should be made for urgent treatments. This is a good starting point and it is important, where practices are at risk of overperformance that reception staff and practitioners stick to this timetable. Avoid the temptation to book in additional appointments and make sure all the appointments are not booked up for check-ups but enough are left for completing courses of treatment.

Regularly monitor the practice's activity to check the figures and forecast are on track. Do this weekly or monthly, whatever is needed to keep the practice on track. Where issues arise with monthly overperformance address these quickly and make all the practice personnel aware of the need to watch activity and the risks associated with overperformance.

Year-end

If a practice is still at risk of overperformance as they approach year end there are certain approaches they can take. As with the rest of the year, a practice cannot turn away NHS patients seeking appointments. The practice should instead offer their next available NHS appointment. This is not the same as the practice's next available appointment. The next available NHS appointment is the next space in the diary where you can perform activity where you have allocation. For example, if all the practice's allocated NHS appointments are booked up for September, October and November, even if a practice has left NHS appointments to ensure they can see NHS patients in a course of treatment, the obligation is to offer the NHS patient (unless they are presenting as an urgent patient) the next check-up appointment which will be in December. At year end, if the practice has used up their allocation, the next available appointment will be the next contractual year. ◆

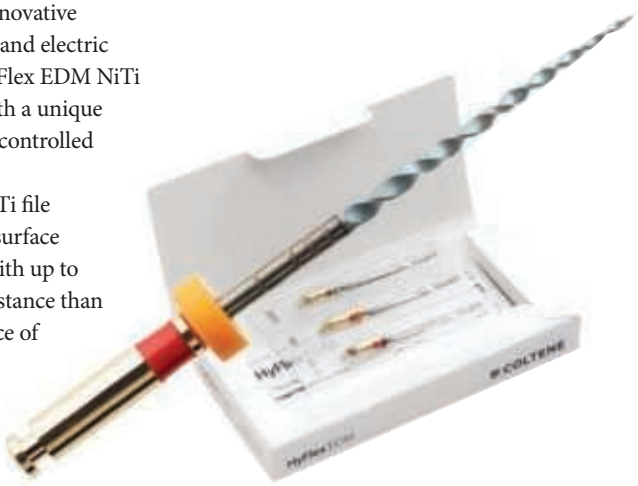
Shaping the future of endodontics

Innovation is the key to success, particularly in elevating an outstanding product into something exceptional. COLTENE's top priority has always been to offer customers state-of-the-art, ingenious products that will serve their needs. The 5th generation HyFlex EDM NiTi heat-treated files from COLTENE are equipped with a host of completely new properties for root canal shaping.

Manufactured using innovative manufacturing processes and electric discharge machining, HyFlex EDM NiTi files provide clinicians with a unique combination of strength, controlled memory and flexibility.

Every HyFlex EDM NiTi file has a specially hardened surface for unrivalled strength, with up to 700% higher fracture resistance than other files for greater peace of mind when conducting complicated root canal procedures. This reduces the number of files needed for cleaning and shaping, preserves root anatomy and ensures increased comfort for patients.

To treat complicated canal systems with safe, predictable and successful outcomes, discover more about the HyFlex EDM NiTi files by visiting www.coltene.com, email info.uk@coltene.com or call 01444 235486.



For 100% results

To help patients achieve a 100% healthy, gorgeous smile that they'll love, recommend the superduo of the CS 5460 manual toothbrush and CPS prime interdental brush from oral healthcare specialist, Curaprox.

Patients are often unaware of the dangers of plaque accumulation in the dental spaces, but with the right education and a little help from Curaprox, you'll be able to help them take their oral health to the next level.

CS 5460 toothbrushes are made using fine CUREN filaments for gentle, atraumatic and efficient cleaning, while the strong yet gentle interdental brushes are made using CURAL ultra-thin surgical wire to access even the smallest of interdental spaces.

To offer the superduo to your patients, contact Curaprox or direct them to shop.curaprox.co.uk/ where they can either purchase the superduo together in a handy pack or separately, should they wish to customise their products.

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

Don't be affected by the recruitment crisis

According to statistics released by the British Dental Association (BDA) in February of this year, 68% of NHS practices in England who attempted to recruit in the last year struggled to fill vacancies. Recruitment issues have been ongoing for some time now, but as Brexit edges closer and delays in processing performer numbers continue, there are concerns that the problem could worsen.

