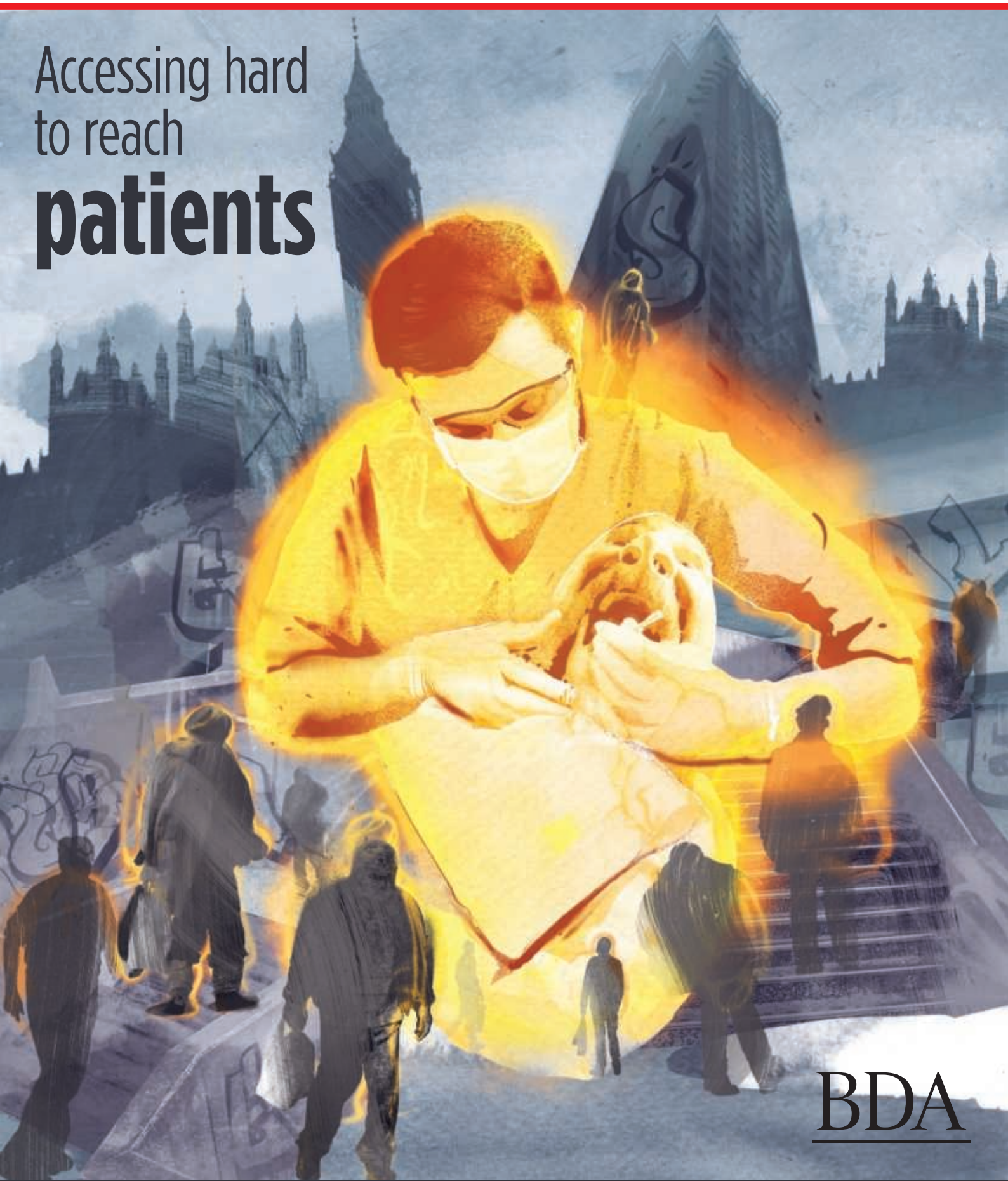
BDJ InPractice
December 2016

Accessing hard to reach **patients**



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BDJ InPractice

DECEMBER 2016

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To contact the **Advertisement Office:** Tel: 020 7843 4729. To contact the **Editorial Office:** 64 Wimpole Street, London W1G 8YS. Tel: 020 7935 0875. Fax: 020 7487 5232. E-mail: bdjinpractice@bda.org. Web: www.bda.org/bdjinpracticeonline. Published for the **British Dental Association** by: Springer Nature, The Campus, 4 Crinan Street, London N1 9XW.

 ISSN 2057-3308.

BDA

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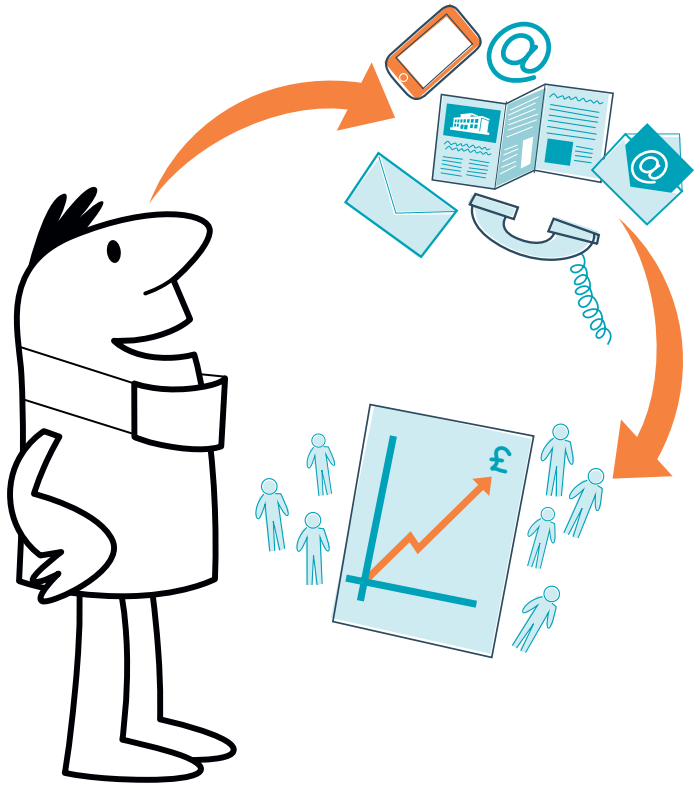

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COLUMN

X-rays and x-rated

Judith Husband, Chair of the BDA's Education, Ethics and the Dental Team Working Group

Unless you have been fortunate enough to secure a ticket on the first passenger ticket into space, it's highly unlikely you missed the news regarding childhood migrants and the use of x-rays to establish their age.

Monmouth MP David Davies had suggested the 'simple' tests would 'reassure' people regarding the migrants' ages. A number of the tabloid press had also run sceptical articles regarding the age of the migrants.

> 'The level of accuracy in these tests changes dramatically with age. X-rays can be used to estimate the age range of younger children much more accurately than in adolescents.'

The emotive response this elicited was quite something. The idea of using x-rays turned social media channels x-rated, showing just how passionate the UK now feels on topics akin to this.

Remove the hyperbole, the emotion and the inaccuracies and you're left with one outcome; dental x-rays are simply not a reliable way of establishing age accurately in older children. No two mouths are alike. I'll add my own to that list, as I still sport two of my baby teeth.

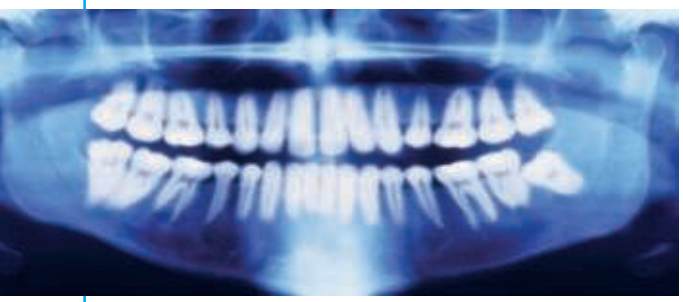
The level of accuracy in these tests changes dramatically with age. X-rays can be used to estimate the age range of younger children much more accurately than in adolescents. As children mature at different rates, the potential margin of error gets ever larger with age. Often we are relying on just third molar development in this age group and we all know third molars erupt at significantly different rates. Some people failed to grasp the difference between what happens chronologically and biologically.

Moving away from accuracy, the ethical debate also stacks up against the idea. Perhaps Mr Davies had an oversight on the fact we are not allowed to irradiate people without good reason, and the issue we refer to as consent. Perhaps.

It is churlish and an insult to our profession that an MP would suggest dispensing with these fundamentals of practising in order to be seen to be doing something. It is unlikely any migrant arriving from Calais would understand the nature of the procedure, its significance, impact and potential consequences before signing up to it, or have someone consent on their behalf.

The Ionising Radiation (Medical Exposure) Regulations are there to protect patients from unintended, excessive or incorrect medical exposures, and if used the benefit of doing so must outweigh the risk. Given the inaccuracies already established, this clearly is not the case in this situation.

It is pleasing that, given ministers have flirted with this idea for the best part of a decade, this idea is now firmly off the shelf. It has been our role as a profession to ensure we adhere to our codes of practice and forcefully challenge an idea that cannot deliver, and should it be brought into the public limelight again, it will be our collective responsibility to ensure we respond in the same manner. ◆



LETTER TO THE EDITOR

Alleviating concerns

Sir, We were very gratified by the positive response of your two reviewers of the Easy IOTN app produced by the British Orthodontic Society[1]. Two issues were raised, however, which might have given a misleading impression and we would like to expand upon them.

Firstly, on the issue of patient confidentiality, we were at pains from the outset to ensure that there could be no possible breach of security of patient data. This was fundamental to the brief due to professional ethics and on a practical level, was essential in order to gain a listing on the Apple Store.

