BDJ InPractice
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Delivering behaviour change

BDA
British Dental Association

A revealing tell ■ Orthodontic tendering ■ Indemnity ■ Myth busting ■ Advice pages

BDJ InPractice

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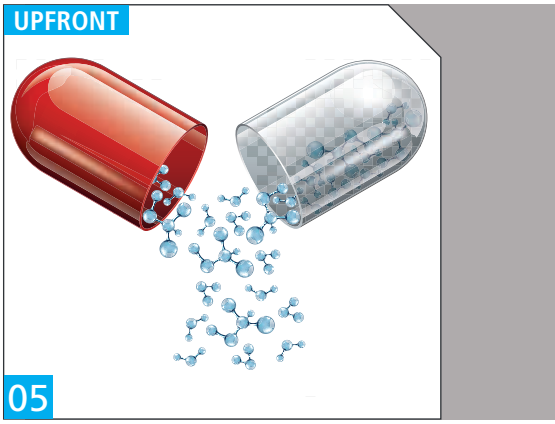

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To contact the **Advertisement Office:** Tel: 020 7843 4729. To contact the **Editorial Office:** 64 Wimpole Street, London W1G 8YS. Tel: 020 7935 0875. Fax: 020 7487 5232. E-mail: bdjinpractice@bda.org. Web: www.bda.org/bdjinpracticeonline. Published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

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BDA
British Dental Association

Universal principles of good complaint handling launched

28 organisations from across the dental sector have joined forces to launch a set of universal principles for good complaint handling today. The six core principles provide a simple template for best practice, helping professionals and patients to get the most from feedback and complaints, for the benefit of all.

> 'The six core principles provide a simple template for best practice, helping professionals and patients to get the most from feedback and complaints, for the benefit of all.'

According to the General Dental Council's (GDC) 2017 Public and Patient Survey, 97% of dental patients report being either very (67%) or fairly (29%) satisfied with their dental treatment and only 8% report having considered making a complaint. However, of those who have, 33% said they had not done so because they didn't know where to start.

According to the principles, the six core principles to communicate to patients are:

1. All of your feedback is important to us
2. We want to make it easy for you to raise a concern or complain, if you need to
3. We follow a complaints procedure and keep you informed
4. We will try to answer all your questions and any concerns you raise
5. We want you to have a positive experience of making a complaint
6. Your feedback helps us to improve our service.

GDC Executive Director, Strategy, Matthew Hill, said: 'We all know that good complaint and feedback handling is an important part of being a dental professional which is why we committed to developing a profession-wide understanding of what best practice looks like in Shifting the balance. There was really strong support from across the sector for this, so a working group was formed which went on to develop the six core principles. These set out a very clear picture of what patients can expect when providing feedback or making a complaint.'

BDA Chair Mick Armstrong said: 'We have been involved in the development of these principles and believe it will clarify and encourage the importance of good complaint handling for both practices and patients.

'Clearly, early satisfactory resolution at practice level is extremely desirable when the alternatives are such forbidding, lengthy and distressing processes for all involved.' ◆

'Pay ARF on time', indemnifier tells members

Dental Protection has reminded dental professionals about their duty to pay the Annual Retention Fee on time to avoid unnecessary disruption.

Failing to pay the ARF by 31 December 2018 will result in dentists needing to apply for restoration to the register in the New Year. Restoration requires the completion of the GDC application form and submission of the relevant evidence. The GDC states that the process will take at least 10 working days during which the dentist must not work. Dental Protection has witnessed the enormous distress and inconvenience that this has caused to dentists as patient appointments have to be cancelled and cash flow is interrupted. Knowingly working when not registered is illegal and a fitness to practice issue which can result in sanctions from the GDC.

The end of the year is also the last day of the Continuing Professional Development (CPD) year. The Enhanced CPD scheme was introduced this year which has seen the implementation of new CPD regulations. Under the ECPD scheme, dentists will need to complete a minimum of 100 hours verifiable CPD over their five year cycle as well as ensuring they declare at least 10 hours during any two year period. It is important to remind all dentists that any CPD done after 31 December 2018 will not count towards the previous year.

Raj Rattan Director at Dental Protection said: 'We would like to remind our members of the importance of complying with the CPD rules. This year, there are some new requirements including a change in the reporting system, which needs dentists to complete the key annual statement and have a Personal Development Plan (PDP) in place. As far as we are aware, the consequences of not having a PDP have not yet resulted in a case.

'Nevertheless, we urge all dentists to comply fully with the requirements to avoid a fitness to practise investigation.' ◆

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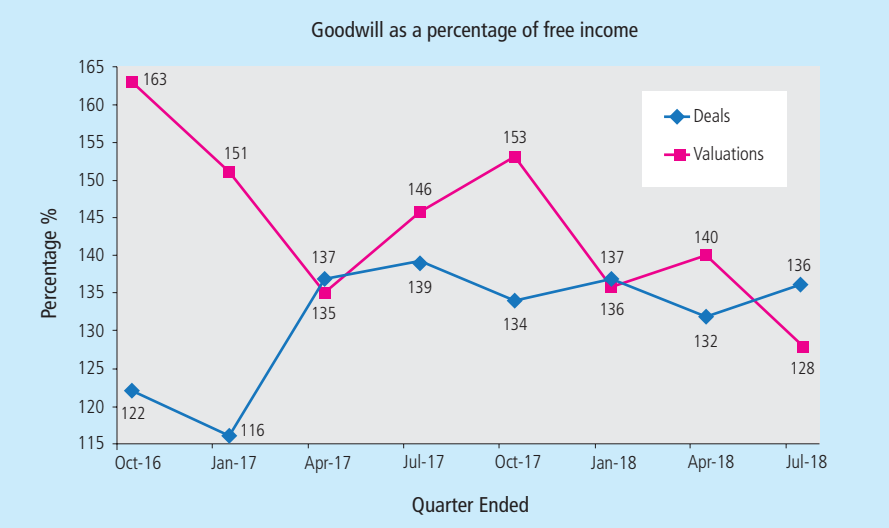
A Divided nation

The release of the latest NASDAL survey, perhaps rather aptly for the current political climate, shows a divided country with a huge disparity in practice goodwill values.

The survey, for the quarter ending 31 July 2018 revealed NASDAL members acted for their clients in the sale of practices with a range of values between 47% of gross fees and 313% of gross fees. A wide range indeed. The headline figure for deals was up slightly – an average goodwill value of 136% of gross fees – a return to the level of the quarter ending 31 January 2018. Average valuations saw a big drop of 12% from the quarter ending 31 July 2018. NHS practices are still in huge demand with a significant number of sales in the quarter at considerably over 200% of gross fees.

Alan Suggett, specialist dental accountant and partner in UNW LLP who compiles the goodwill survey, said: 'I think that a range of more than 250% illustrates how divided dental practice sales are in the UK (and also how difficult it is to make predictions for the UK market as a whole).



NASDAL Quarterly Goodwill Surveys

'When I started specialising in dental accounting, if someone had suggested a goodwill value of 313%, they would have been laughed at! But, if your practice 'ticks the right boxes' then it seems that the market will pay what you want. However, if it doesn't, you may have trouble selling it at all.'

He added: 'There is a whisper in the market that 2019 will see all of the corporates buying practices again.

This time may see a little more focus and selection about where and what type of practice is to be bought. Watch this space.'

'More broccoli than dentistry': Hancock fails to grapple prevention challenge

The British Dental Association has questioned Health Secretary Matt Hancock's priorities, following the launch of his new 'prevention focused' vision for the NHS which failed to meaningfully engage on wholly preventable oral diseases like tooth decay. While deep and preventable oral health inequalities persist in both child and adult populations, in the last five years the Government's spend per head on NHS dentistry has fallen £4.95, from £40.95 to £36, while patient charges have increased by over 23%. Tooth decay is the number one reason for hospital admissions for children aged 5-9, and paediatric extractions have cost the NHS £165 million on extractions in hospitals since 2012.

Dental leaders have criticised the Health Secretary for failing to unlock the preventive potential of the service. The Prevention is better than cure document, makes one passing reference to improving oral health of children. The government's centrepiece Starting Well oral health programme, which is targeting high needs children, has not received a penny of new investment, and is operating in parts of just 13 local authorities in England. The vision does not touch on delivery of a prevention-focused NHS dental contract, which has been a Conservative Manifesto commitment since 2010. The current system continues to fuel patient access problems across England.

BDA Chair Mick Armstrong said: 'The Health Secretary says he wants to champion prevention. Sadly, he's had more to say about broccoli than wholly preventable oral diseases that are costing our NHS millions.

'When tooth decay remains the number one reason for child hospital admissions, treating dentistry as an afterthought looks more than careless.

'England's huge oral health inequalities are fuelled by poverty and the lack of a coherent strategy. The starting point for any solution won't be 'Big Data' or Apps, it requires political will from Westminster and an end to year on year cuts.'

Restricting dental check-ups to once every two years could put lives at risk

Dentists have warned that plans to extend the gap between appointments to beyond 12 months could jeopardise efforts to tackle Scotland's fastest growing cancers.

As the British Dental Association Scotland launched its action plan to combat oral cancers in Holyrood on 13 November, it has revealed survey evidence showing 97% of dentists in Scotland now have concerns that moves to extend recall intervals could undermine detection or oral cancers – with 77% defining it as a major or severe risk.

Dentists are often the first health professionals to detect oral cancer during routine check-ups. While the BDA has welcomed the ambitions set out in the new Oral Health Improvement Plan (OHIP), it has expressed dismay that it will be funded by cuts to annual appointments for many supposedly 'lower risk' patients. Oral cancers can occur in patients with good oral health and a healthy lifestyle - nearly 5 oral cancer cases are diagnosed every working day, with survival rates improving from 50% to 90% with early detection.

Dentist leaders have published new analysis showing oral cancer cases are now costing NHS Scotland up to £90,000 per patient – with an estimated annual cost of over £65 million – set to more than double by 2035 if the disease goes unchecked.

Scotland has seen a 37% increase in oral cancer deaths in the last decade. Incidence rates are among the highest in Europe – with residents in our most deprived communities twice as likely to be diagnosed or die from the condition as those in more affluent areas.

Anas Sarwar MSP has now tabled a motion in the Scottish Parliament calling for sustainable and innovative approaches to oral cancer treatment and expressing concern over the potential impact of the OHIP. BDA Scotland is calling for a strategic focus on early detection, prevention and joining-up services, with measures including sufficient resources for alcohol treatment and smoking cessation programmes, and a catch-up programme to offer 140,000 older school-aged boys access to the vaccination programme for the cancer-causing Human Papillomavirus.