If you're struggling to recruit associates and dental care professionals to your practice, it might be worth contacting specialist recruitment agency, Dental Elite. With years of experience behind them, extensive knowledge of the market, and an unrivalled network of contacts, Dental Elite could be your best chance of filling a position during these difficult times.

To find out more about Dental Elite or to enlist the help of the expert team to find a suitable applicant with the relevant skills and experience, call or email today.

For more information on Dental Elite visit www.dentalelite.co.uk, email info@dentalelite.co.uk or call 01788 545 900.

A new treasure Nobel

Known for being a leader of innovation in implantology, Nobel Biocare has recently added a new string to its bow with the introduction of NobelPearl implants.

A soft tissue friendly implant solution, NobelPearl is a 100% metal-free, two piece ceramic implant with an internal cement-free locking mechanism that provides a unique alternative to titanium.

Geared towards aesthetic excellence, these implants help to support the natural soft tissue appearance and are especially useful for cases where patients may have a thin gingival biotype.

Furthermore, as the implants are made from zirconia they have been designed to encourage excellent soft tissue attachment and minimise inflammatory response, encouraging predictable results.

Combine these benefits with a low plaque affinity and natural looking aesthetics, and you can see why Nobel Biocare's new solution is a treasure well worth discovering.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com/pearl

The best place to work!

At Dental Partners, we talk a lot about being 'the best place to work', but what exactly do we mean?

We mean giving our clinicians the freedom to work in the way they want, with a wide choice of equipment and materials. We mean taking away the administrative and financial burdens of running a practice while providing access to a large pool of expertise, in terms of professional support, development and advice.

We know that work is only rewarding if there are opportunities to learn new skills and develop through internal and external training. We actively encourage our practice teams to pursue new challenges.

We believe that racial, religious, cultural and gender diversity strengthens our team, and we want our practice staff to reflect the communities it serves. We know that life is about more than work and actively support flexible working arrangements and family-friendly policies.

Find out more at www.dentalpartners.co.uk or email contact@dentalpartners.co.uk

An elite unit

Designed and manufactured in Italy using the latest technology and materials, the Puma ELI Ambidextrous is up there with some of dentistry's most elite dental chairs.

One of the features behind the chair's unique, popular design is its changeability. In just a few minutes the instrument set-up can be adjusted from right to left and *vice versa* so that both right and left handed users can practice comfortably in an operating style that best suits them. This helps to prevent the risk of debilitating musculoskeletal disorders and optimise the delivery of dental care.

The Puma ELI Ambidextrous also has a very simple to use control panel featuring a digital display that enhances control and management of instrument working parameters.

For more about the Puma ELI Ambidextrous visit us at www.rpadental.net or call the London and Manchester Sales and Service Centres on 08000 933 975.

'iSy' does it

iSy, the intelligent implant system from CAMLOG, is the perfect partner for CEREC, providing dentists with the ultimate in digital dentistry.

iSy is a complete implant system with high primary stability and the ability to provide fully digitised restorations. This intelligent approach to workflow provides dentists with superior time and cost efficiencies.

With CEREC, the scan adapter and scan body, purchased separately, are simply snapped onto the pre-mounted implant base; there is no need for a screwdriver during the digital impression. Some work steps are eliminated completely with iSy, while others are considerably simplified.

For those who prefer it (or 'this'), iSy restorations can be completed using an analogue workflow as well. With ultra-lean processes, one platform and one abutment shift, the workflows remain simple and the treatment period comparably short.

For ease of use, everything needed for a single implant surgery is contained within the iSy set, including a single-patient form drill, an implant with pre-mounted base, two multi-functional caps, a cover cap and a gingiva former.

For more information on the iSy implant system, visit www.isy-implant.co.uk or contact the exclusive UK and Ireland distributor, BioHorizons; email infouk@biohorizons.com or call 01344 752560.

Keeping their guard up

Dental trauma can occur in basketball just as often as in contact sports like rugby and boxing.

Make sure your patients are protected whenever they head to the courts with the Saber Protect mouth guard from CosTech Dental Laboratory.

Completely bespoke to the patient's oral cavity, Saber Protect is the proven way to help prevent and lessen the harmful effects of dental trauma for patients who play basketball and other limited contact sports.

Specifically designed to guard the mouth, lips, gums and head, Saber Protect mouth guards are moulded to reflect the sport that the patient plays, offering tailored protection no matter whether they are a beginner at school or a professional who plays for their career.