At no stage is the app connected to a network and the image is permanently deleted from the cache once the app is closed. Since the image cannot be stored or downloaded to the device, the accidental sharing of the image is precluded and this is considered to provide robust data security.

Regarding cross infection control, routine use of dental cameras is now part of contemporary clinical practice. Photographic hardware is not autoclaved or disinfected, therefore the use of a smart-device in a similar manner is not considered to pose a cross-infection issue providing routine procedures are followed.

Easy IOTN will continue to evolve and changes will be made in response to feedback (which is welcomed). But readers of *BDJ In Practice* can rest assured that regulatory and risk management aspects have been and will continue to be an utmost priority. ◆

S.J. Cunningham
G. Deeming
Via email

1. Westgarth D. Easy as IOTN. *BDJ In Practice* 2016; **11:** 21-22.

Dramatic improvement in children's teeth but Scotland still lags behind

The BDA is pleased to see children's dental health in Scotland improve by 24% since 2000, with new data that show 69% of 5-year-olds have no obvious signs of tooth decay.

The BDA welcomes the progress made but is disappointed that the figures from the National Dental Inspection Programme also reveal a huge gap between 5-year olds from more affluent areas and the lowest income households. Only 55% from the most deprived areas are free from tooth decay compared with 82% from the least deprived.

Despite the overall improvement in children's dental health, Scotland still lags behind countries of similar development, such as England and Norway. Comparable figures show that 75% of 5-year olds in England are decay-free, with broadly similar figures for Norway (73-86%).

©Tara Moore/Getty Images Plus

Robert Donald, Chair of the BDA's Scottish Dental Practice Committee, said: 'Scotland is leading the way in investing in children's dental health. The huge improvement we have seen in youngsters' teeth since the millennium is testament to investing in an early years' prevention scheme, which operates in our nurseries and schools. Undoubtedly ChildSmile has saved many young children from distress, days out of education, and ultimately avoidable dental treatment.

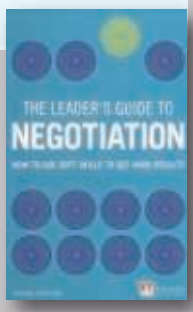
'However, despite this improvement Scotland is still playing catch-up with our neighbour south of the border, so there is no scope for standing still. There is no escaping either the fact that far too many children from our most disadvantaged communities still bear the burden of tooth decay, a largely preventable disease.

'Government ministers must continue to invest in ChildSmile, to tackle this unacceptable inequality in dental health. The BDA has also called on the Scottish government to expand the ChildSmile programme to 5 to 12-year-olds and we have championed wide-ranging action on sugar, including taxation, public education and marketing, and for proceeds from the sugar levy to be directed to oral health initiatives.'

BOOK REVIEW

Good cop bad cop

The leaders guide to negotiation - how to use soft skills to get hard results
Simon Horton
FT Publishing, 2016
ISBN: 978-1-29211-280-0
£16.99



The latest title in the excellent FT Publishing 'Leader's Guide' series is written by Simon Horton, a world-leading negotiation expert and a visiting lecturer at Imperial College, London. Even the most cursory glance will reveal that this is a well-constructed paperback and at over two hundred and fifty pages and with a reassuringly comprehensive subject index, Horton has most definitely done his homework. From the very start Horton defines what he understands to mean by the term 'negotiation'. This, he observes, is the first part of a bigger process and ideally should be followed by reaching an agreement and then implementing action. It is this last stage which is the most important. Negotiation is simply a means to the desired end.

Throughout the text, Horton provides some genuinely critical illustrations of various outcomes. The 'win-win' result is offered in surely what was the ultimate negotiation outcome, when describing the Kruschev-Kennedy 1962 Cuban missile crisis talks, which luckily for the whole world, succeeded. He also gives examples of multipartite negotiations such as the Northern Ireland peace process.

Another key element to successful negotiation is preparation. Horton cites the example of Richard Branson carefully researching the seller of Necker Island and thus managing to purchase it at a preferential price because he already knew the current owner had sizeable financial issues. This pre-preparation also includes discovering in advance what exactly are the other party's motives and aspirations. This is a case of knowing thy enemy sometimes better than they know themselves which in turn affords an invaluable leverage position in negotiations.

Then there is also the instrument of rapport which can strategically change negotiation results as demonstrated in the example of Ronald Reagan effectively ending the cold war by – sensing the summit with Soviet Union President Gorbachev was not going as planned - simply restarting it by saying 'My name is Ron, can I call you Mikhael?' This equally plain-speaking book is studded with such memorable examples and thereby offers the reader a true insight into how to negotiate and win. ◆

PENSION NEWS

Updates on pensions

Online pension benefit statements

NHS Pension Scheme members can get online personalised statements in the form of a Total Reward Statement, which summarises their pension benefits.

Scheme members need to register to use the system via the Government Gateway portal. Once they have done this they be sent a user ID and activation code. Some scheme members, however, will not be able to access their full details online if they have purchased added years, additional pension or AVCs or if they have moved between working as a practitioner and an employed officer in the hospital or community dental services. In this case a paper statement is available.

For further information please visit www.nhsbsa.nhs.uk/TRS.aspx. Alternatively NHS Pensions can be contacted on 0300 3301 346.

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Lifetime allowance

On 6 April this year, the lifetime allowance for pension savings reduced to £1m. If you had £1m or over in your pension savings on that date you will be may be affected by the change, but you can apply for HMRC protection.

If you had savings of over £1.25m at 6 April 2014, when the allowance was last reduced) you can still apply for *Individual Protection 2014* up to July 2017.

Visit www.gov.uk Pension schemes: protect your lifetime allowance – for further information.

Lifetime allowance enhanced protection 'affected by 2015 NHS scheme'

The government's rules on the lifetime allowance for pension savings has affected the transitional arrangements for the NHS pension scheme

Those who obtained enhanced protection (savings over £1.25m) for their NHS Pension benefits in 2006/2007 but either have tapered or no protection from moving to the 2015 NHS pension scheme (i.e. they were born after 1 April 1962) will be at risk of losing their enhanced protection once they move to the 2015 scheme.

As the 2015 Scheme is considered to be a new pension scheme – despite objections by the BDA and other NHS unions – NHS dentists that move to it (even though it is not voluntary) cannot keep their enhanced protection for earlier benefits.

If you are affected by this you will need to seek urgent independent financial advice. ◆

PENSION NEWS

Pensions choice 2 in Northern Ireland

Further to the impact of Pension Reform, particularly on retirement age, Choice 2 – members of the 1995 section of the HSC Pension Scheme were given an option to move their accrued benefits to the 2008 section of the scheme – is again being offered to active members who are affected by a change in their retirement age. Letters have been issued to the affected members and further information and guidance is available on the scheme website.

To be eligible for Choice 2 a member must:

- Have been an active member of the 1995 Section of the HSC Pension Scheme on 31 March 2015 and
- Have Tapered Protection or no protection. ◆

BOOK REVIEW

Delivering change management

The little black book of change: the 7 fundamental shifts for change management that delivers
Paul Adams and Mike Straw
Capstone, 2016
ISBN: 978-1-119-20931-7
£12.99

According to the authors of this short hardback, the concept of change management is almost an oxymoron. Delivering extraordinary results often derives from serendipitous events and these results are therefore not at all predictable. Part of the essence of effective change is to understand the context or environment of the workplace.

All based on real, not theoretical, examples, the successive hundred pages go on to outline seven context shifts within seven chapters. The first stage is letting go of the past, which means abandoning the 'normalised' position. It also means thinking about what the ultimate or ideal vision of the business is, even if this seems unachievable, and this is consolidated in shift two's 'developing breakthrough ambition'. The next stage is to create a bold new vision of the future whilst shift four involves engaging the players (ie staff) in the bold new future. A good example here is of a failing hospital operating theatre team learning from the methods of a Formula 1 pit stop crew with astonishingly successful results. Shift five, possibly the most interesting, concerns cutting through a company's 'DNA'. This essentially is a questioning of the culture of 'we always did it like this'. The final two shifts are focused on keeping the organisation future-focused and finally, gaining energy from setbacks, which should be embraced since they demonstrate the limits of the company's current thinking. In offering insightful explanations of how to shift an organisation's thinking and behaviour, and despite its brevity, this extremely readable little black book is actually worth its weight in gold. ◆

A problem not close to home

By David Westgarth,
Editor, *BDJ In Practice*

When I've sat down to interview someone, I've often discovered there's a fairly significant change in demeanour, in attitude and in tone when access is brought up. Some believe it is better than ever, some say it's no better now than it was prior to the introduction of the contract. Either way, it can elicit an emotive response.

The same can be said of when you're walking down the street and you see someone huddled up on the floor asking for help. Some people walk on by, some people stop to offer something.

According to Crisis, there is no national figure for how many people are homeless across the UK. Although many people associate homelessness with rough sleeping, which does have a national figure, the sheer volume of 'hidden homeless' is just too vast and difficult to monitor. Sleeping rough has doubled in the last five years. There is greater demand than ever before for hostel beds yet there are fewer available.

So, as a profession, how do we reach out to a group of patients that even statistics can't find?

Smile4Life suggests a three-tiered approach to providing dental care for those experiencing homelessness; the provision of emergency care services, one-off access to a dentist and comprehensive dentistry, should it be desired. For some homeless patients, gaining access to dental treatment will only be a consideration when there is active pain. Competing priorities place health towards the bottom of the ladder. The basics we probably take for granted – food, warmth, shelter – that enable us to place health at the forefront of our minds is a luxury those experiencing homelessness do not have. For those people who are homeless and would like to attend a dentist routinely, uncertainty around what they are entitled to, competing priorities and access have all been identified as barriers to accessing services.

All of this is set against a backdrop of savage funding cuts, not just to dentistry, but across the board. Martin Burrows, Project Manager at Groundswell, believes this is one reason why dental professionals need to step up.