David Cross, Vice-Chair of the BDA's Scottish Council said: 'Dentists are on the front line of a battle against some the fastest rising cancers in Scotland. Early detection is key, but now risks becoming a casualty of a cost-cutting exercise.

'People in otherwise good health are succumbing to this disease. Telling our 'lower risk' patients to come back in two years will only handicap efforts to meet a growing threat, while putting further pressure on NHS cancer services.

'Oral cancer now claims three times as many lives in Scotland as car accidents. Rather than chasing quick savings we need to see concrete plans and real investment to help turn the tables on this devastating but preventable disease.'

Oral Cancer: A Plan for Action, BDA Scotland, (November 2018) is available to download at: www.bda.org/dentists/policy-campaigns/public-health-science/public-health/PublishingImages/Pages/Scotland-oral-cancer-awareness-campaign/Oral_cancer_plan_WEB.pdf ◆

NICE 'should change antibiotic guidelines for dental patients'

New research has revealed the impact a change in US guidelines had on the prescribing of antibiotic prophylaxis (AP) to prevent a life-threatening heart condition infective endocarditis (IE) in patients before undergoing invasive dental treatment.

The findings of the international research provide further evidence that the UK's National Institute of Health and Care Excellence (NICE) were wrong to call for a complete ban on the use of AP before invasive dental procedures – even for those considered to be at high-risk of IE such as patients with artificial or repaired heart valves or a previous history of IE.

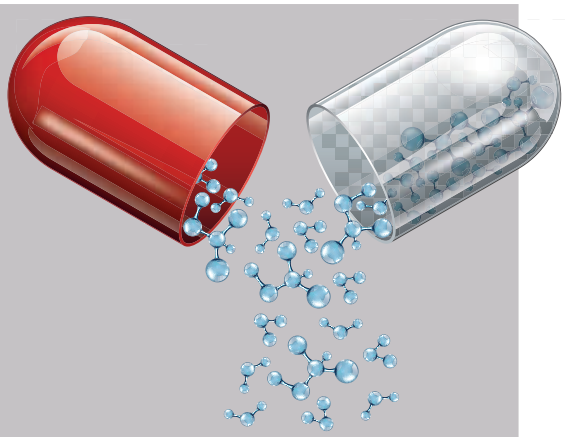
The study is the largest and most comprehensive research into the 2007 American Heart Association's (AHA) recommendations that AP should continue to be given to patients at high-risk of developing IE, but not to those at moderate-risk.

The research showed a large fall in AP prescribing for those at moderate-risk of IE (64%). However, it also identified a concerning fall in AP prescribing to those at high-risk (20%) – despite the AHA's recommendation that high-risk individuals should continue to receive AP before invasive dental treatment.

In parallel, the study also identified a significant increase in IE (177%) in those at high-risk but only a barely significant increase in those at moderate-risk.

Lead author, Professor Martin Thornhill from the University of Sheffield's School of Clinical Dentistry, said: 'Although the data do not prove a cause-effect relationship between AP reduction and IE increase, they are very supportive of the AHA recommendation to give AP to those at high-risk but not to those at moderate-risk of endocarditis.

'It also provides further evidence that the 2008 NICE recommendation that AP should cease completely in the UK, was probably wrong and should be changed. Current



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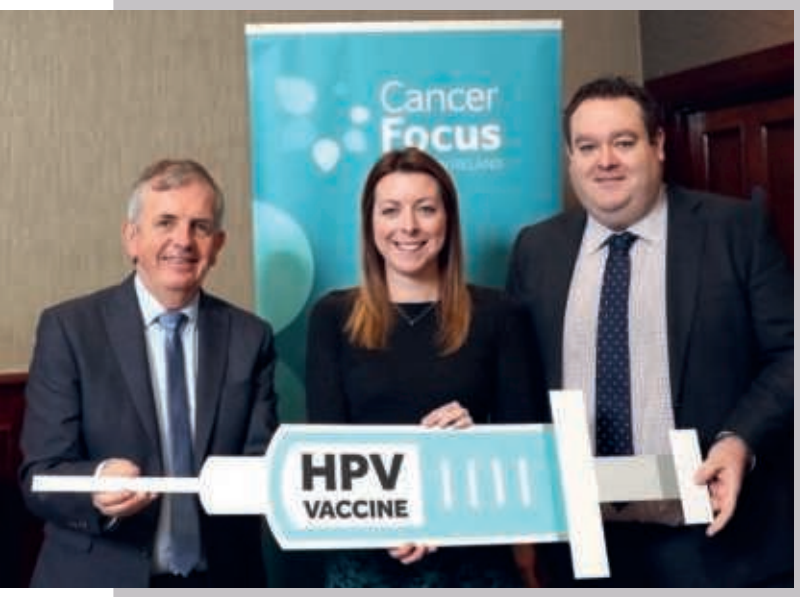
NICE guidance on the use of AP to prevent IE is confusing and unhelpful for clinicians and patients, and probably wrong.

'In the absence of clear and sensible advice from NICE, the recent attempt by the Scottish Dental Clinical Effectiveness Program (SDCEP) to provide advice for dentists about how to implement the NICE guidelines – effectively suggesting they follow the AHA recommendations, is very welcome.' ◆

Men's health conference calls for urgent action on HPV vaccine for NI boys

The urgent need to introduce the HPV vaccine for local boys has once again been highlighted at the annual Cancer Focus Northern Ireland Men's Health Conference.

Unless an implementation plan for the vaccine's roll out is made available soon there is a danger that boys in Northern Ireland will be left at risk, it was claimed. Health professionals from all over Northern Ireland attended the conference in Antrim which focused on the theme of inequality for men and boys.



Guest speaker Dr Gillian Prue, from Queen's University Belfast (QUB), said she was concerned that no announcement had been made as to whether local boys will receive the HPV vaccine.

Cancer Focus NI has already urged the Department of Health at Stormont to provide clarity on whether or not funding will be made available to ensure boys here will benefit from the vaccine along with those in the rest of the UK.

Dr Prue said: 'HPV is a very common sexually transmitted infection that can cause a range of cancers (cervical, vaginal, vulvar, penile, anal, and oral) as well as genital warts. There has already been a vaccination programme for 12/13 year old girls here since 2008.The Joint Committee on Vaccination and Immunisation recommended in July that boys as well as girls should receive this vaccine to ensure that both sexes are protected against the cancers and other diseases caused by HPV.

'By the end of July, it was confirmed that boys in England, Scotland and Wales would be vaccinated and work on implementation is now underway in those regions. It is expected that these boys will start to be vaccinated from September next year. We are also expecting confirmation that Ireland will decide to vaccinate boys in the near future.'

Dr Gerry McKenna, Chair of the British Dental Association NI (BDA NI) Hospital Group said: 'We've seen a rise in the number of mouth and throat cancer cases in recent years and the number of cases looks set to double by 2035. Major risk factors of mouth cancer are tobacco use and drinking alcohol and a number are related to HPV exposure – cases which would be easily prevented by the introduction of this important vaccine to boys. We stress that early diagnosis can really make the difference.'

Social media e-learning course launched

The DDU has launched a new e-learning course to help dental professionals use social media ethically and effectively, without experiencing career-damaging pitfalls. The resource includes fictional scenarios that are based on common queries and concerns they receive from members. Topics covered include:

- Communication with patients and colleagues
- Marketing yourself using social media
- Relevant legal and ethical obligations.

So far, feedback to the tool has been positive with participants commenting '[the tool is] extremely helpful and informative, particularly with real life scenarios and referring to GDC Standards' and 'easy to follow content, beautifully presented'.

Leo Briggs, Deputy Head of the DDU said: 'Dental professionals have embraced social media and overall it is having a positive impact on dentistry by, for example, helping them to market their practice or giving patients access to more healthcare information from the profession itself. However, mistakes on social media, such as an inappropriate comment or photo, are easy to make and can damage your reputation and career.

'Consequently, the aim of this e-learning tool is to help dental professionals and students maximise the benefits of using social media and appreciate its pitfalls whilst continuing to meet ethical and legal obligations.'

Andrew Chandrapal, former President of the British Academy of Cosmetic Dentistry (BACD) and member of the DDU's Dental Advisory Committee added: 'Professional development is vital for dentists who wish to enjoy a long and rewarding career. The DDU's e-learning course enables dental professionals to promote their practice ethically on social media, understand the reputational risks associated with social media and how to respond appropriately to online complaints.'

Following completion of the course, individuals will receive a certificate of an hour of verifiable CPD.

To complete the social media e-learning course visit: https://www.theddu.com/learn-and-develop/social-media-e-learning.

A revealing tell

David Westgarth
Editor, *BDJ In Practice*

As the festive season descends upon us once again, there are certain words and phrases that, rather like Michael Bublé, Christmas films and Mariah Carey's '*All I Want For Christmas*', are being dusted down and wheeled out of their lexicon cupboard.

Take any supermarket advert. They will tell you about their indulgent offerings. You'll be ever-so gently reminded this festive season to indulge in your favourite chocolate, wine, cheese, desserts and alike. Offices across the nation will begin to see mince pies stack up 'because it's Christmas'. The Coca Cola truck is a prime example. It hibernates away and tours the country for a meagre eight weeks of the year, 'because it's Christmas'.

I was involved in a social media discussion with a prominent paediatric dentist, and I'm sure she won't mind me saying I enjoyed the debate. It centred on the Coca Cola truck and her call for it to be banned, given the very real problem that is tooth decay. Even now I read the coverage of the truck 'scaling back' on how many visits it was due to make in 2018, and one phrase crops up more than most; 'but it's Christmas'.

As an advocate of better oral health and a consumer, I see both sides of the argument. I see the need for the preventable burden on our NHS that is tooth decay to be eradicated, and I see the value of indulgence every now and again – within moderation, of course.

Take the '*State of Mouth Cancer Report 2018/19*' highlighting a staggering 135% increase in cases of mouth cancer compared to 20 years ago. A startling increase, of which lifestyle factors play a significant role. Yet plenty of those in attendance at a recent mouth cancer related event were happy to mark the occasion with a glass or two of wine.

Far from me to suggest this should not be the case, but what sort of message does it portray? Can the profession truly rally around a cause – of which alcohol consumption to excess accounts for 1 in 3 cases of the disease – while toasting this with a glass of wine? It becomes a tell rather than a discussion, an approach Professor Elizabeth Kay suggested at the recent Sugar Summit would not bring about changes in patient behaviour every dental professional desires.