Each mouth guard shields against different impact levels, providing shock

absorbency in the places that most need protection. As such, you can guard your patients from harmful effects such as tooth avulsion and other potential injuries by providing them with a mouth guard they can really rely on!

For more information about CosTech Dental Laboratory, please visit www.costech.co.uk or call 01474 320076.

A glimpse into the future

'Trust Experience. Discover Excellence' was a fitting motto for the 2018 Ankylos Congress held in Berlin at the end of June. The event attracted more than 1,000 dental professionals from over 50 countries, who gathered to learn more about the Ankylos implant system which has been used to successfully provide 'front row smiles' for 17,000 patients.

Ankylos is a system with 33 years of implant heritage and long-term proven success, but this Congress looked forwards and not backwards, giving the assembled delegates a new vision, of modern protocols including digital dentistry and new product innovations.

Fresh scientific findings in implant dentistry formed the event's foundation, and this was perfectly blended with news of the industry's latest and most relevant trends, all presented by 40 renowned international guest speakers.

A diverse range of focus sessions, held on day 2, explored treatment options and enabled delegates to discover new techniques and hone their skills. Two-hour workshops, lectures and hands-on opportunities enabled clinicians and technicians to deepen their knowledge on topics relevant to their day-to-day work.

Of course, no implant congress would be complete without reference to the impact that digital dentistry is having on this treatment. 'Why digital? Why now?' was a short presentation by Mark Ludlow (USA), which brought the Congress to a close, and Mark reiterated the importance of lifelong learning in applying these new techniques to create faster, more predictable treatment.

The congress effectively managed to convey its central theme – how implant dentistry and a dedicated community with a focus on the digital future can create the best results for patients.

To find out more about the extensive range of implant solutions, materials and equipment, please visit dentsplysirona.com or call 01932 853 422.

You can also access a range of education resources, video tutorials, courses and CPD webinars at dentsplysirona.com/ukeducation.

Practice growth

MiSmile Network is the fastest growing network of Invisalign-focused GDPs in the UK which already has 60 independent practices under its umbrella 3 years after launch. The concept was born after Dr Sandeep Kumar recognised Invisalign' s direct-to-consumer marketing potential and value back in 2015; developing and implementing a highly targeted Invisalign lead generation and nurturing strategy. This transformed his seven Invisalign case submissions in 2007 to over 400 cases annually today. Asked so often about the secretes of his success he pioneered a system to help like-minded practitioners to emulate his success.

Fundamentally, The MiSmile Network offers practice growth based on four core pillars: lead generation, lead conversion, clinical confidence and profitability. Part of the offer includes an online tool called DenGro and which helps simplify the complex lead management process, and stimulate a greater number of case conversions.

Every member of The MiSmile Network has access to DenGro which automatically collects Invisalign leads generated from the Network's digital marketing activities and helps funnel and track them until each lead is in treatment. But it is not limited to the network, DenGro plugs into the practice website and digital marketing activity, automatically collecting and collating leads into one central dashboard, ready for anyone in the practice to follow up. The benefits of being fully automated, always accessible, and totally trackable allow practice owners to stay in control with a lead management tool that leaves other, more traditional methods, like Post-it Notes or computer spreadsheets, firmly stuck in the past.

The MiSmile Network provides a unique opportunity to be part of the a successful dental brand with a unique support business growth support model, whilst allowing dentists to lead, control and drive their clinical practice.

More information can be obtained by visiting mismile.co.uk or emailing leanne@mismile.co.uk.

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

Midlands

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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

East Anglia

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

South East

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

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Specialist Referral Centre In London
Mount Vernon Hospital, Gate 1, Rickmansworth Road
Northwood, Middx, HA6 2RN
Tel: 01923 840 571
Email: info@mvdentalspecialists.co.uk

Specialist in Periodontology: Dr Zanaboni, Dr Stern
Specialist in Prosthodontics: Dr Yerbury
Specialist in Endodontics: Dr Ardeshna
Special Interest in Periodontics: Dr Jagdev

Interests: Prosthodontics, Restorative and Implants Dentistry, Implant complications, Aesthetic Dentistry, Endodontics, Periodontics, Hygienist, OPG

302373

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

J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

Childrens Dentistry
82 Berners Street, Ipswich, Suffolk, IP1 3LU
Tel: 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Consultant Orthodontist
Dentist with special interest in Periodontology
Clinical Psychologist
Specialist Prosthodontist for adults
Endodontist, including implants

301883

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

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

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

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

Branches and Sections

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British Dental Association

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bda.org/branchesandsections

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In Practice CPD

Q1: How much overperformance of a practice's contractual target is allowed to be carried over in England?