'We run a health peer advocacy service that offers those currently experiencing homelessness the opportunity to get to health appointments with the help of someone who has previously been in the same situation. The fight for funding from Clinical Commissioning Groups is getting tougher and it leaves less room for innovation.

'This is a problem on its own, but drug and substance misuse interventions, alcohol misuse interventions and mental health services – to name but a few – are all having their funding cut. People who find themselves homeless are often at the extreme end of social exclusion. All safety nets in place to catch them – i.e. the services having their funding cut – have failed them. It leaves them with an air of distrust and a lack of understanding of how to navigate the system.

'The system – healthcare professionals are part of the system, but a larger issue is that 'the system' for accessing healthcare/dentistry can be longwinded, complicated, formal – and when at a point of crisis in people's lives that can make healthcare completely inaccessible. Peer advocates provide an intermediary that can make accessing healthcare more effective.'

Janine Doughty, Academic Clinical Fellow in Special Care Dentistry at the Eastman Dental Hospital, believes a degree of flexibility is required amongst those dedicated to treating the homeless.

'It is well-documented that there is a propensity for those experiencing homelessness to miss appointments due to chaotic lifestyles, but I believe there needs to be greater understanding that this can happen. It is of little use if dental professionals have no flexibility.

> 'For some homeless patients, gaining access to dental treatment will only be a consideration when there is active pain.'

'In my experience, despite initial enthusiasm for rehabilitative dentistry, with multiple-appointment treatment plans attendance would dwindle. Much of my experience in providing care for the homeless was based on mobile dental units in locations convenient for the patient group. On days when the mobile unit was out of action, the service was transferred to a fixed-site clinic within easy walking distance, unfortunately very few patients were willing to attend the clinic and this resulted in multiple missed appointments. Careful timing of appointments or adopting a flexible 'drop in' working style was absolutely essential. At some locations breakfast would be served from 7am and an early start increased the number of patients who attended at that site. In other locations patients would collect their methadone at a specific time of day and would begin to become anxious if they were worried that they might be unable to collect their dose. Other challenges included frequent loss of dentures, uncertainty around claimant status and patients attending appointments under the influence of alcohol or drugs.

'Moving forward, input is required at all levels from downstream individual education and engagement of dental professionals, grass roots initiatives and local ownership of projects tailored to meet the needs of the community, right through to shaping the environment to facilitate health promotion and developing public policy to support those with the greatest need for dental care.'

Is it too easy to point to money as the problem? Is it the root of all evil? It would appear that there are simply too many vulnerable patient groups competing for the same pot – funding commissioned to community dental services to provide care for the homeless, the elderly, those with learning disabilities and those who are medically compromised. Should there be prioritisation of funding? Perhaps if there was an impetus to include more outreach programmes and oral health promotion projects in undergraduate and dental core training we would have an active, engaged and enthusiastic young workforce who could be the initiators of projects to engage socially excluded patients. If more research is targeted at ways to improve sustained engagement with these groups, then naturally, funding will follow.

'In order to address the unequal distribution of oral disease, not only amongst the homeless but also amongst other socially excluded groups including vulnerable migrants, sex-workers and travellers, a multi-professional and multi-faceted approach is essential', Janine said.

'After visiting successful homeless centres providing dental care in Boston and Copenhagen, I've experienced first-hand how successful a multi-professional model can be.

'These centres combined health services, hostel accommodation and social space with a flexible approach to appointments, same-day inter-professional referrals (e.g. Nurse, GP, psychiatry) and a supportive environment. It's a model that works, and something we should be looking to follow.'

In 2009, Revive Dental Care in Salford was awarded an access contract by Manchester PCT. Led by Dr Ben Atkins, half of the patients through the service were to be access patients from the Out of Hours telephone triage service and the remaining half for continuing care. The service, based in a multi discipline health centre in central Manchester, was – and still is – the first of its kind in the area. It's an example of getting the system right and patients following – the premise of Janine's argument.

'Dental care for homeless people is as essential as it is complex', Ben said. 'Homeless people have similar levels of dental disease to the housed population but with much higher levels of untreated disease. Patients from different centres have different levels of disease, from Dickensian decay to a patient needing a few fillings. It's a stable but hardcore group of people. It might sound like an impossible task treating these hard to reach patients, but the basics stay the same; it's about behaviour change. Patients often take their anti-psychotic medication inappropriately and relapse into opioid usage. Patients often reported a reduction in ability to eat associated with painful oral conditions. We can intervene. It's a case of understanding.

'What you often find is patients develop a problem and don't know where to go. To deal with the pain, their alcohol intake or their drug use increases. The problem doesn't go away. The pain increases over time. Their substance misuse increases. It's a vicious circle.'

Challenges

Like many aspects of the profession, success does not come without its challenges. And like much of the general population, signposting to dental availability – or the lack of – played a huge role in the work Revive did.

'Many of the service users simply did not know how to access emergency or regular dental care', Ben said. 'Rather like children with severe dental decay, most users simply attend A&E, usually for acute swellings rather than pain as self-medication often controlled their pain.

'Working with the care groups to fast track these patients has been a real success. If a service user attends one of the shelters in pain, the shelter can contact Revive Dental Care who co-ordinate getting the client to the clinic for treatment. The patients are seen that day and their treatment is completed.

'However we discovered transport for some patients is an issue. Depending on the patient's circumstances they would often make their own way to the clinic. From our point of view it really helped the dental practices concerned to know the situation of the patient, as the dentist would take multiple teeth out at the visit rather than just curing individuals presenting condition, thus reducing the risk of pain later on.'

Louisa Rose, Dental Core Trainee in Paediatric Community Dental Public Health pointed out a different challenge she encounters.

'Fear is an often overlooked reason why many hard to reach patients do not regularly attend dental services. Similarly, negative experiences, pain or poor knowledge of how to access services may all contribute to a lack of engagement. Whilst this can be overcome with acclimatisation and time, it can be difficult to access and retain this cohort to the completion of treatment.

'Homeless patients should not be treated any differently. A knowledge and understanding of their circumstances and priorities is important in establishing an essential trusting relationship. Appropriate clinical care options should be provided on a flexible basis in order to ensure patient-centred care. The provision of access services is important in allowing a gateway for this cohort to access health care services and address the rising issue of dental pain.

Communication

As Dr Atkins has alluded to, many of the basic challenges faced by the profession accessing hard to reach patients are also issues faced when treating the general population. There's perhaps no greater example of this than communication.

'It's something we see all the time', he added. 'There is so much confusion as to eligibility to free or subsidised care. This is especially a problem with asylum seekers and English is not their first language. This is a growing problem and has knock-on effects surrounding consent, treatment and offering basic oral hygiene advice. It also means they don't know where or how to access benefits.

'We also discovered patients with

psychological issues often found it difficult to hold a conversation for a prolonged period of time. For some patients this was enough to stop accessing dental services for pain relief. Cuts to other services severely hamper our attempts to offer a basic healthcare right.'

As far as Martin is concerned, this is one of the most important points.

'It is not just one-to-one communication that is an issue. There is a huge problem with text messages and letters as methods of notifying people. Homeless people might change numbers regularly and not have a fixed abode. It's also written information and forms to fill out to register. Low literacy levels are common and if someone is at a point of crisis the ability to digest information can be limited, making filling out forms a real challenge.

'A point for receptionists to take on is that you might have to go the extra mile to fill out a form with someone, dentists need to make sure they explain things more thoroughly. This is one of the functions our advocates often have to do.'

> 'The provision of access services is important in allowing a gateway for this cohort to access health care services and address the rising issue of dental pain.'

Providing an opportunity

'Anyone who tells you there isn't a stigma surrounding homeless people probably isn't being 100% truthful', Martin said. 'We see it all the time. Many of our advocates who have turned their lives around are in a position to not only listen, but to see what people want from their healthcare and to support them to get it. They are not trained to give advice, particularly medical. What they can offer is a 'role model' – a bit of inspiration to say to our clients that there is a route out of homelessness.

'What they do have is a familiarity with how the healthcare system works and can help people to navigate it. By knowing these things an advocate can add 'weight' to a person's voice.

'For example, we have a continued problem with GPs and dentists asking to see a patient's ID or evidence of their fixed address. We have even had some not register patients because of their immigration status. The reality is none of these three issues should be barriers to registering a patient. Those experiencing homelessness might not have ID nor a fixed address. It's great that we have people to fight their corner.'

Fig.1 Number of procedures performed

Procedure	Number of procedures performed
Dental consultation	439 **12% increase**
Scale and polish	206
Oral hygiene instruction	280
Permanent fillings	211
Extractions	129
Fluoride varnish application	148

Attitude isn't confined to those on the receiving end of the service. Refusal and rejection from practices may be financially-motivated, but some issues persist. Out of 3,000 appointments Groundswell helps to facilitate every year, around 10% of those are dentistry-related. Martin described one particular story highlighting how their peer-led programme can and does work.

'We were working in a hostel where a big issue for a number of clients was significant dental issues. There was a NHS dentist across the road but they weren't accepting patients. We discovered the surgery was paid per appointment, and given the client group was particularly chaotic, it was challenging to keep appointments booked weeks ahead. There was an attendance rate of 40%, which was the basis for the dentist's ban.

'You can understand their stance to a degree, but there does have to be more understanding of the problems a homeless patient experiences. Given the severity of the problems, we arranged regular 'unnamed appointments', whereby clients would be accompanied straight to the dentist. We achieved a 100% attendance rate over a six-month period, and in one particular client's case, solving tooth pain was instrumental in stopping one client drinking. They have now resettled and are in work.'

Janine, Deputy Service Co-ordinator at Crisis for Christmas, paints a similar story of professional engagement.

'From my experiences with Crisis at Christmas, I have encountered nothing but enthusiasm from dentists who have been willing to donate their skills and time over the festive season to provide much needed care to the homeless population in London.