It was a point that made me reassess every visit I have had to my dentist and hygienist. Did they tell me to do X, Y or Z – a naturally confrontational method of communicating – or did they engage me in discussion about my current dietary habits and where I could consider making some changes? Maybe it's because I'm an adult who (probably) should know better, but I recall a tell.

And this is the catch-22 position we find ourselves in when it comes to sugar. Marketers tell us it's ok to indulge because it's Christmas – the action and the justification – yet when we tell patients to change their behaviour because they have rampant caries – the action and the justification – we're bombarded with reasons why they can't, won't or have not and it's back to square one.

Can we win?

Perhaps the problem lies within the message itself. Do we have clarity? Do we have every dental professional pulling in the same direction? Are we telling patients that it's OK to have treats with mealtimes yet calling for Spiced Pumpkin Lattes to be banned because they have too much sugar in them? Where is the conformity in the message?

Is there a clear and obvious solution? There is no silver bullet, and it will take a cross-party, multi-organisational effort to crack the nut. It has often been mooted that 'sugar is the new tobacco', but in the face of reformulation, efforts to reduce sugar and the Soft Drinks Industry Levy, can we hand on heart say sugar is as dangerous as tobacco? Try telling a fellwalker Kendal Mint Cake isn't good for them when they're half way up Skiddaw and exhausted. It's much easier to tell them a beer or a cigarette won't do them any good, no matter how much we know athletes have poor oral health because of the frequent consumption of energy drinks.

Perhaps the profession needs to be less 'do as I say not do as I do' and really head up the discussion about the perils of sugar. Perhaps we do need to be more forceful with patients – after all if we carry on treating them even after they consistently fail to heed warnings about sugar consumption, smoking, alcohol, are we letting them off the hook?

We need more collective discussion and pooling of ideas in forums like the Sugar Summit. After all, together, we are stronger. ◆

Behaviour change: Failed, failing or fulfilled?

By David Westgarth,
Editor, *BDJ In Practice*

Stubborn. 'Having or showing dogged determination not to change one's attitude or position on something, especially in spite of good reasons to do so.'

It's a word and a meaning we're all aware of, and to varying degrees it's a character trait you see in most people. Yet for dental professionals, it's a word that starts a discussion about the very nature of the profession we are in. You may think I'm referring to those bleedin' patients – and you are correct – but when was the last time we took a look at the other side of that relationship?

It's widely acknowledged by scholars across the globe that bringing about behaviour change is difficult. It is perhaps the most difficult thing one can do. There are so many reasons for this, and I'd soon run out of space – not to mention bore you – were I to begin to list them all. Multiple reasons aside, there is only one thing realistically in the way of changing behaviour; the individual. You can only begin to change behaviour once the individual is ready to change.

There is a recognised need to deliver oral health information to people during clinical encounters to enable them to develop personal skills in managing their own oral health in ways and means they will retain and implement. 'Traditional approaches' to individual oral health education have been shown to be largely ineffective – a discussion and a bit of a telling off don't quite cut it, particularly with a generation who have an inflated sense of entitlement. New approaches are required to address personal motivations for preventive behaviour, but have we swum too far upstream in order to properly encourage behaviour change, and if so is that by desire or default?

The river of intervention

If I ask 10 dental professionals where they believe our profession lies on the upstream/downstream model (fig 1), no doubt I will get 10 different answers with 10 different reasons. There are a number of possible objections to attempting to construct behaviour change and link to the best method of intervention. The most obvious criticism is that the area is too complex and that there is no 'best practice' and therefore too ill-defined to be able to establish a useful, scientifically-based framework. After all, it's a method and concept every practitioner regardless of job title works to.

Another is that no framework can address the level of detail required to determine what will or will not be an effective intervention. So does that mean downstream activity is abandoned in favour of upstream activity?

As Richard Watt wrote in 2007, '*The dominant preventive approach in dentistry, i.e. narrowly focusing on changing the behaviours of high-risk individuals, has failed to effectively reduce oral health inequalities, and may indeed have increased the oral health equity gap*'.[1]

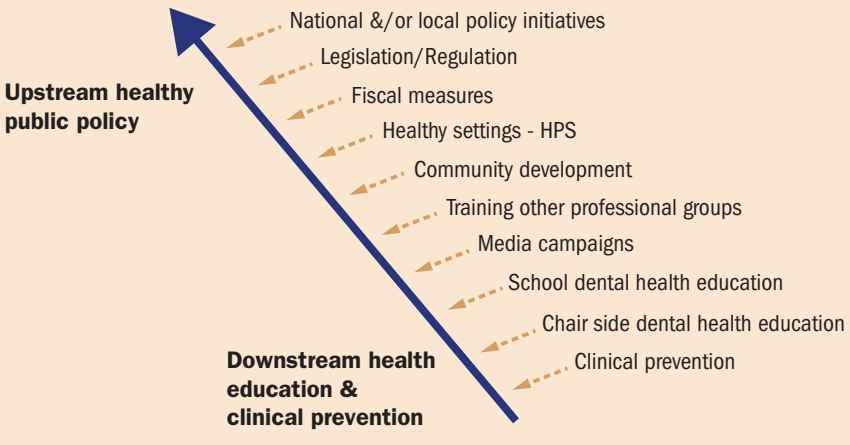


Figure 1: Upstream/downstream[1]

'Does knowledge through a 'tell' alone empower me to change my behaviour? Sometimes it can, but only when the environment allows.'

To date, many health promotion programmes have made grossly inaccurate assumptions that health education will automatically translate to behaviour change. It's the same flawed logic that being told to do at least 30 minutes of moderate-to-vigorous physical activity each day will help. Does knowledge through a 'tell' alone empower me to change my behaviour? Sometimes it can, but only when the environment allows. Can you prevent a child from getting dental decay when a single parent living off the minimum wage is trying to raise and support four other children and they don't have the budget to eat healthily? Unlikely. So we look at the environment.

And this begs an interesting question; is there a strategic plan or the requisite co-ordination between services to promote oral hygiene improvement in communities where cost is a major determinant of their decision-making process?

One blog I read was particularly scathing, and although from Australia, perhaps reflects a growing sense of public ambivalence towards the NHS:

> 'Behaviours that affect health result from the interplay of many economic, social, and cultural factors, making the understanding of complex behaviours difficult.'

'Public servants in air-conditioned offices write hygiene promotion strategies that fail to address the functional state of housing infrastructure and the unique environmental conditions of remote communities. Obesity and micronutrient deficiency in remote communities is a direct result of food insecurity caused by low incomes and the high price of fresh, nutritious food. This is unlikely to ever be overcome as long as local stores (often the sole providers of food in remote communities) continue to be viewed as a small business, rather than an essential service such as health or education. The past and continuing erosion of Indigenous culture and language serves only to perpetuate the vicious cycle of poverty and poor health.

'Government departments are often only as far apart as a different floor in the same building, yet the level of communication and collaboration between departments would suggest there is in fact a chasm between them. Multisector collaboration and high-level engagement and partnership with Indigenous peoples are the only hope we have to close the gap.'[2]

Sounds relatable, doesn't it?

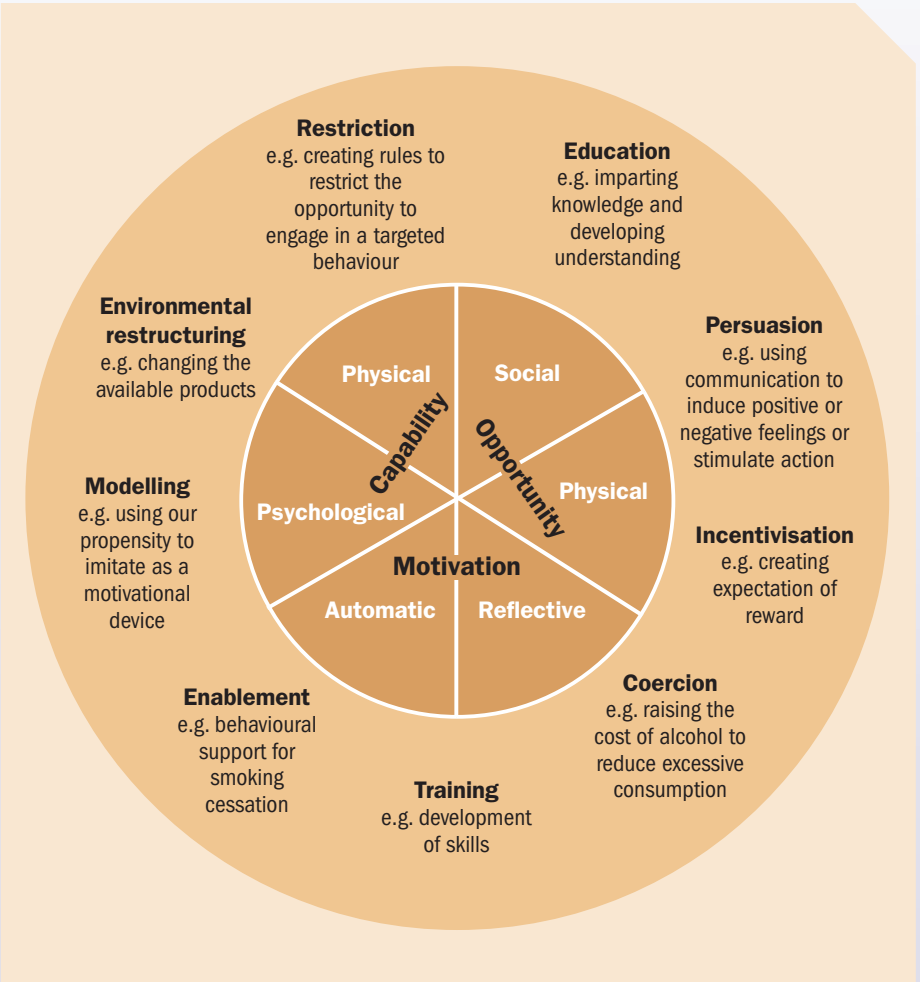


Figure 2: The Behaviour Change Wheel[3]

Perpetual motion

In the United States an estimated 50% of annual deaths can be attributed to lifestyles and behaviours such as the use of tobacco, alcohol, and other substances, diet, and inadequate physical activity. Even with one in two deaths, this has not led to success in changing those behaviours. Behaviours that affect health result from the interplay of many economic, social, and cultural factors, making the understanding of complex behaviours difficult. Change does not come easily even when the individual is aware of the effects of certain behaviours on his or her own health.