A 2%
B 4%
C 6%
D 8%

Q1: How much overperformance of a practice's contractual target is allowed to be carried over in Wales?

A 2%
B 4%
C 6%
D 8%

Q3: Which virus is known to cause Herpetic Whitlow?

A HSV-1
B HSV-2
C HSV-3
D It's unknown

Q4: How often does BSADS produce vital signs on COMPAS?

A Every month
B Every two months
C Every three months
D Every four months

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.

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Need help?

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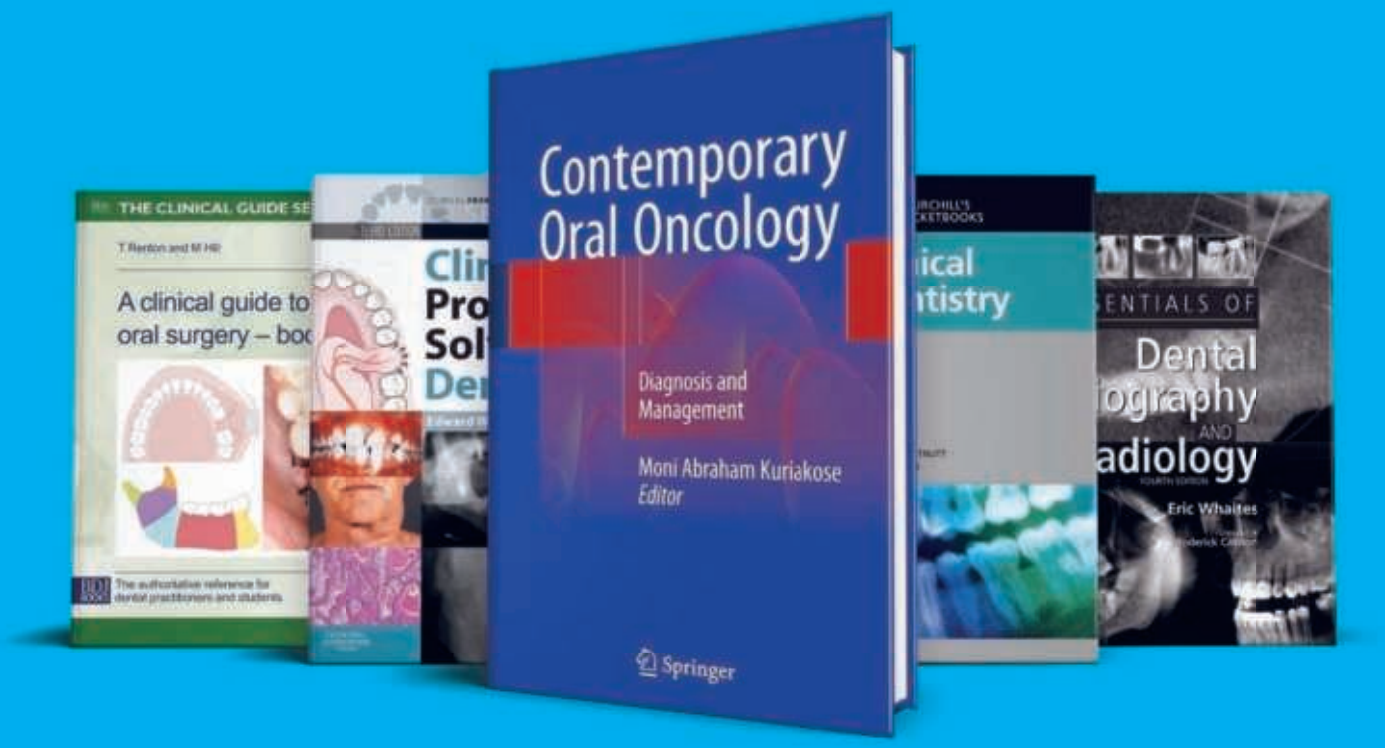
British Dental Association



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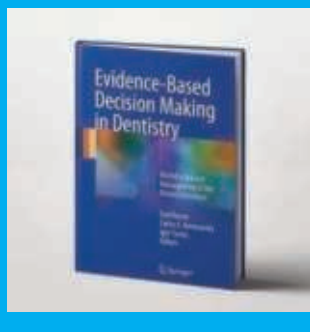

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