'Every year we are inundated with applications from dentists wanting to be involved and to make a difference to a grossly underserved population. If there were more avenues available for dentists to easily contribute their time throughout the year, not only at Christmas, we as a profession could go a long way toward improving the oral health of the homeless population.

'For many of those patients, this is the single dental contact that they have throughout the year. Of course we could do better. There is some funding for homeless dental services, perhaps not enough, but are we fully utilising our trainee dental workforce and using our initiative to its full potential to develop grass roots, volunteer-based projects that run throughout the year.'

Do we know what they need?

Bearing in mind some of the issues presented, there are fair assumptions to be made about what treatment patients need. In 2015, Crisis at Christmas performed more than 400 dental consultations alone, a 12% increase on the previous year (fig.1).

Rob Edgar, Project Worker at Groundswell, wonders if the right dental treatment is being given to the right patient.

He said: 'My approach as an advocate is to respect their wishes, for better or for worse. Motivational preferences will differ from patient to patient, but what is constant is the system. It is not designed to be pro-active. Having sat on both sides of the fence, I know how much bureaucracy there is involved with treating patients from this background.

'What concerns me the most is whether patients are getting the right treatment or not. Dentures are not suitable for everyone, likewise implants. Is giving someone basic functionality knowing they may well need to come in a number of times a year the right thing to do? When you take into account the barriers of getting patients to the practice in the first place, are you then placing unrealistic expectations on them returning? We have also had occasions when dentures have been lost, which is far from cost effective.

'What we need is a joined up approach to ensure time is being used properly.'

The differences in patient wishes and expectations is something Janine has also experienced.

'After interviewing service users, each is at a different rehabilitation point', she said. 'Some may not want to engage, some may need pain relief, others need new smiles and are willing to engage. Understanding where patients are in their journey is a key factor and a skill to be a guide for these patients. Toothache might be the reason the patient relapses into drug use, and often is. It might not be the dentist who can spot which patient is ready to engage. It is a team approach.

'It should spread further than the dental team. Creating links with allied medical services such as podiatry, TB screening, needle exchange and others to create fluid, flexible, regular one-stop-shops for health care needs may make managing multiple appointments less challenging and increase uptake of a range of medical services.'

'We have to deliver these services against a backdrop of not only cuts but expectations' Martin said. 'It's a difficult balance to strike. Our service works. The 'did not attend' statistics are in line with the general population. Our patients with good, strong advocate relationships are consistently showing improvements. They are attending their appointments and keeping to them over a period of time. It's these examples we hope will become advocates in the future.'

The future

It's entirely possible that homelessness will continue to increase. Global financial pressures continue to be a significant source of household stress. An ageing population means the type of dentistry the profession is providing is changing. With this potentially older homeless population, the provision of services must adapt to meet this need. Louisa explained: 'Dentistry needs to be delivered to these patients in targeted areas most in need, with an emphasis on prevention. Dental care professionals need to ensure that they utilise every opportunity and interaction with this cohort to improve general health outcomes, as well as dental health. The 'Making Every Contact Count (MECC)' approach should be utilised to signpost this cohort to as many health care services required in order to improve integration and engagement with the health service over a sustained period of time.

'There is variation in the demographics of homeless people, which is ever expanding. Dental services need to adapt to meet their needs, which may include an increase in the provision of care.'

Rob added: 'There are a number of projects in the pipeline looking at how those experiencing homelessness view oral health. The beauty of our research is how organic it is – we involve those experiencing homelessness throughout the process. If we have a better understanding, we can work with healthcare services to improve the pathway for patients.

'We're seeing the number of hostel beds being cut. We know single men experiencing homelessness aren't as much of a priority as families. We know the process of applying for temporary accommodation is harder than it should be. All of this is before patients even consider their health. It's our job to find out how we can help.'

'The profession can lead here', according to Ben. 'I work on the premise of 'who stole my cheese?' It's a book about coping with change. Cheese is a metaphor for what you want to have in life. It's not an easy thing to say but there is a feeling that too many people within the profession have their lot and are happy with it. That's fair enough, but we should be asking 'where is the decay?' We should be seeking it out to eradicate it.

'I firmly believe the future of treating patients experiencing homelessness relies upon a change in attitude. My cheese keeps moving, and that keeps me motivated.' ◆

'Dental care professionals need to ensure that they utilise every opportunity and interaction with this cohort to improve general health outcomes.'

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Refugee dentists – a difficult story

The BDA has supported refugee dentists for many years. From informal advice throughout the years, a more concerted effort was developed in the early 2000s when the BDA chaired a Refugee Dentist Group, bringing together professionals, government and NGOs, and looking at the different issues affecting this particular group of migrant dentists. The group later merged with the BMA's refugee doctors' group to form the Refugee Doctor and Dentist Liaison Group, as refugee healthcare professionals are served by the same support organisations.

Refugees do not usually have a choice of where they find their safe haven, and have to start anew wherever they have been registered as an asylum seeker. Only once the Home Office has considered their case and agreed that they can be granted refugee status can they really start to rebuild their life, and this can take months and in some cases, years.

The war in Syria has resulted in millions of humans leaving the country, and the BDA has seen a clear increase in contacts with Syrian refugee dentists. In previous years, refugee dentists may have come from Iran, Iraq, the former Yugoslavia, the Democratic Republic of Congo, or the Yemen; and there is a long history of people seeking refuge here, including during the Second World War.

The system in which refugee dentists have to find their footing is not an easy one. The road to registration and work is the same as for any other non-EU-qualified dentist, but most refugee dentists have no funding beyond that received from the government and possibly from support organisations, and the courses and exams they need to take are expensive and time-consuming.

Language requirements

Of course those practising in healthcare must be able to speak English at a standard necessary to communicate properly with patients and fellow professionals. Achieving the required standard (currently an academic IELTS certificate at level 7) is by no means easy, however, preparation courses cost significant amounts of money unless the individual has access to a free course, and it is not unusual to need more than one attempt.

Professional exams

Once a refugee dentist has reached the required IELTS level, they can apply to sit the GDC's Overseas Registration Exam (ORE). The exam is in two parts, one theoretical, one practical, and the total cost for both parts is £3,735 (£806 + £2,929) – a prohibitive cost for many. Financial support for fees is difficult to obtain given the risk of failure to pass at the first attempt.

The Royal College of Surgeons of England provides a separate registration exam, the Licence for Dental Practice. The curriculum mirrors that of the ORE and the prices are slightly, but not significantly, lower. There are not many sittings.

The BDA provides learning materials – journals, books, advice sheets as outlined in the recommended reading list for the exam. Getting the right paperwork together for the application itself may also be tricky, as refugees may have had to leave their paperwork in their country of origin and might not be able to ask for certified copies, for fear of persecution. The GDC and other authorities do have procedures for this eventuality.

VT/DFT equivalence

Having achieved high level language competence and registration with the GDC, maybe the biggest hurdle for a successful professional life in the UK lies in the need to undertake further training to be allowed to work in NHS general dental practice. Limited NHS budgets and UDAs, as well as competition in the job market, means that some refugee dentists who have ticked all the other boxes find themselves stuck without this necessary training and experience, especially if they are based in England. We have had reports of refugee dentists being exploited by practices which profited from training them, with high-hour-low-payment contracts and bind-in clauses that would not

be possible if the individuals were not so dependent on a successful training period in that given practice, and on the reference provided afterwards. It is sad to see that such exploitation should be happening in the dental profession, when what is needed is support for colleagues who will eventually be able to contribute to patient care.

It is also sad to see that a number of refugee support organisations have recently stopped working with refugee dentists (while continuing to support doctors), because of the uncertainty of ever finding a VT/DFT equivalence training post that will take them to the proper and hard-earned start of professional life in the UK.

BDA activity

The BDA has long provided free membership for dentists with refugee status; at the moment, this is available for two years, although we are currently reviewing the timescales. Membership is most importantly helping with access to educational materials for preparation for the ORE. We do not provide direct financial assistance for course or exam fees, but access to journals, website resources, seminars, the library, Branch meetings will help both with improving their English and later with preparing for the exam. Attending Conference and Branch meetings in particular also provides a chance to engage with colleagues in this country.