In 2011 Susan Michie, Maartje van Stralen and Robert West identified there were a plethora of frameworks for behaviour change interventions. Seven years later, dentistry still has a tendency to work in silos and do their own thing – an approach that has advantages and disadvantages – but one thing still defines an approach practitioners can take; the Behaviour Change Wheel (fig 2).

So where are we on the wheel? Ben Atkins, owner of Revive Dental Care and Trustee of the Oral Health Foundation, believes behaviour change will be stuck in a perpetual cycle until we truly shift the focus.

'NICE has said dentists are not doing prevention well enough, that our approach to date had been ineffectual. And while that is not an easy thing to say – nor an easy message for all practitioners to take on board – when you peel the layers away, there's a degree of truth about it.

'Quite simply, I believe dentistry has too many messages, and conflicting messages with overall healthcare. How is a patient supposed to understand, learn and digest? When it comes to oral hygiene, for me, it doesn't matter to too many patients. There is an entire generation that relied on sugar to live on, and there's no shame in saying it would be foolish

to say to those who lived through wartime that sugar is going to ruin their teeth. They had bigger things to worry about.

'If you consider the current generation's addiction to social media, a high-profile beauty blogger would not want to be seen on their channel with missing teeth. They are far more likely to realise the cause and effect.'

Rebecca Harris, Dean of the Institute of Population Health Sciences at Liverpool University, suggested a change in attitude amongst the current generation may play a part in driving current behaviour patterns.

'The difference in approach is quite stark', Rebecca said. 'Access to information has never been more readily available, and what it means is patients do their research prior to a visit.

'As Ben suggests, social media is certainly changing the demands of the patient. It is increasingly challenging to have the kind of two-way discussions that will have the desired effect for everyone concerned. Patients are more cosmetic-driven in what they want than ever before, and often to the detriment of their oral health. While there is little doubt that at a population level oral health is improving, there is still a significant amount of work to do in the sub-sectors; look at the number of children still having teeth taken out under general anaesthetic. Look at the gap between those at the top end of the socio-economic scale and those towards the bottom. The messages simply are not getting through.'

Hand-in-hand

The World Health Organisation (WHO) Commission on Social Determinants of Health issued the 2008 report *'Closing the gap within a generation – health equity through action on the social determinants of health'* in response to the widening gaps, within and between countries, in income levels, opportunities, life expectancy, health status, and access to health care.

In 2010, WHO published another important report on '*Equity, Social Determinants and Public Health Programmes*', with the aim of translating knowledge into concrete, workable actions. Poor oral health was flagged as a severe public health problem. Oral disease and illness remain global problems and widening inequities in oral health status exist among different social groupings between and within countries.

A report prepared by the World Economic Forum and the Harvard School of Public Health, in advance of the 2011 UN Summit, identified five key points around the financial burden of the major non-communicable diseases (NCD):

- Cardiovascular disease
- Chronic respiratory disease
- Cancer
- Diabetes
- Mental illness.

These five NCDs could contribute a cumulative output loss of $47 trillion in the two decades from 2011, representing a loss of 75% of global GDP in 2010.

The investment required to reduce and prevent NCDs is estimated to be around $11.2 billion per year, reason enough for the WHO to develop a comprehensive global monitoring framework with voluntary global targets and indicators for NCDs. Yet, there is no mention of the largest NCD – tooth decay.

As is a frequent story, it reflects the feeling dentistry sometimes seem to exist in a different silo to healthcare in general. And this begs the question, is the upstream and downstream activity enough, and if no why not?

> 'While deep and preventable oral health inequalities persist in both child and adult populations, in the last five years the Government's spend per head on NHS dentistry has fallen'

Take the large increase in upstream activity, the latest of which is the Mayor of London's decision to announce a ban on junk food advertising across London's entire public transport network. Under the scheme, posters for food and drink high in fat, salt and sugar will vanish from the Underground, Overground, buses and bus shelters.

Add that to the Soft Drinks Industry Levy, to the calls for junk food ads to be banned on TV pre-watershed, to chucking sweets off the checkout, to calls for the sugar content in festive hot drinks and milkshakes to be banned and energy drinks to be banned for under 18s, and you soon see a pattern developing.

These are all great in theory, but according to Rebecca will only work when they go hand-in-hand with what goes on in the dental practice.

'Talking to a patient about why their six cans of Coke a day isn't good for their teeth can be difficult', she explained. 'There is no shock or increased threat level – the patient is not going to die as a direct result. That's where smoking cessation is an easier conversation because you have that threat, and ultimately patients respond.

'People grow up in systems designed for them. Their behaviour is a way of coping in the system. The individual becomes shaped by this, so for a patient struggling financially, asking them to swap the cheap, sugary drink that they have grown up with for something healthier and more expensive is a difficult sell.

'That is where the benefit of the traditional family doctor no longer applies. Not too long ago you had a patient that would see the same doctor and the same dentist, who would have treated older family members and known the social circumstances in which their decisions are shaped. The growth of the corporate market has put pay to that, and as a result we're not treating the all-round patient, we're treating what we see.'

Closer to home

Perhaps we need to look no further than our own government. The British Dental Association has recently questioned Health Secretary Matt Hancock's priorities, following the launch of his new 'prevention focused' vision for the NHS which failed to meaningfully engage on wholly preventable oral diseases like tooth decay.

While deep and preventable oral health inequalities persist in both child and adult populations, in the last five years the Government's spend per head on NHS dentistry has fallen £4.95 from £40.95 to £36, while patient charges have increased by over 23%. Tooth decay is the number one reason for hospital admissions for children aged 5-9, and paediatric extractions have cost the NHS £165 million on extractions in hospitals since 2012.

Which begs the question, are these initiatives, visions and 'investments' politically-motivated to win over voters on the fence and keep current voters sweet, or are they designed to bring about real change? The British Dental Association's Chair of General Dental Practice Henrik Overgaard-Nielsen, has previously stated that the government has shown 'no interest in getting hard to reach families to attend, when prevention could save our NHS millions', so how are patients supposed to show an interest? The *Prevention is Better than Cure* document makes one reference to improving oral health of children. The government's centrepiece *Starting Well* oral health

programme, which is targeting high needs children, continues to receive not a single penny of new investment, and is operating in parts of just 13 local authorities in England.

Ben explained: 'A lot of money is spent treating NHS patients, and in high needs areas you do not get the level of engagement that sees these patients come back with meaningful progress. Is that wasted money? That's not for me to say, but we need to have a discussion whether we can sit down with a patient and say 'unless you change your behaviour, I cannot or will not treat you'.

'It is an approach we take to a lesser extent in our practices. If a patient wants restorative or cosmetic treatment, they have to go through a process of seeing the dental nurse and hygienist before I see them. Unless we see progress and compliance, we don't do the work. It is difficult to implement, but ultimately it's a way to bring about behaviour change in a heavy-handed manner.'

According to Rebecca, the problem close to home is an all-too familiar one for dental professionals.

> 'The major drawback is they don't have the patient profile to bring about behaviour change – their job is more of a 'see problem fix problem', with little time for anything else.'

'The massive increase in litigation, no-win no-fee lawyers and the feeling of fear within the profession created by the regulator means there is very little room for manoeuvre.

'Fear is a word I hear too often. Many practitioners have used the phrase 'defensive dentistry', which aside from the burden on the practitioner themselves does not work in the patient's best interests. You end up treating what you see, rather than listening to the patient and matching their needs. It is a climate that does not encourage behaviour change downstream, but rather one of leaflet dispensing in the hope what you said throughout the appointment sinks in.'

Situation dictates

There's a phrase I use quite a lot, and that's 'right place, right time. It was a bit of luck'. While the application of the message is different, the same can be said about matching the right message to the right patient at the right time in the right way.

For example, those working in paediatrics, special care and hospital-based dental units tell me they simply could not and would not go back to working in general practice. They may have the same pressures, but they have more time with patients. The major drawback is they don't have the patient profile to bring about behaviour change – their job is more of a 'see problem fix problem', with little time for anything else.

The story in general practice is very different. The recurring theme is the contract allows for very little deviation from 'see patient treat patient', yet the demand placed upon general dental practitioners to instil the seeds of behaviour change remains a great one.

'I wonder if the environment of a dental practice means too few practitioners see patients as people rather than a number', Rebecca added. 'Public attitude and perceptions of dentistry have shaped the tone of the interaction, and it can be very transactional. Yet we know that people want to be treated as individuals. They want personal, relatable information in a way they understand and in a form they are prepared to engage with.

'Too often the transactional nature means patients are spoken at rather than a conversation; too often it means loaded questions with an interrogatory nature. Perhaps if we asked patients fewer questions and simply started a discussion, we could form a basis to begin a relationship and deliver changes to behaviour.'

'We treat a number of hard-to-reach patients in a variety of clinics', Ben added. 'The environment dictates the kind of discussions we as a team have. The old model of UDAs leaves no time for us to do some of the things Rebecca mentions above. And for the outreach clinics, they're not interested enough in their oral health to engage.

'Unless a patient wants to change, and until a patient decides to change, we have to keep chipping away and give them a platform and the knowledge to make the change.'

Stubbornness. A word, a state of mind, or the description of the barriers to behaviour change in dentistry? I'll let you decide.

References

1. Watt R G. From victim blaming to upstream action: tackling the social determinants of oral health inequalities. *Community Dent Oral Epidemiol* 2007; **35**: 1-11.
2. Smith C V. Upstream or downstream? *Med J Aust* 2015; **203**: 412-413.
3. Michie S *et al*. The behaviour change wheel: A new method for characterising and designing behaviour change interventions. *Implementation Science* 2011; **6**: 42.
4. Glick M, Monteiro da Silva M, Seeberger G K, Xu T, Pucca G, Williams D M, Kess S, Eiselé J-L, Séverin T. FDI Vision 2020: Shaping the Future of Oral Health. *Int Dent J* 2012; **62**: 278-291.

Busting employment myths

Alan Pitcaithley
Practice Management Consultant, BDA

Employees only have rights in Great Britain after two years' service and in Northern Ireland after one years' service. But do practice managers understand the rights of the new employee, and does the employee understand their own rights? **Alan Pitcaithley** busts some myths around the first few years of employment.

The two/one year rights only apply to an unfair dismissal claim. In, fact this timeframe is not even correct. You need to take into account the statutory notice period (of one week) and as well as some other factors, such as how notice is given, around the giving of notice, such that in GB the time frame is around one year 50 weeks of service and in NI it is around 50 weeks of service.

Myth: I engage my employees on 12-month temporary contracts and then at the end of the period I issue them with another 12-month temporary contract.

Reality: A temporary contract should only be used when you genuinely only need to employee the person for a fixed period of time, for example, to cover another employee's maternity leave/long term sickness or even to complete a piece of work at the practice.

Putting (permanent) employees on temporary contracts does not lessen their rights. They will also still gain their unfair dismissal rights (see above) after round 50 weeks (NI) and one year and 50 weeks (GB).

A tribunal judge will be unlikely to view an employer who uses this model to employee staff favourably.

Myth: I do not need to give my employee a contract of employment since they are only in their probationary period.

Reality: No matter if an employee is on a temporary contract, on their probationary period, work part-time or only work occasionally you are required to provide all employees with a contract by the end of the second month of starting at the practice.

Best practice would be to provide the employee with a contract in advance of their start date. This will also ensure that the terms of employment are clear to the employee before they start work. It can also help in addressing any miscommunication or misunderstanding at the interview state. The employee can make an informed decision if they want to join the practice.

If an employee has not been given a contract by the end of the second month then an employee can seek an award from the Employment/Industrial Tribunal of up to four weeks' pay. While this is not a standalone claim (i.e. it cannot be the only claim submitted) it does provide a disgruntled employee with further incentive to take legal action against their employer. Employers who fail to issue contracts within the correct time frame are likely to gain disapproval from a tribunal judge.

Myth: I do not need to give my cleaner a contract.
Reality: If you pay your cleaner directly under PAYE then they are your employee, and as your employee the cleaner must also be given a contract of employment as described above.

Even if your cleaner is not an employee it is best practice have a written contract in place.

Myth: Since my employee is still in their probationary period they have less rights and there is no need to manage their performance.
Reality: Your employee will have the same employment protection (excluding the right to claim unfair dismissal – see first statement above) as any other employee at the practice. Employees cannot suffer a disadvantage – such as face disciplinary action/be dismissed – for the following protected characteristics:

- Due to a disability
- If they took time off in relation to a pregnancy
- Because of their age
- Due to their religion
- Because they took time off to arrange emergency care for a dependent
- Because they raised a grievance
- Tried to enforce their employment rights
- Raised their concerns about the practice not being a safe place to work etc.

If an employee is successful in persuading a judge that their situation falls under the protective characteristic heading and they have suffered, they may be able to pursue a claim against you. These employment rights apply equally to employees on their probationary period, on a temporary contract.

Myth: I can only put my employees on a 12 months probationary period.
Reality: You are not using a probationary period correctly. A probationary period in a dental practice setting needs to be long enough for the employee to find their feet, learn the role yet short enough to address any concerns promptly. Typically, a probationary period will last between one and three months.

Myth: My employee's probationary period ended three weeks ago so I have decided to extend it.
Reality: If you have not told an employee they have passed their probationary period, this does not mean the employee is still on probation. In fact, there is case law to say that if an employee has not passed their probation period then then the employee must be told, preferably in writing so that there is evidence of this, before the expiry of that period.

Failure to tell the employee (and have evidence so prove this) that their probationary period was extended could result in the employee passing their probationary period by default.

It is best to conduct a review meeting with the employee to discuss their performance prior to the end of the probationary period. It is best practice to confirm in writing to an employee that they have successfully passed their probation. This will be of particular importance where employee benefits are linked to successful completion of a probation period.

Myth: My employee is in their probationary period so I can terminate their employment without the need for any process or give notice.
Reality: All employees are entitled to receive at least statutory notice. However, during the first month of employment there is no entitlement to notice. Within the first two years of service the statutory notice period is one week.

However, you should always check what the contract states as this may offer a greater notice period which would then need to be adhered to.

There are characteristics that an employee may have that provide them with an element of protection during their probationary period. It is not mean that an employer cannot dismiss an employee during the employee's probationary period. An employer may need to justify the reasons for dismissal to a judge. If no process has been followed and if there is no evidence or paper trail then this may be difficult. The difficulty increases with allegations of discrimination where if the employee falls under a protective characteristic it is then for the employer to prove that they did not discriminate. Without any evidence or paper trail this could be very difficult to show.

Before considering dismissing an employee in their probationary period you should still consider following the dismissal and disciplinary procedures that are outlined in the employee's contract and/or the disciplinary/dismissal policy. These procedures will help provide the evidence and objective proof to show the dismissal is not discriminatory or in breach of a protected characteristic. Failure to follow your own procedures may in turn give an employee the opportunity to pursue a claim against you for breach of contract for wrongful dismissal. Typically, the employee's claim would be for the pay that they lost out on due to you not following your own procedures. In Northern Ireland where the rules are different and the risks, depending on what the employee alleges, may therefore mean that the costs to the employer can be higher.

Some employers may however choose to have written into their disciplinary procedures that they reserve the right to follow a simplified process to dismiss an employee on probation. However, you should always try to give an objective reason for the dismissal and give the employee a chance to respond to any allegations prior to dismissing them. ◆

Probationary period

A probationary period should be used to closely monitor an employee's conduct and performance over the first few months. When approaching the end of the probationary period employers need to have a review meeting to discuss how the employee has performed, what they are doing well and any areas that they still need to work on. A decision then needs to be taken if the employee has passed their probationary period or if the probationary period will be extended. You would hope that employees in their first few months of service are the 'best they will ever be' that they 'will do everything you ask them'.

There is a strong argument that there is a psychological factor that needs to be considered, that is, the employee feels they need to 'pass' their probation to keep the job.

It is a useful tool to initiate an employee into the practice provided however that the employee's first few months of employment is properly managed so that issues or concerns are discussed and documented. It should be used to ensure that the employee really does have the necessary skills to do the job and to get them up to speed with all the policies and procedures relevant to the practice. Passing' probation should mean that the employee is then able to do all, or at least most, of the tasks in that role.

It may also be that new employees only get certain benefits, such as enhanced occupational sick pay after passing their probation.

In the deep dark wood...

Peter Ward
BDA Managing Director, on playing the game

If dentistry were a game, what type of game would it be?

It occurs to me that the genre that I remember as *Dungeons and Dragons* and which is now described as 'fantasy fiction' would lend itself rather well in describing the challenges of the journeyman UK dentist of the 21st century.

The dramatis personae are all there; The innocent dentist voyagers trying to make their way doing good and earning gold; the predatory lawyer trolls seeking to trip them up and cause them harm; the other travellers intoxicated by the trolls to believe that they can make great wealth by harming our heroes; the misguided kings who make ridiculous proclamations and who oversee their kingdoms oppressively, carelessly, stupidly and without thought to anyone's long term good; the wizards and elves and witches who sometimes genuinely help and who sometimes cause more harm than good; and of course there are the honest patient villagers who watch on with confusion not knowing who they can trust.

Why so difficult?

So, what are the prevailing factors that cause the quest of our dentists to be so difficult?

The challenge starts with self-belief, or more correctly the lack of it. Lots of anecdote and quite a bit of direct interaction tells me that societally we have managed to terrify our graduating professionals. We have persuaded them that they aren't competent or qualified to do anything but the most simple of interventions. While due caution may be a positive and laudable trait, levels of fear that inhibit the necessary acquisition of skills by activity cannot be in the interests of patients, taxpayers or the profession itself. This phenomenon has caused lots of in-fighting between a variety of educators who blame each other for what is missing.

My contention is that it is not about what is missing, but what is present, and what is present is a heap of anxiety that would terrify anyone. I don't believe the dentists of my generation were any different to the 22-year olds emerging now. Ours skills were new and unrefined, but we were surrounded by older peers who encouraged us to have a go and rescued us when things didn't go to plan. I contend that an immersion of that kind is more likely to generate a body of enabled practitioners than one that involves 'my seven worst GDC cases'.

As our nervous novitiates emerge into the world we immediately plunge them into a set of national systems that range from the mean and miserable, through the confused, up to the biggest of them all, which is

wilfully misconceived and destructive. When it comes to dentistry, the NHS in all its national complexions and all its service systems is badly broken. From the English GDS that controls by fear and penalty to the cash-strapped salaried services that expect under-qualified dentists to take on work well beyond their pay grade (and in the latter case then dismiss them when they fail by virtue of the stress they have been caused).

The lack of a government in Northern Ireland has paralysed everything – dentistry included. Back in time, the NHS was deemed to be a safe start. It was where honest work and effort generated decent incomes and good practitioners thrived. The passing of those halcyon days is sad indeed. This is not an environment to calm the nerves of the anxious.

A noble steed to the rescue!

But have no fear! There exists a regulator which claims to stand above all sway. Its purported purpose is the protection of patients (or consumers as it prefers to call them). It takes very little to evoke a '*... the GDC is not here to protect or argue the case for dentists...*'. So little, in fact, that the officers there will often reassert this fact even when the matter hasn't been raised. The thing is, we all know that. The GDC's role as a regulator is about patient protection and ensuring that the clinicians are fit for purpose. But so entrenched is its commitment to not look out for dentists, the GDC seems to have chosen to disregard them, blame them and to regard them as the problem rather than the solution. The truth of the matter is that the real threat to the well-being of patients is a rotten NHS that is abysmally and destructively-led. That system punishes and penalises dentists to a level that their obedience and good behaviour is more to be marvelled at than expected. Take Christie Owens's piece in the previous issue of *BDJ In Practice* on clawback and handback in Wales.

The perverse and cruel drivers are well known and have been known for over ten years. They harm dentists, they destroy practices and they impede the access to care of vulnerable patients. My question here then is; If the GDC exists to protect patients and to ensure good clinical standards, and if it stands above all influence, why does it wilfully disregard a contracting ecosystem that is patently and visibly the main plank of the problem.

And it's not just the GDC that seems to have forgotten its purpose. If the design of the operating system is corrupt and no-one seems prepared to challenge its excesses, those who administer it have all the capabilities to make it better or worse. The various types of local commissioning arrangements in both GDS and salaried services have got a huge job. In delivering it they must make choices and compromises: volume vs price, quantity vs quality, money vs care. In their 'can do' moments they will tell you that of course they want and expect all of the above.

The plain and simple truth is that they can't have it all. Their choices are made easier because they have the unique opportunity to outsource not quality, but the responsibility for quality. This is to say that in letting ever and ever more impossible contracts with ridiculous volumes of things that can be counted, they are able to disregard the rest. The unfortunate dentist who bids low and secures a big contract effectively underwrites the clinical outputs of themselves and their team. They will receive no quarter if the volume is good but the quality poor. And if the quality is great and the volume is low she can expect punishment and penalty. Make no mistake, at the commissioning end dentistry is a numbers game. The commissioners want as much as they can get for as little as they can get away with. When the quality slips they are also the ones first in the queue to pillory the once-golden-boy who took on that massive amount of work.