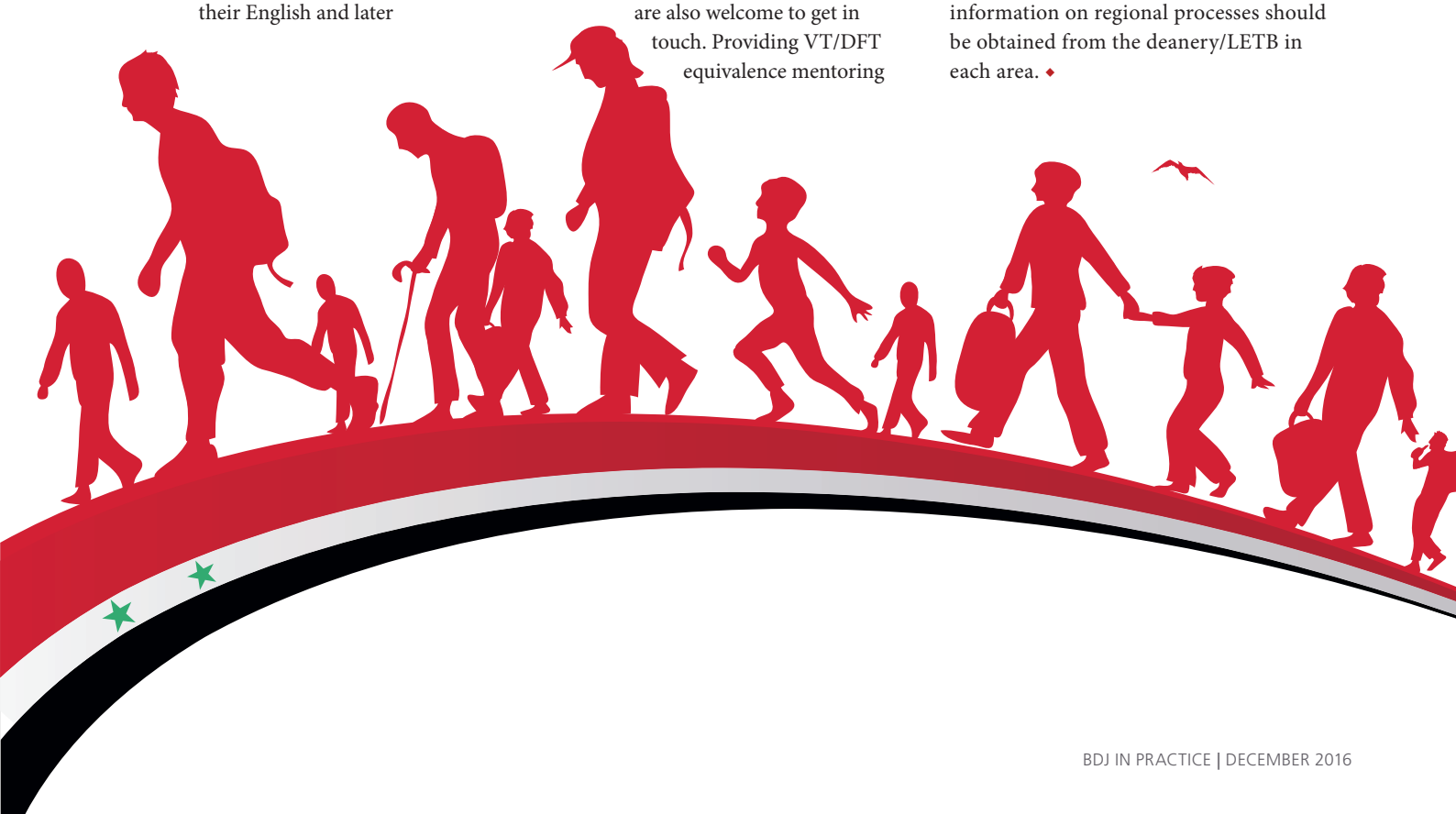
'The BDA has long provided free membership for dentists with refugee status; at the moment, this is available for two years, although we are currently looking again at the timescales.'

Would you like to help?

Members who are interested in supporting a refugee dentist working towards registration are welcome to get in touch with the BDA; professional contacts are always welcome. We work closely with refugee support organisations and might be able to provide information and put people in touch. Individual refugee dentists will be at different stages of the requalification process, and collegial individual support will always be an invaluable addition to any services we can provide from here.

Members who own practices and/or who have experience in mentoring or DFT are also welcome to get in touch. Providing VT/DFT equivalence mentoring involves similar support to that provided in formal DFT, although you will be dealing with an experienced dentist rather than a new graduate. However, the UK system and its requirements will be new to them. There is little or no funding, so the practice arrangements will be made through a performer contract (assistant contract in Northern Ireland and Scotland). The mentee is assessed by the deanery/LETB or indeed the NHS Area Team clinical director (regional processes vary) for their training needs, and given conditional inclusion in the performers list (in England and Wales).

The requirements for the training period of up to a year will usually include attending an *Introduction to the NHS* course as well as specific CPD courses, undertaking a clinical audit, running a patient questionnaire. The mentor is usually required to provide tutorials and support in practice where necessary. There are usually also progress meetings with the deanery, and at the end of the recommended training period the mentee will be signed off and receive full inclusion in the performers list. At the time of writing, it was not clear what effect the plans for satisfactory completion of (formal) DFT would have on equivalence training. More information on the general process can be obtained from the BDA; information on regional processes should be obtained from the deanery/LETB in each area. ◆



How does it get better than this?

Andy McMenemy,

Andy practises what he preaches and he leads by example. He is committed to embracing challenges and constantly pushing beyond his own comfort zones in business and in his personal life.

Andy worked in senior management and sales roles in the motor industry for organisations with turnovers of £1.3 billion and £550 million including Peugeot, Reg Vardy plc and Avis Group.

Somebody once told me that dentistry falls into two categories; playing to win and playing not to lose. Forgive the sporting analogy, but there's something in that sentiment.

If you play to win, you strive for excellence, you do the very best, you go over and above for patients. If you play not to lose, you do the minimum required to satisfy both patients and those above you. The difference may be one of attitude, but the repercussions go further than that. It's the difference between a visit 37 Wimpole Street and not.

So where does the difference in attitude take you? **Andy McMenemy** has his say.

'Having worked in some very large sales companies, at multiple levels of responsibility, I can see the difference in someone who has the right attitude and someone who doesn't', he said. 'I lived in a military environment as an interpreter in Germany. I wanted to enrol at Sandhurst, but a knee injury forced a change of plans.'

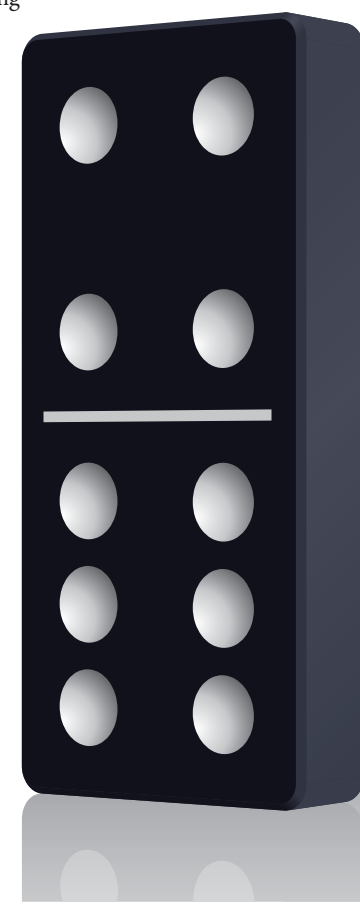
That may seem like a negative, but Andy thinks it's something we can all use to good effect.

'There are some people in life who have purpose, who have passion and who are persistent. For me this wasn't something to get downhearted about. Yes it was difficult to deal with, but it was a decision that wasn't one I made – it was taken out of my hands.

'Dental professionals can learn from that. Practice owners, practice managers, associates and even students can and should know that if they have the right mindset, they can achieve anything. Some things, like my injury, can't be accounted for, but in their absence, you can always ask yourself 'where do we go from here?' and 'how does it get better than this?'. Those are questions I believe are absolutely fundamental to a practice's and a practitioner's development.

'Although the proportion of the pie is shrinking, practice owners are still the driving force behind collective and individual success. If you have a good rapport with staff and you're a people person, you can become a leader and instil qualities into your staff. People getting into practice ownership may be out of their depth to begin with. It's my job to give them the tools to make it a success.'

Andy's progression through the sales ranks at various companies means he's well aware of the implications and practicalities of moving through from team member to leadership role. As he



explained, many business leaders excel in their chosen field, but are often found wanting in one fairly crucial area.

'In my experience a lot of business leaders – especially those progressing or finding themselves in the role for the first time – have 'soft' people skills. They sort of know how to work with someone, but they won't know how to bring the best out of them.

'It was a situation I found myself in, so I can empathise completely. For those in a hiring role, it's about spotting the potential. However you can only spot traits in others you have in yourself. That's why transitional training is so important. It can be tough moving from being part of a team with a lazy culture to the management responsible for that lazy team. You don't want to find yourself unable to un-couple from that culture and take it into your management. That would be a disaster.'

I put it to Andy that dentistry faces a unique set of challenges. Sales targets may be the same in principle to hitting UDA targets, but the differences are stark in contrast. I suggested that while practice owners may have different pressures and a more back seat role than front-line dentists, their stress levels are just as high as those on the front line.

'Practice owners have many, many things on their plate, but I feel being the conductor of the orchestra is just one of them. Yes you have to give your practice a direction, set a growth pace, develop a strategy and execute it, but you have to be on the lookout for individuals with key attributes that can take your practice and your vision to the next level. It can help to release the pressure if you know you have a high-class team.

'You also have to have a degree of flexibility in your approach. Most staff don't see beyond a year in practice, which is quite realistic given the variables in life they deal with. Staff retention is an issue for many owners and management, and quite often you find it's those with the three P's – passion, purpose, persistence – that want to carry on climbing up the tree. If you have the nous to reward high-performance individuals, there's more chance of them staying and improving your practice than someone else's.'

> 'Rewarding is something Andy insists is an area every practice owner should review. His belief in meaningful staff engagement centres around four R's – recognition, respect, reward and responsibility'

Rewarding is something Andy insists is an area every practice owner should review. His belief in meaningful staff engagement centres around four R's – recognition, respect, reward and responsibility. If you can engage your team and create a culture for them to thrive in, Andy believes things will take care of themselves.

'It's like a set of dominoes. If you recognise performance, have the respect to praise staff, you will begin to develop a feel good factor. If you have that, then reward and recognition publically will inevitably follow. This process creates leaders and brings out the best in people. It's something to bear in mind if you're long in the tooth and you work in a family-owned practice. 'It's only a small difference, but viewing everyone you interact with as a person rather than a patient or an employee will go a long way.'

For any team looking to set a high standard, asking themselves what 'world class service' looks like is a start. Provided everyone on the team understands what this means, Andy thinks it can help to identify those who don't share the same purpose, passion and persistence.