> 'During the worst excesses of the unrestrained 'no-win-no-fee' days, the lawyers were shameless in their greed and profligacy. They would frequently drive cases in which the plaintiff won a few thousand pounds in damages while they recouped 20 or 30 times that in legal fees.'

The sharks

And circling around in this toxic mess of over-expectation and punitive systems are the shark-like lawyers. This whole crucible lends itself well to underperformance, mistakes and fallibility. The constant pressure of time, money and threats leaves the profession stressed and liable to slip. Sometimes the slips are significant, but many times they aren't. Yet the opportunistic industry that litigation has become is masterly at fanning flames, inciting dissatisfaction and finding problems that patients never knew they had. Their mission, of course, is to drive cases that generate fees for themselves.

While they self-righteously proclaim the mantra of appropriate restitution for those who have been harmed, the facts of the matter speak to something else. During the worst excesses of the unrestrained 'no-win-no-fee' days, the lawyers were shameless in their greed and profligacy. They would frequently drive cases in which the plaintiff won a few thousand pounds in damages while they recouped 20 or 30 times that in legal fees. That was not a business that was acting in the interests of patients – but i suspect it did buy a few Porsches. As their opportunity receded with the reforms introduced by Jackson LJ they have had to regroup and redefine their battleground. The latest version of the money train is to focus on periodontal disease. Their contention is that a dentist is culpable for a very long time for the onset of a patients gum condition. Having started with a modicum of perfectly legitimate science, they have twisted and distorted it and have now sought to argue that, in essence, the initiating mis-treatment happened decades ago, thereby circumventing limitation periods and legitimising the next round of their outlandish claims.

In light of all of this, the BDA has had enough. We have argued assertively with policy formers, we have repeatedly exposed the misbehaviour of our regulator and we have sought to make sure dentists receive the support they deserve. We will now actively engage in challenging those who seek to profit at the expense of hard-working committed dentists.

We already offer that support in a legion of different ways and we have pages and pages of testimonials revealing how good we are at it. We are busy looking into ways that we expand our service to offer dentists in the UK the ultimate service in protecting them within their professional lives. We will facilitate peer to peer support and tackle the root causes of stress and anxiety that threaten our profession.

In 2019 the whole profession will have something to cheer for, but especially BDA members. ◆

Orthodontic tendering: What you need to know

Paula Slinger
The BDA's Paula Slinger on what you need to know about the process

Since 2006 and the introduction of the new PDS orthodontic contract, the face of NHS orthodontics has completely changed. This is set to happen again with re-procurement of PDS contracts across the whole country.

Since its inception, the process has been fraught with anxiety and apprehension. As we know, humans are innately resistant to change, be it good or bad.

We are fortunate to have an NHS orthodontic service. But the public purse is only so deep and so the restriction of treatment to a limited number of patients across the country has led to waiting lists for treatment or assessment or both in nearly all areas, some as long as three years. This has led to an undeniable amount of stress to all involved – to parents wondering if their child will be too old to have treatment, to reception staff managing enquiries and to practice owners who are trying to run their practices on a fixed budget but with ever rising costs. The most stressful part of the new system, however, is undoubtedly the time limit put on contracts. These are standard in other areas of business, but are not designed for clinical services and orthodontics is being shoe-horned in without consideration of the complexity or the patient's needs.

We are often asked, 'What is the BDA doing about this? Why can you not stop this?' Whilst other ways of selecting who gets an NHS contract may be fairer, the NHS is working within the procurement rules and not outside of them. If you signed a contract with an end date, then you have no right to that contract beyond that end date.

What we can do under these conditions is try and give you information to give you a fair chance of successfully applying for contracts coming up for tender. You need to be careful because some practices will engage experienced bid writing professionals, and some corporates may have somebody in-house who is skilled in this area. We are therefore taking this opportunity to help you understand the approach of the people who will be judging your tender documents.

Some dentists who have lost NHS contracts are simply not responding to the tender questions as well as they could. And that is likely to have contributed to why they lost their contract. It would be wonderful if the NHS procurement teams could come to your practice to see how good it is, and speak to

your staff and your patients. But they won't. They will only look at your tender responses.

What you need to do is write a response that will give you a higher score. It would be a shame if a practice that provided an inferior service to you got a higher score because they had a better tender response. Judging panels do not have access to the scores existing contractors have achieved under BSA assurance processes.

Some practices have, for example, scored badly on areas such as staffing, equipment and mobilisation of services should they win the new contract. It may be that these practices have assumed they have all these things already and that is good enough. It is not. Nor is it good enough to write that you have 4 dentists/orthodontists working at the practice for 6 years already when asked about staff retention.

The key is to treat this like an exam paper. So, let us focus on staffing to provide you with an example.

You have the service specification from NHS England detailing the service they want. You see now that they are looking for 21,000 UDAs/UOAs. Based on your history you are already delivering this service and you have in place 3 dentists/orthodontists delivering 7000 UDAs/UOAs each.

It is likely that there will be numerous questions set out in the tendering document that will touch on staffing. There will likely be questions on recruitment, retention, training, supervision and mobilising services. For an existing practice it is likely these things are in place. But, you must act as though you have no existing relationship with NHS England. Even if you meet for coffee, the local contracts manager does not know you and may not be on the marking panel. Your written responses will be scored; presumptions that the NHS know what you have, will not. For the process to be fair it needs to be based on what you have written down and this is where good NHS practices have unfortunately failed.

So when thinking like a bid writer, no matter what you already have in place it is wise to include, but not limited to, things such as:

- To deliver 21000 UDAs/UOAs you have identified that you need 3 dentists/orthodontists operating from 3 surgeries. You will also need 3 full time or equivalent nurses. One hygienist. One full-time practice manager and one receptionist. Even if you have them, write it down anyway and then confirm they are in place and will continue in existing roles. Think about using skill mix too.
- Each one will have an associate agreement in place to deliver 7000 UDAs/UOAs per contracted year. You will have staffing contracts in place for team members like nurses, receptionist and the Practice Manager and these set up clearly what is expected from each of your dental team. They will have job descriptions and access to and training in all practice policies and procedures. You can also use your staffing and associate contracts as part of the dental team retention and appraisal systems because staff have a clear understanding of what their roles involve. You can monitor performance against these.

> 'We are fortunate to have an NHS orthodontic service. But the public purse is only so deep and so the restriction of treatment to a limited number of patients across the country has led to waiting lists for treatment or assessment or both in nearly all areas, some as long as three years.'

- You will comply with NHS Employment requirements and ensure that all dentists and staff (even existing ones) working under the contract will have, relevant qualifications, GDC registration number (if clinical), Performer Number (if dentist), enhanced DBS check, 2 clinical references, occupational health check, up-to-date vaccinations etc.
- You in return will ensure you have adequate staffing policies such as confidentiality policies, equality in the work places policies, holiday and leave policies, stress policies, appraisal and disciplinary policies for example. You will conduct clinical and record audits to help pick up any training needs. You will have a clinical supervisor in place. You will have regular one to ones, training plans, CPD time, team meetings and dedicated in-house training. Again, these add to the retention of staff.
- You will minimise the risk of the not delivering the contract by having staffing rotas, and targets and having absence policies, a business continuity plan, links to locum agencies, a suitable rota that allows for flexibility, contract management by pro rating UDAs/UOAs.
- All staff will be educated about the NHS contract and their role within it, including things like the NHS Dental Charges Regulations and how to claim under the contract. Also remember this will be a new contract and not your existing one, so say that although they are familiar with existing systems that you will train them on the requirements of the new contract too.
- You might want to write about staff working within their competency and providing a safe environment for your patients.
- You could discuss how your team members do and will involve patients in their care and how you use patient satisfaction feedback to help your dental team with their development.
- State how you do and will work in line with all employment related laws Equality Act 2010, Employment Rights Act, Working Time Regulations, National Minimum Wage Act.
- Even if staff are in place when talking about recruitment you can write that you need X dentists and X nurses who are already in place and confirm they were recruited in line with your recruitment policy, for example an advertisement placed, fair and transparent scoring system to produce a shortlist and assess interview performance, candidate selected, pre-employment checks, commencement. If you are doing a mobilisation plan for new team members you can show dates, such as advert placed 1 November, selection for interview 18 November, interviews 1 December, decision 2 December, pre-employment checks 3-12 December, start date 15 December.
- You could also write about your staff being aware of local policies and procedures such as local NHS referral requirements and their existing relationships with patients and other key stake holders such as GPs, GDPs, social services, community groups etc.

So, you will see from the above example, there is a lot more to a question about your dental team than just saying you have them, and they've been with you 10 years already. Be careful of word counts, most questions will have a word limit for responses so you need to make every sentence count and add value. ◆

Aligning the future

On 9 January 2007, the world changed. On 8 January 2007 there were no apps. No imaginary walking lanes for people who cannot look up from their phones. No bunny ears on pictures. And that is because there was no iPhone.

Dr Monik Vasant,
Director, Freshdental Clinics

Dr Christopher Orr,
Principal Dentist,
Advanced Dental Practice

It's probably not a stretch of the imagination to suggest former Apple CEO Steve Jobs will go down in history as the man who changed life as we know it. And that is the power visionaries in a field can have.

Closer to home, digital technology has truly revolutionised the way dental professionals across all sectors can manage patient expectations. You would be hard pushed to think of a better example than the way Invisalign, for example, has changed orthodontics. *BDJ In Practice* spoke to Monik Vasant and Christopher Orr about how the treatment has changed and defined the last decade of orthodontics.

What changes have you witnessed in the last decade of dentistry and how have they changed the way you practice?

MV There has been a massive influx of technological advances in dentistry. Particularly over the last few years, practitioners have really begun embracing technology which meant that the rules of traditional dentistry started to change. I am not saying that this was a sudden shift – actually if we look at CEREC, they are already celebrating their 20th year, and the iTero intraoral digital scanner is seeing a third generation of doctors – but all this is now becoming more mainstream. It's the natural progression driven by the need to be one step ahead of the competition and to meet patient expectations. Of course more practitioners will adopt these new trends as the technological benefits appear more obvious as technology offers more refined and much more predictable treatment outcome.