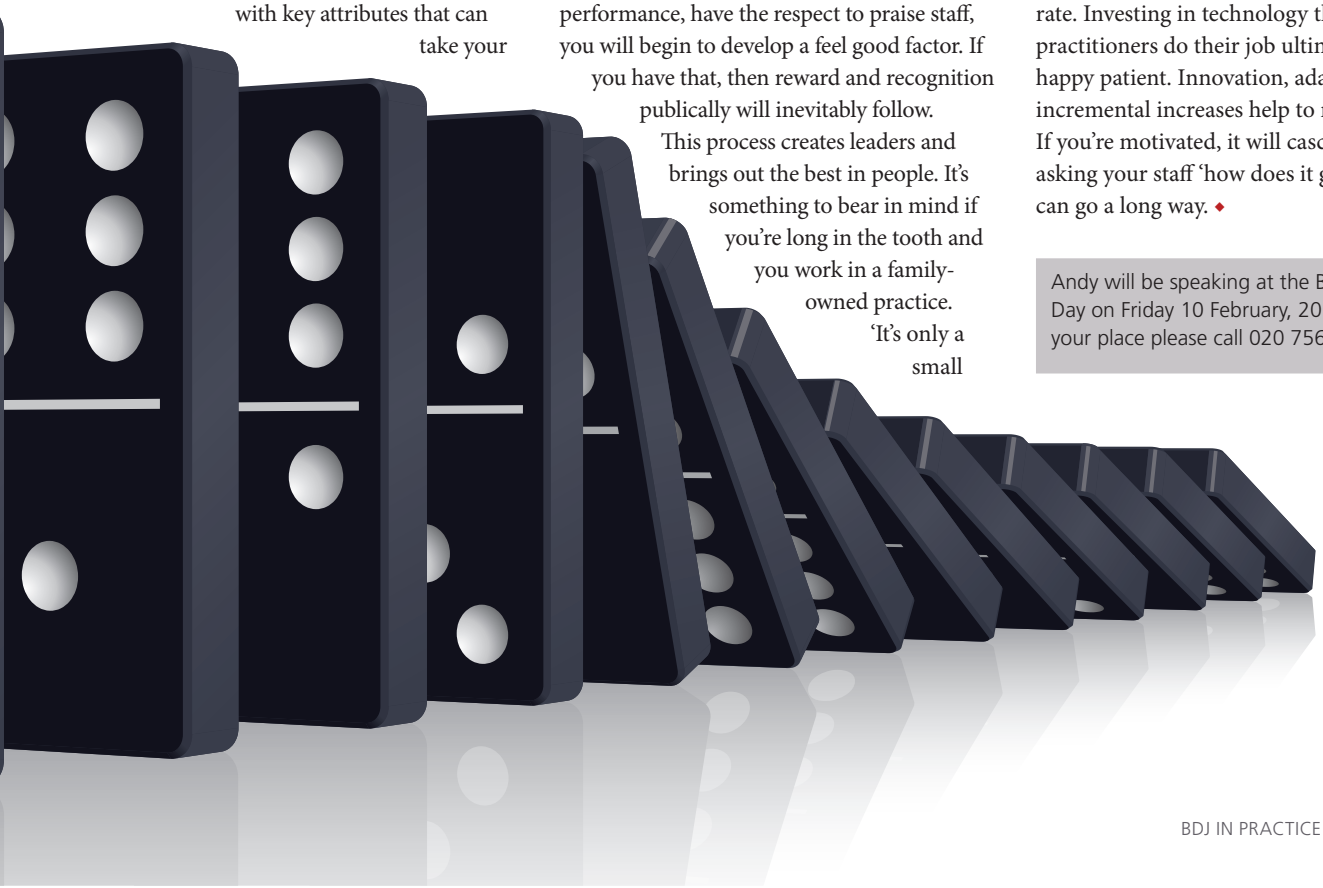
'Camaraderie is an undervalued part of team work', he said. 'If six out of seven team members are delivering world class customer service, it's easy to spot the seventh who may well need some additional help. It goes back to the four R's. If you can bring them to the table, your team can help to become cheerleaders to encourage that staff member. It's at this point you have a team of leaders.'

Previous research conducted by the BDA has highlighted significant issues in staff morale. With pay in real terms for associates dropping by 35% in the last decade, coupled with a contract that just does not work, it's not difficult to see why staff might just be playing not to lose.

'It is a problem, and it's one I certainly do not overlook', Andy said. 'I've seen a number of people from practice owners all the way through the practice who have become demotivated. You have to keep setting benchmarks. Standing still means you're going backwards, because someone will overtake you.

'Keep asking yourself 'what is possible?' There are some great things in dentistry. Technology is advancing at a rapid rate. Investing in technology that helps practitioners do their job ultimately means a happy patient. Innovation, adaptability and incremental increases help to retain focus. If you're motivated, it will cascade down. By asking your staff 'how does it get better', you can go a long way. ◆

Andy will be speaking at the BDA Careers Day on Friday 10 February, 2017. To book your place please call 020 7563 4590.



Digital assisted learning

Wouldn't it be great if a machine could answer the questions before they were even asked? **Roland Felber** from the Goethe University in Frankfurt spoke to *BDJ In Practice* about this very eventuality

When I was at secondary school, due to its popularity, I often found myself in classes of 30 plus pupils. One of my lasting memories is how the teachers would often comment – pretty much every day – how difficult it was to teach such a large class, and how often I'd have to wait to have a question answered.

Fast forward many, many years, and the problem of large classes still persists. Dentistry remains a popular career choice, both at home and abroad. In Frankfurt, the head of the pre-clinic Department of Prosthodontics Dr. Paul Weigl has this very problem. Every October he and his four assistant professors welcome an intake of more than 120 students. Even if the groups were split, that still leaves 60 students to 2 professors. If half of those want to ask questions, not only do students have to wait longer than necessary to have their question answered, but the time taken away from clinical teaching increases.

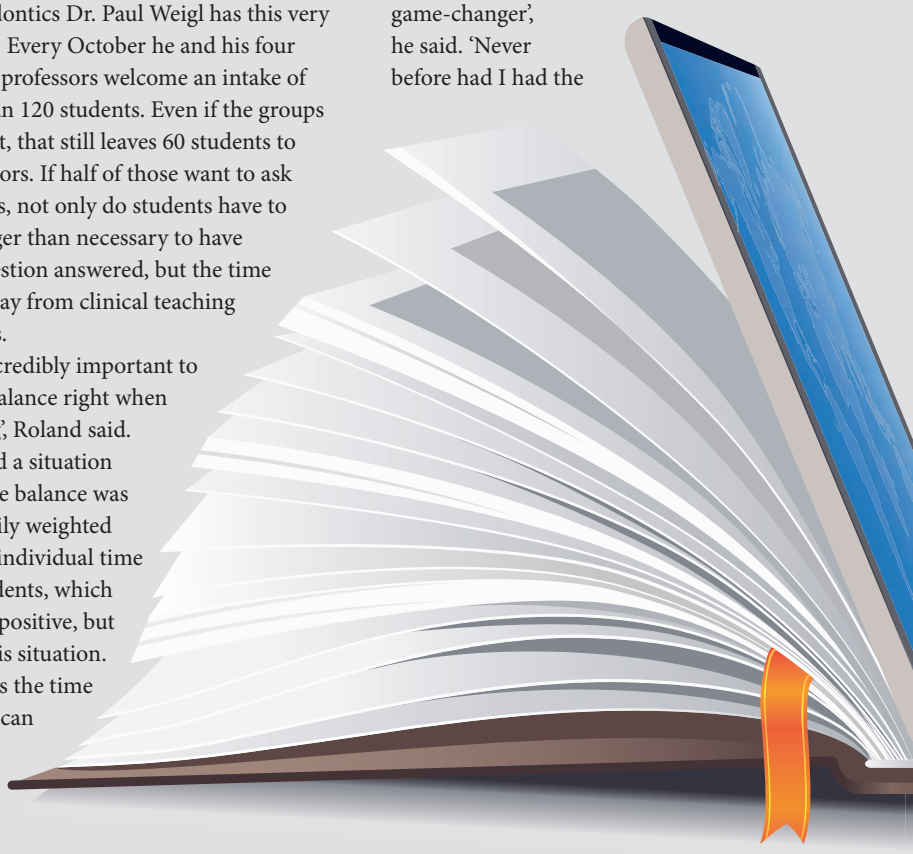
'It's incredibly important to get the balance right when lecturing', Roland said. 'We faced a situation where the balance was too heavily weighted towards individual time with students, which can be a positive, but not in this situation. It reduces the time students can interact and learn from other students, and it takes away the time lecturers spend teaching.'

It was here the idea of digital-assisted learning was born. If Roland could find a machine that answered questions student may have and teach them along the way, it would make a significant difference for everyone concerned.

'We were very keen to combine analytical software and measuring with intra-oral camera capabilities', he explained. 'It was here that the idea of prepCheck was born.'

So why was Roland so keen to discuss the merits and functionality of prepCheck?

'For me it was a game-changer', he said. 'Never before had I had the



'There are no lecturers available, but students use the software as their teachers. I really feel this is the direction learning is going to take in the next decade. Students are perhaps too reliant upon clinical work being taught rather than being given the basic information and discovering their limitations.'

opportunity to use technology that would assist learning in this way. It's not a clunky system – it's a mobile unit so it can be brought chair side. You can use it in pre-clinic on a phantom head and on a patient. This is quite unique. Other systems that provide the same level of analysis require you to take the tooth out and put it in an external scanner, and of course you can't do that with real teeth!

'Every patient is different and you need to find unique solutions for each of them. You can use standardised numbers to measure success. If you have an error margin of say 5mm, that doesn't leave you a lot of room for manoeuvre. If you can see what you're doing on a large monitor that is zoomed in, it's easier for the student to understand. After all, everyone is human. You may have had a bad night's sleep, be feeling unwell or be feeling emotional about something. That is naturally going to distort a student's ability, even if they claim otherwise. This system removes that human element – it's an exact science.'

The more I chat to Roland the more I discover the extent to which he is a progressive thinker. For example, he explained to me how his university in Frankfurt takes a slightly different approach to learning compared to other universities.