A bit like the now-iconic *iPhone* which, since its arrival in 2007, has matured into an indispensable life organiser and entertainment device, the evolution of comprehensive dentistry took time to get to where we are now. There were not, in my view, any specific milestones and it was more the cumulative effect of events happening all at once. With the increased awareness of risks and a boom in minimal invasive techniques, we also witnessed more scanners, better composite materials, a better knowledge of bonding. Look at it as a snowball effect – the ship gradually gathered momentum and became more mainstream.

CO As Monik suggests, the trend towards realistic implementation of minimally

invasive dentistry has involved several things: better restorative materials, better adhesives and a blurring of the boundaries between general and specialist practice.

When Align Technology came to the UK in 2003 they were at the forefront of a big game change with a blurring of boundaries between orthodontists and general dentists. Invisalign allowed general dental practitioners to offer orthodontics to their patients in a way that the patients would agree to.

In a way the 'behind the scenes' work a dentist can do has been driven by vast technological advances too. Composite and ceramic products have improved enormously. Twenty years ago, if you were lucky enough to come across a 'superstar' dentist who delivered amazing results with composite, you knew it was because of their unique skills, and not materials, which were of a barely acceptable standard. Now a general dentist, with an above average level of skill and motivation, can easily achieve a good level of restoration, in a clinically realistic period of time too. This has been achieved thanks to advances in material technologies (better ceramics, better composites, better adhesives). These better materials bring about some better outcomes and offer new possibilities for general dentists.

If we can continue to encourage general dentists to embrace these changes and move away from what they have been traditionally doing, with a view to improving their clinical skills, their practice workflow, developing an optimal patient journey whilst making their working environment a less stressful one is inevitable. With digital dentistry, GDPs can anticipate complications, manage them before they arise and minimise any invasive interventions. Less stress in the world of litigation we operate in can only be a positive thing for practitioners.

What future trends do you foresee for GDPs?

CO I envisage that GDPs will be elevated to the level of 'doctor of the whole mouth', as a result of embracing a concept of comprehensive care where aesthetics and function evolve and merge to be seen as 'normal dentistry'.

They are also being given genuine opportunities to move away from doing dentistry in an analogue world since the price point for digital technologies is now right, and it is indisputable that the way it will affect the dental workflow will benefit both the dentist and patient.

MV We have gradually seen more treatments performed by GDPs which may have been previously reserved for specialists with advanced skills. Dentists were used to refer out, but technology has enabled them to work more predictably and this is why they do more endodontics, implants etc. The key is technology and good training. Furthermore, with NHS funds drying up, career progressions have taken a different dimension and doctors do need to consider 'upskilling' and we find that dentists are more enthusiastic about CPD as opposed to them ticking CPD boxes.

You have both mentioned minimally invasive dentistry and digital smile design – what's your take on how these two integrate?

CO Digital scanning makes it easier for patients to see the potential for their treatment, and as a result they have a better understanding of the implications. It also helps them reach a decision about their treatment faster. Let alone the gooey stuff that patients hate and can now avoid, and this gets them to talk to friends and relatives about their positive experience at the dentist.

GDPs adopting digital technology have a big advantage over others, so it is definitely time to get on-board now, and not in five years to come.

As for Invisalign, every patient says yes to not having to wear braces, so it is a no-brainer. What it means in my opinion is GDPs can now be the next generation of these 'super heroes' of dentistry.

MV Digital smile design has taken phenomenal strides around the world looking at patients' profiles and helping with predictable design of patient's faces. What a fantastic starting point – it's like entering a destination into a Satnav. This gives dentists the right tools to work towards that perfect smile without damaging teeth like we used to or without doing something irreversible.

How has digital intraoral scanning changed the way you practice?

MV There are so many positives with this: first and foremost, it is more comfortable for the patient, by having a scan on file, you do not need to bring them back for impressions and dentists are also able to regularly monitor the conditions of their teeth over time. Digital intra-oral scanning streamlines the workflow, is less workforce dependent and more flexible for everyone.

CO Digital scanning adds another dimension to the patient experience. Beyond that it removes the need for traditional impressions and bringing many of the processes in orthodontics and restorative dentistry into the 21st century.

How has Invisalign and iTero changed the patient treatment experience? And the dentists?

MV With brackets and wires there are so many unknown risks and potential complications, so having improved predictability of orthodontics outcomes thanks to the Invisalign system is just remarkable. It also means a lot less emergencies, which are painful to manage, so ultimately it translates into less surgery time, simpler procedures, and patients get an overall better experience. Plus, the consent process is so much easier since patients can see their outcome before the end.

CO If teeth are in the wrong place, restorative correction is often very destructive. In the past, patients found it hard to agree to orthodontic treatment because of concerns about wearing fixed appliances. Over the last 15 years, Invisalign has made it easy for patients to agree to the best treatment for them by removing that concern.

This makes it easier for dentists to do what is best for their patients in a predicable way. ◆

Monik Vasant
Dr Monik Vasant is a highly experienced clinician with a special interest in minimally invasive aesthetic dentistry. He has trained under many of the world's leading clinicians and has a postgraduate Masters in Aesthetic & Restorative dentistry.

Chris Orr
Dr Christopher Orr is one of the UK's most prominent cosmetic and aesthetic restorative dentists, who practices in his multidisciplinary clinic in central London. He is an Accredited Member and Past President of the British Academy of Cosmetic Dentistry and also a Certified Member of the European Society of Cosmetic Dentistry.

9 skills for success

By Isabella MacLean
Isabella is a practice management consultant in the BDA's Business Team, she is a qualified solicitor and advises general dental practitioners on NHS general dental regulations and on other practice management issues.

To be a great manager of a thriving business try to focus on fundamentals first and watch your dental practice grow how you want it.

1. **Financial management** This is essential. Manage your income and expenditure flow with care. If an NHS contract is a key component then manage the activity with foresight throughout the contractual year; make sure your associate and staffing levels are properly aligned and have in place contingency plans to cover all aspects of the business.

Good financial management skills will help profitability, aid stability and protect your investment.

2. **Market your practice** Make sure your marketing is always GDC and GDPR compliant but use opportunities to let people know who and where you are, what you do, and what is special about your dental practice that will make patients want to go there. If you have a member of staff in control of your marketing, ensure that you maintain oversight and have initial input into the overall strategy.

Have a marketing strategy in place and keep it under review.

3. **Communication** Talking to staff, patients, associates and suppliers respectfully will build good working relationships and should reflect the image of the practice that you want to project. Be consistent and think about the control you are giving up if you leave it up to the practice manager to do all the communicating for you.

Maintain a good level of communication with all the team.

4. **Leadership** By example, sounds clichéd, but there is some truth in it. Motivate your team to improve productivity. Take some time to mentor and coach your employees and encourage staff to develop new skills. Be able to lead your team through change by using performance reviews and record audits.

Your active involvement is a motivational force.

5. **Project management** The running of a successful dental practice will require you to oversee a range of projects from website development to recruitment, developing policies and procedures and business negotiation. Knowing how to manage your time, money and staff will help you achieve these goals. Its not easy and consider extra training in this area.

Finely tuned time management is very important when multitasking of this nature.

6. **Planning** Think about setting priorities for your business and your team now. People and businesses perform better when they have a clear vision and priorities that they are trying to achieve. It ensures that everyone is on the same page and there will be a sense of achievement when a priority is met, positively impacting motivation. Don't just think about what your priorities are right now, also consider the future goals of the business and the team and how you will achieve them.

Strategic and operational plans provide a clear vision and give staff something to work towards.

7. **Don't forget to delegate!** Good business management requires appropriate delegation. Make good use of the skills of your practice manager allowing you to concentrate on the tasks that generate revenue.

Well-planned handling of delegation by you does not lead to a loss of control.

8. **Problem solving** However much planning you do and however good your plans are, problems will always arise. Be ready to make good decisions but think about sharing the problem and taking expert advice. For instance, you could have a patient who makes a totally unreasonable complaint against the practice which threatens the wellbeing of your business. There are a range of factors which need to be considered before deciding how best to tackle this complaint and you want to make sure you have addressed it all correctly and in a way that puts your business in the best possible light. Take confidential advice on how do this and get the opinion of others on the best way forward since two heads are often better than one for problem solving.

Don't be afraid to share a problem and seek expert advice.

9. **Networking** Last but by no means least. It's so important to keep up with the networking and the more you do the better it works. Build it in to your schedule. Use BDA events, LDC events and any other business networking opportunities. You can meet and talk to other dentists and established practice owners who have the knowledge and experience to share. Networking happens at every level of our lives and needn't be restricted to organised events either. You never know who you are going to meet and sometimes the most unexpected people in the most unexpected places can in some way make an offering which helps your business move forward. People will fire off your enthusiasm and will want to be part of what you are doing.

Life is one big networking opportunity – use it! ◆

Responding to bad publicity

By Paula Slinger
Paula is a practice management consultant, helping BDA members with all aspects of business planning, buying and selling practices, incorporation, conversion to private practice and other related areas

A patient has a choice of any one of the dental practices in your area, and so you need a unique selling point to attract those patients. You want and need to stand out. You want to promote your business in a way that makes patients want to pick you.

Business success comes down to a collection of things such as meeting a patient's needs and even convenience; but one of the key things to influence business success is reputation. Why do you think review sites do so well? Think about it, when you go to buy something new do you research it on line? Do you read reviews? Do you listen to what your friends have to say? For most people, the answer would be yes.

Many successful businesses have failed because of the knock-on effect of a one-off incident. A complaint from an influential person has the potential to change everything overnight. Marketing is not just about an enticing advert, selling your patients a dream smile at an amazing price; it's also about the comments people make, the reviews they leave on sites like Google or NHS Choices. The issue is those comments are there to stay. So how do you deal with these?

A bad review can elicit a variety of responses – emotional and defensive are two of those. In the public arena you must put these feelings to one side. It is in your interest to be strategic and ensure negative comments do not spiral out of control.

Think about these two responses to an online comment stating that your dental team is rude:

Response 1: *'Thank you for your review. We do not agree with the views expressed here and as a result will not be accepting you as an NHS patient from this moment on.'*

Response 2: *'Thank you for taking the time to comment on the service you received. We are very sorry to see that you were unhappy with the service. Of course, we take your feedback seriously and we welcome all comments. We want to be sure that our patients are happy with the service they receive. Therefore, we would love to invite you to discuss your concerns further, so we can see what went wrong. Feel free to contact us so that we can resolve this issue for you.'*

As much as you may disagree with the patient's comment, an external person reading your reviews is more likely to appreciate the second response. It reduces the effect of the negative review and shows that you are pro-active and patient centred. It shows that you care about the experience people have when visiting you and that you want to put things right. They will have more faith in you as a business.