'It's very interesting. Each university has its own concept. Mine in Frankfurt is very open-minded. We like to extend the amount of time students can have. This gives them access to after-hours skills labs, which is only really made possible by using prepCheck.

'There are no lecturers available, but students use the software as their teachers. I really feel this is the direction learning is going to take in the next decade. Students are perhaps too reliant upon clinical work being taught rather than being given the basic information and discovering their limitations. The same can be said for some lecturers – they are too reliant upon 'old fashioned' methods of teaching without embracing the digital aspect. Yes – producing a model and sending it to the lab is a good way to learn, but digital is here. A system like this can help both of these groups of people develop.'

So what are the next steps in digital dentistry?

'There are a lot of new things on the market of interest', Roland said. 'Google Glasses are phenomenal. Imagine making a video of how to prepare a patient with visual instructions. If you can see in your glasses how to perform a procedure as you're working on it, it could revolutionise dentistry. I think video instruction will become embedded in how we teach, how CPD will evolve and how we will learn. Books might even become outdated.'

Given Roland's insistence that times will change, is the already sizeable increase in cosmetic dentistry affecting how dentistry is being taught?

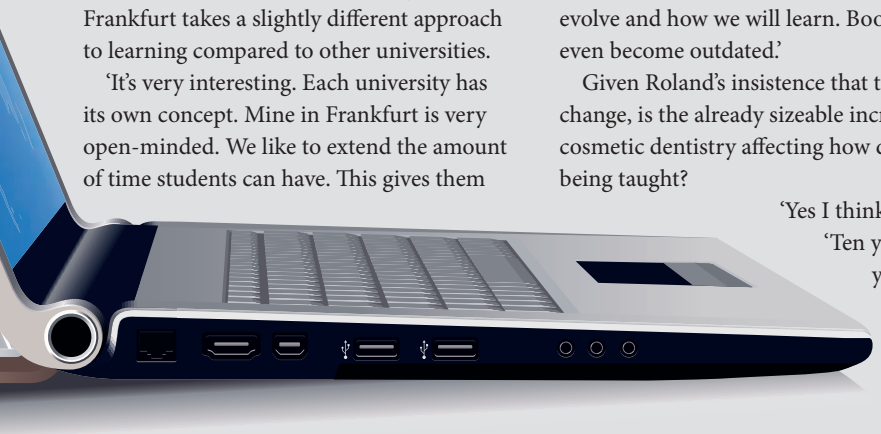
'Yes I think so', he said. 'Ten years ago if you lost a tooth a bridge would be the only option on the table. Now that isn't the case. You have to destroy two neighbouring teeth, so everyone takes an implant, even if you have to pay for it. No-one wants to lose good teeth. Levels of oral health have improved dramatically and people are keeping their natural teeth for longer and they're living longer, so it's no real surprise.

'However as we know that the patients are living for longer, we're still doing the same number of crowns and bridges. It's just moving the pattern of treatment back a generation. That's why students have to be fully prepared for every eventuality. In the future treatments like crowns and bridges may become a thing of the past.

'Older people will have more complex dentitions, and we have plenty of data to suggest patients don't like to be kept waiting. They don't even like attending in many cases, so it's a big advantage if we can do the work faster. Speed is of the essence, and I firmly believe prepCheck is just the beginning. There's a much greater chance of surgery healing much faster with digital-led surgery.

'All of this means the students of today aren't fully equipped to deal with needs of tomorrow. Universities here in Germany lag behind developments that are happening in practices, and it is my understanding this is a situation replicated across Europe. American institutions have stellar technology, as do many of their UK counterparts. Germany is free to study, and we lack the financial might to keep up.

'Technology changes so much. It's going to be interesting to see how – or if – students can keep up.' ◆



The value of collaboration

Everything is better with collaboration. Think Tom Jones and Shirley Bassey, Mork and Mindy and cheese and wine.

It's the same within our profession, and it's little wonder the CDO for England is calling for greater collaboration across all areas. The idea that we should be 'putting the mouth back in the body' will ultimately rely upon other healthcare professionals engaging with the dental profession – and *vice versa*.

In North Manchester, the art of collaboration is in full swing. *BDJ In Practice* spoke to **Dr Rachel Isba** and **Dr Richard Valle-Jones** about how they are getting children the right dental care they need.

Rachel Isba

BM Bch, PhD, MPH, FFPH, is a Consultant in Paediatric Public Health Medicine working in the Emergency Department at North Manchester General Hospital

Richard Valle-Jones

Director for Dentistry at the Pennine Care NHS Foundation Trust

What is the background to the scheme?

RI In the Emergency Department (ED) at North Manchester General Hospital it seemed that we had a significant number of children attending with non-traumatic dental problems such as toothache, abscesses and swellings that in reality could be better cared for in primary dental care territory. Given that doctors don't have too much training in the way of dentistry, many of these patients were referred to the max fax team, often un-necessarily. These referrals meant that children were in the department for longer – which isn't great for the children or the (often very busy) department. .

After an audit of attendances, it was found that of all the children who came to the department, only 1 in 8 ended up actually being admitted to the ward. The vast majority of children were sent home from the ED and told to see the dentist, with no formal follow-up. Additionally, the discharge letter from the hospital automatically gets sent to the GP, so even for the children who had a dentist (and we know that some of our local families don't access primary dental care for a variety of reasons), they wouldn't necessarily know that the child had been to hospital. We realised something needed to be done to join up our secondary medical care with existing primary dental care services and to improve the management and referral of these children in the department.

RVJ I can't take any credit here! It's Rachel's project! I run an unscheduled dental care service in the region and a colleague of mine mentioned that a doctor at a local hospital was doing some audit work into children attending A&E. It's well-documented that barriers exist for getting children into primary dental care, so this particular project was of great interest to me.

In a nutshell, what is the scheme?

RI I wanted to develop a programme whereby children accessing emergency care could get the right treatment they needed

– both whilst in the ED but then also back in the community. It sounds simple, but it is far from it, and it took 18 months to get the scheme off the ground. We also worked together to develop a clinical pathway for use in the ED that would help support the correct management and appropriate referral of children within the hospital, as well as identifying those suitable for referral to services like Richard's. I've definitely learned a lot about teeth during this process!

Now, if a child is identified using the clinical pathway as needing urgent dental care (but not in the hospital setting), a 'referral' is made by giving the parent or carer a 'golden ticket' voucher (we have two community services involved and parents are given the choice of which one is easiest for them to get to). The parent can then call the number on the voucher, speak to someone in the Urgent Dental Care centre, and make an appointment. These children are prioritised and are given the first available appointment. The vouchers are numbered so that we can track the scheme's success. We also developed an advice sheet for the parents and carers of children who attend the ED, giving them advice on how to prevent oral health problems from developing and how to access emergency dental services, should they need them in the future.

Everything is designed to provide the most appropriate care to the children but also to try and release the growing pressure on A&E services – the theory being that if children access dental services for their toothache now, this may prevent them from re-presenting to the ED in the future with an abscess. This scheme will also hopefully increase the number of children receiving routine primary dental care.

RVJ I can't understate the importance of seeking ways in which we can get children – and adults for that matter – away from A&E services and into unscheduled care services for dental problems. As Rachel points out, too many discharged from hospital don't get the right follow-up care they need. We're happy to take them because we know we are in the best position to give them the right treatment.

Patients are turning up to their appointments too, so we know this is a viable product.

How much work is involved in getting the various teams on the right page?

RVJ From a dental point of view, it is quite challenging. The shared responsibility for a patient is where the healthcare system is moving to. From a health economics stance, it will help to free up significant amounts of money spent on unnecessary treatments. It takes a number of like-minded individuals to get in a room and begin to understand the complexities involved and the basics.

RI It took me 18 months to get everything in place and we are now six months into the project. After conversations with supportive colleagues working in Dental Public Health at Public Health England, doors began to open up, and I was having the right conversations with the right people. I think all medical and dental services are stretched at the moment, so I'm not likely to fulfil my dream of a dentist working in my department just yet, but I think that this project shows that with the right people and the right framework, approaches like this can really work and make a difference to children.

> 'this project shows that with the right people and the right framework, approaches like this can really work'

Why does Manchester need something like this?

RVJ There are some severe pockets of depravation. National statistics put the region towards the bottom of pretty much every table relating to child and adult oral health status. Some of the issues we have already covered – cost specifically – has a lot to do with it. If we can make any gains for the healthcare system on a small scale and prove they work, it could provide a platform for taking the pathway and rolling it out on a national level.

Access is another perceived barrier, both on a dental and a physical level. Oral health problems can cause some real pain. It's our job to get that on other people's radars.

RI That's the goal. Our small scale project is due for evaluation in the first part of 2017, but was produced with no additional resources, and with the potential to save money in the future. I have a background in paediatric emergency medicine as well as public health, and the advantages of an approach like this are potentially enormous. Having a foot in both clinical practice and public health camps has really helped get people behind the project.

It's worth noting that there's actually nothing new here. We are not inventing any new services, rather just joining up two existing parts of the wider system. There has been some interest from across Greater Manchester and we hope that the approach we have used will be adopted and adapted elsewhere.

If it's so simple why hasn't this been adopted by more local teams or rolled out from the CDO's office?

RVJ It's actually a classic example of putting the mouth back in the body. Much of the barriers faced are relating to attitude, understanding, time and cost, which is ironic given those are the very barriers the public cite for not accessing dental care.

If we can provide training for teams, it gives junior doctors more tools to be able to do their job properly. The NHS has to deal with a high turnover of staff, which can put some departments back. For others it allows the doctors to pass on what they know to colleagues and peers, which can only be a good thing.

RI Dentistry and medicine are very much evidence-based arenas, so with a project like this we need to evaluate it as fully as possible. The scheme launched in March, and once we have run for a year, I will be evaluating what we've done and sharing it with those involved, for wider dissemination.

In addition to the pathway, there have also been a number of other activities that have arisen out of this work. For example, we are currently looking to develop some joint inter-professional training for early career doctors and dentists, so that they can learn more about how to manage children with dental problems who may present to them in any setting. I think from the medical perspective, we need to remember that the mouth is an important part of the body, not an afterthought, and that poor dental health in children can have a massive impact on their health and wellbeing. From a personal perspective, this project has been a fantastic opportunity to do some whole system working, meet and work with some really enthusiastic colleagues, and hopefully improve the health of local children.

RVJ I firmly believe there is scope to work with pharmacists and general medical practitioners on this too. I see no reason why it can't be adopted by other healthcare professionals. Once the data is available to upscale the pathway, hopefully we will see rapid developments. ◆

Smoking at work

by James Goldman
the BDA Practice Support Team's Special Adviser (Legal). James trained as a barrister and advises dental practices on employment law issues and has represented practitioners in many Employment Tribunal disputes

Smoking at work divides people. For those who don't smoke, the smell is absolutely horrible. For those who smoke, the need to get nicotine is strong. But few patients are going to be happy coming into a reception area that smells of cigarettes, or being treated by a dentist or nurse who reeks of cigarette smoke.

Whilst fewer people smoke now than have done for many years, it is inevitable that some dental practices will have to deal with staff who smoke. As with many things in the work place, a good, clear policy is essential, so that staff know whether they can go for a quick cigarette or not.

Taking breaks

The legal starting point is not particularly friendly towards people who smoke. Staff are not entitled by law to cigarette breaks. And it is illegal to smoke in the workplace or for employers to allow staff to smoke in the workplace. Therefore the cornerstone of any policy on smoking must be that staff are not allowed to smoke in the practice, or outside the entrance of the practice or other public places in close proximity to the outside of the practice. It should be clear that a breach of these rules could amount to a disciplinary offence. Nevertheless, you can also consider some ways to be understanding of smokers needs.

A time and a place

Generally, those employees who smoke have to do so in their own time, away from the practice. For the most part this should mean before and after work and at lunchtime. But it may be that a practice allows staff to take smaller breaks during working hours, say for making a cup of tea, some staff who smoke may be able to take this time in order to have a cigarette. However, it is important that all staff get equivalent time off – it may be that smokers have to take more frequent, but shorter, breaks than staff who do not smoke. It is also important that staff who have to take breaks for a cigarette do not leave extra work for staff who remain, leaving them to do their work. This means that breaks, for whatever reason, during working time have to be well defined and clear and fair to all staff. In such circumstances, it may help if the question of breaks is raised periodically at team meetings to allow any grievances to be raised and resolved.

Discuss where staff should smoke. Allowing staff to smoke outside the front the practice, or anywhere near it, will likely be off-putting to some patients. They should move out of sight of the practice front, waiting room and patients. It may be that they need to take a walk around the block. You may have a back yard they can use. Be definite about places where staff cannot smoke, perhaps within a certain distance of the practice entrance or in the practice car park.

Clearing the air

After smoking the smell of cigarettes can cling to the smoker. Practices should also consider having clear procedures for staff to follow after a cigarette so that they do not smell of cigarette smoke when they come into contact with patients or other staff. Such procedures should include a change of clothes so that they are not wearing their surgery outfit whilst smoking, washing their hands and face, and brushing their teeth; perhaps even using mouthwash.

Helping to quit

According to Action on Smoking and Health (ASH), about two thirds of smokers do want to give up[1]. With more and more smoking cessation products on the market, now is an easier time than ever before to give up smoking. The practice would do well to encourage staff to stop smoking, and refer staff to the NHS helpline on quitting smoking, or to any of the many other resources giving help to people who want to quit smoking, possibly even arranging a cessation programme for them to participate in. ◆

1. Health and Social Care Information Centre, Statistics on Smoking – England 2015, 29 May 2015.

Hand dermatitis and latex allergy

by Edward Sinclair

a dentist and Compliance Adviser in the BDA Professional and Advisory Services Directorate, helping members on all aspects of health & safety law, infection control requirements, practice inspections and compliance with professional regulations

Dental workers are particularly at risk of hand dermatitis because of continuous glove use and frequent washing of hands. In all it can affect up to one in three healthcare workers[1]. Hand dermatitis is a general term describing three different skin reactions: irritation; delayed hypersensitivity; and immediate hypersensitivity. Irritant contact dermatitis is by far the most common reaction. Of the allergic reactions, delayed hypersensitivity is more common than immediate, although immediate hypersensitivity is potentially much more serious. Because allergies are preceded by a period of sensitisation, ranging from a few minutes to many years, anyone is at risk, at any time in their career. About one person in 10 coming into regular contact with latex gloves may develop sensitivity to latex proteins[2].

The likelihood of something causing an allergy depends on a number of factors, including its allergenic potential, its concentration, an individual's predisposition to developing allergies and previous levels of exposure. At work, allergies are commonly due to chemicals in latex and non-latex gloves; chemicals in hand-washes; and natural rubber latex proteins. Also, an already irritated and inflamed skin may be more susceptible to penetration by allergens. Generally, the higher the allergen levels, the higher the risk. Sensitisation can be brought on by repeated contact with high levels of an allergen. Multiple glove changes, sweating hands and moisturising cream can liberate latex proteins increasing risk of allergy due to cutaneous exposure. However, once allergic, someone may experience reactions at much lower levels.

Seek help

If you suspect hand dermatitis or latex allergy seek medical advice from your medical practitioner, local occupational health expert or dermatologist. This is particularly important if you think you may have become sensitised to latex. Latex allergy can be potentially life-threatening and expert advice must be sought immediately.

Management usually depends on the cause and severity, and medical advice is required to confirm a diagnosis and decide the best way to manage the problem. Various tests can be used to determine whether dermatitis is allergy-based. Failure to identify an allergen may then mean looking at potential skin irritants for the cause.

Risk assessment

Latex allergy and contact dermatitis should be included in your practice COSHH risk assessments. There is no need to have a separate policy on latex allergy as long as you have carried out a proper assessment that identifies exposure to latex and ways in which exposure can be prevented or controlled.

Practices should not scrimp on glove quality. Lower quality gloves are more likely to cause allergy. Gloves should have the lowest levels possible of chemical accelerators; if latex is worn the levels of extractable proteins should be <50µ/g. However, it is imperative that there is a non-latex alternative in terms of gloves available to staff that can be used whenever required. Potential alternatives include nitrile and neoprene. Practice managers should ensure that those ordering stock are aware of the types of gloves to be ordered. In addition, staff should be trained not only in identifying latex allergy risks but how to deal with anaphylaxis in an emergency.

Many other latex containing products are used in the dental surgery, this includes rubber dams. A non-latex alternative should be used in these situations, whenever possible.

Contrary to some reports, the risk of latex allergies from local anaesthetic carriages is minimal. Some have been manufactured with latex diaphragms and plungers can also contain latex. However, given the lack of evidence, it is difficult to directly attribute this particular source of latex to allergies within the dental surgery.

In theory, there could also be some cross reactivity with gutta percha material. Again, this is only theoretical given both materials have common sources. There is no evidence in the literature to substantiate such a comparison. In patients known to have a latex allergy, it may be prudent to allergy test for gutta percha sensitivity.

With your patients around 1-6% of the general population are thought to be potentially sensitised to latex. Control measures to prevent allergy to latex include taking an excellent medical history, considering co-morbidities that may increase the risk of latex allergy and the use of barrier protection from contact with latex containing materials. It has been suggested that early morning appointments could be helpful in preventing patient exposure to allergens that have become aerosolised. ◆

1. Flyvholm M A, Bach B, Rose M, Jepsen K F. Self-reported hand eczema in a hospital population. *Contact Dermatitis* 2007; **57:** 110–115.
2. Allergy UK, Rubber Latex Allergy. Available online at https://www.allergyuk.org/rubber-latex-allergy/rubber-latex-allergy (Accessed November 2016).

Full national guidelines Latex allergy – Occupational aspects of management, are published by the Royal College of Physicians, see www.rcplondon.ac.uk

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GSK is leading a campaign to raise awareness among dentists, DCPs and patients about two common conditions – erosive tooth wear and Dentine Hypersensitivity (DH).

77% of British adults exhibit signs of tooth wear[1]. It can lead to changes in tooth shape, yellowing of teeth and translucency at the tooth edge.

Early stages of this irreversible condition may be difficult to spot, however using the Basic Erosive Wear Examination (BEWE) tool can be a useful guide to diagnosis. You can now download the BEWE app for a comprehensive guide to erosive tooth wear diagnosis and condition management.

Management techniques include diet and lifestyle changes as well as the use of a fluoride toothpaste. The optimised fluoride formulation of Pronamel strengthens your patients' demineralised enamel to help protect against the effects of erosive tooth wear[2].

DH is characterised by short, sharp pain in response to stimuli and needs to be diagnosed differentially. 41.9% of adults have experienced it[3] and, according to the Dentine Hypersensitivity Experience Questionnaire, over 70% of sufferers consider the sensations to take pleasure out of eating and drinking[4]. Dentine hypersensitivity can lead to adaptive behaviour with patients developing restrictive eating habits and avoiding brushing their sensitive teeth in order to cope with the pain.[5,6]

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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
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Interests: Fixed and removable prosthodontics, endodontics and dental implants
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Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics (68916)
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Interests: Endodontics
On Specialist List: Yes, Endodontics (79246)
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Q3: Which of the following is *not* one of the three P's?

A Pride
B Passion
C Persistence
D Purpose

Q4: How many people coming into contact with latex gloves may develop sensitivity?

A 1 in 5
B 1 in 10
C 1 in 15
D 1 in 20

Q5: If a member of staff wishes to smoke during working hours, which of these should they consider?

A Changing out of scrubs
B Washing their hands
C Using mouthwash
D All of the above

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