Some practices are at risk of breaching confidentiality when responding to a complaint publicly. That is because it's assumed that the patient has mentioned it and so you can respond with what happened. Such as '*we saw you had an appointment at 3pm*'. You cannot make any reference to the patient's visit that may reveal their identity.

Another way to minimise the potential for negative comments is to enable patients to leave positive comments. Have a touch screen available in the waiting area open on the comments page, for example.

One of key things you can do is a risk minimisation exercise around complaints. Thinking about the types of things patients are likely to complain about. Usually you will find the way to minimise issues is clear communication and 'bedside manner'. For instance, complaints may be about:

- Being unable to get an appointment
- Appointments overrunning
- Treatment and failure.

All of these things can be dealt with through the way you communicate with staff. For instance, if a patient phones for an appointment and they are all gone, a less favourable response for the patient would be, 'we don't have any appointments'. A more favourable response would be, 'our appointment slots for today are taken but we do have our next appointment available on X date. Alternatively, we can add you to our cancellation list for today'.

In relation to appointments overrunning, think about how you structure your rotas at the practice. How do you minimise the likelihood that a dentist will overrun? How do you plan for unforeseen absences and planned absences? Having all these things in order can help reduce the complaints you will receive.

When treating patients, it is in your interest to be very clear. You may have a patient who is demanding something different to what you think is in their clinical interest. Back it up in writing and have them sign to say they fully understand. The key to reducing complaints is to have very clear communication on why you recommend your treatment and not what they are demanding. At the end of the day, it is in their best interests – and yours. ◆

Using social media to get ahead

By Paula Slinger
Paula is a practice management consultant, helping BDA members with all aspects of business planning, buying and selling practices, incorporation, conversion to private practice and other related areas

Usually a business's success comes from its ability to adapt. It is no secret that the world in which we live is becoming more and more influenced by and reliant upon technology. Social media plays a huge role in today's society – just look at 'influencers' and YouTube bloggers. As a result, patients may see having a social media presence to assess if a business is 'current' or not.

It may be that you provide domiciliary services to care homes and think this is not relevant to you. But who are the people actually sourcing your services? There is no harm for anyone making sure they have a presence in an ever-growing online world. It presents the opportunity to have your business information there at someone's fingertips. For younger dentists the use of social media for business use maybe second nature, but for some, there is a lot to learn.

In this fast-paced social media world there are new trends coming and going all the time. There are various social media platforms such as Facebook, Twitter, Instagram and YouTube, but just because they are big now, does not mean they will be the social media leaders in a year or two. With any form of marketing it is good to know who you are targeting your services to – for instance, more people under the age of 30 are more likely to use YouTube than Facebook. According to statista.com 96% of Americans aged 18-24 use YouTube, whereas those aged 25-34 are more likely to access Facebook over YouTube.[1,2] Think about who you want to entice to your practice and their social media preferences.

With any social media, the first requirement is to set up your profile. The key is being found and so you are going to want to use a profile name which matches your business. It would be pointless to use Joe Bloggs if everyone knows you as 'ABC Dental Practice'.

Your profile is the perfect page to reflect who you are. You can usually provide a bio on who you are, although some sites have a limited word count. Here you can provide your contact details and a link to your website if you have one. It maybe that there is only room for short description, and so think about what description informs people about who you are and what you do; for instance, 'ABC Dental Practice, delivering high quality NHS and private dental services. or 'ABC Dental Practice, providing dental care and non-surgical cosmetic procedures.' Focus on your key services if given a limited word count.

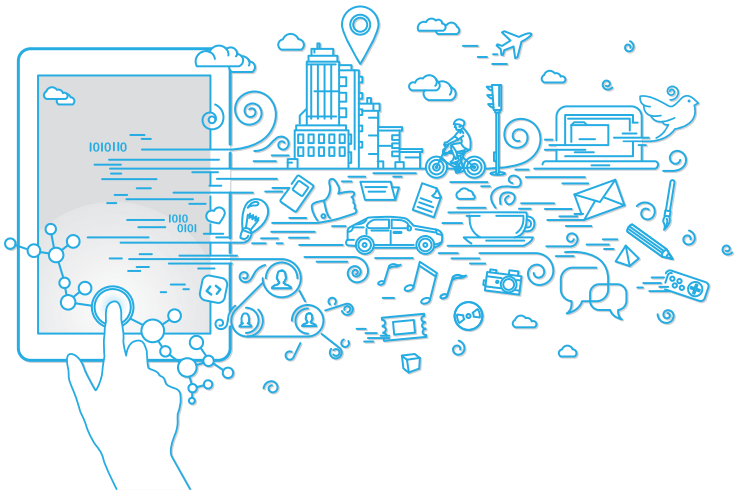
Another thing to consider when setting up your social media profile is the GDC guide to ethical advertising.[3] It may not be a website as such, but you still have to make sure that your information is true, claims are backed up by fact and any information does not mislead patients. When using social media, it is likely that you will use images and so it is important that these images do not mislead also.

When having a social media presence, make sure you have consent to use any images. You cannot just go and use any image. Some images will be owned and so you may need a licence to use the image. There are many companies available online selling stock photography. Some of them have free images available but there may be restrictions on use.

One of the best ways to use social media is to engage with the social media community. You can do this by using hashtags before keywords such as #dental #beauty #smile and of course #ABCDentalPractice. This allows people to find you by searching those key words. You can also do a search to find what words are searched for the most. It maybe you can then find ways to use those words on your posts.

Your posts need to draw people in. You need to be clever and not just post endless pictures of teeth. If for instance you want to attract 30-40 year-old people who are into appearance, food and fitness with a high disposable income, then you may consider posts they are likely to like, such as a picture of a well presented sugar free coffee with a pretty little leaf on top with a quote like 'starting my day with coffee. #Dentist #sugarfree #greatteeth #coffee.' This is a way to widen your audience and appeal to the 'lifestyle' of your patients.

Finally, you will want to think about the boring parts of social media such as security settings and GDPR. Make sure your posts are visible to the public. That is the point of having a social media presence. You want to attract people. Do not use it to bombard people about your services, you could be in breach of GDPR regulations by using their social media accounts to make unsolicited contact. Also remember patient confidentiality and avoid falling into any traps of discussing an appointment publicly with a patient.



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References

1. Statista. Distribution of Facebook users worldwide as of October 2018, by age and gender. Available online at: www.statista.com/statistics/376128/facebook-global-user-age-distribution/ (Accessed November 2018).
2. Statista. Percentage of U.S. internet users who use YouTube as of January 2018, by age group. Available online at: www.statista.com/statistics/296227/us-youtube-reach-age-gender/ (Accessed November 2018).
3. General Dental Council. Guidance on advertising. Available online at: www.gdc-uk.org/professionals/standards/gdc-guidance (Accessed November 2018).

Setting up in practice

By Sarah Cook
Sarah is a practice management consultant in the BDA's Business Team and a qualified solicitor. Sarah advises members on all aspects of NHS dental regulations and agreements.

When I speak to associates, often their career aspiration is to own their own practice. For those who achieve that, this dream can easily turn into a nightmare. Setting up a new practice needs careful consideration, research and planning.

Location

First, consider the type of business you want and where you want it. Do you want to establish a private practice? If yes, research your potential client base. Is it an affluent area where people have disposable income? What is the age range of the people living in the area? What treatments are likely to appeal to those people? You can gather a lot of this information on the local population from the local council or from the latest census information. Researching areas online will also be helpful.

Ensure that you look at your competitors. How many established practices are there in the area? Are there going to be enough patients? Do you feel confident that you can attract enough patients to your practice?

It is also wise to consider the future of an area, for instance have a look at upcoming planning applications. If a large housing estate is to be knocked down it could be that you would lose patients; conversely, if one is to be built you could gain patients. Have a look at your local planning office website to see current applications.

A good way to research and understand the oral health needs of your local population is to look for a copy of a local oral health needs assessment. You should be able to find this online. This is useful for both potential private and NHS practices.

I speak to members who assume that because they want to open an NHS practice, they can provide NHS dentistry. This is not the case. There is a competitive tendering process which needs to be completed, and even then, you are not guaranteed the NHS contract at the end.

Premises

After location your next consideration should be the premises. You will need to ensure you have the proper planning consent. A D1 licence is required for England, Wales and Northern Ireland. Class 2 is required in Scotland. You cannot operate as a dental practice without this.

The premises should be fit for purpose and comply with all of the relevant CQC/RQIA, health and safety, infection control and radiation requirements.

You will also need to comply with other requirements. For instance, you will need to have in place relevant insurances such as personal indemnity, public liability and employer's liability. GDPR and CQC/RQIA registration also need to be in place and licences if you play music or watch TV in the practice. From a staffing perspective you will have to have DBS checks conducted, pre-employment checks and employment or associate contracts in place. Do not forget to register with HMRC for yourself and PAYE purposes. All of this costs money and should be factored in when predicting your businesses financial outgoings.

For those considering bidding for NHS contracts you must ensure that you are situated close to good transport links with parking available. You must also consider access for anyone with a protected characteristic such as disability or age. Ideally you should look for a ground floor surgery with the possibility of installing a ramp, handrails, wide doors for wheel chairs, low reception counters, disabled toilet, hearing loops to name but a few.

Staff

Staff wages will be one of your major business outgoing as a business owner. You will need to think about how many people you will need to employ to cover tasks including reception, nursing and cleaning. You will also need to consider engaging a practice manager to co-ordinate and run the business. Also, what about recruitment of associates, hygienists and therapists?

Finances

Business planning, cashflow forecasting and fee setting are also an essential part of setting up a practice. It allows you to research what your business-related costs will be. Once you know this you can combine it with your research on potential patients. Understanding the local population and their treatment needs may assist you in realistically predicting how many patients you can see in a month. This then allows you to set your fees so that you can cover business costs. Remember that you should factor in the appropriate material and lab fees for the treatments that you think you can realistically deliver each month.

You will not be able to get financial backing unless you can show that you have carried out a comprehensive and rigorous financial analysis. A robust business plan and realistic cash-flow forecast will demonstrate that you have given careful thought to your proposals.

Setting up in practice needs thorough planning and consideration. Be prepared to work harder than ever before. Take advice from colleagues, professional experts and family and friends. Engage capable staff and focus on meeting patients' needs. If you do this carefully then there is no reason why your career aspirations cannot come true!

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The world's most incredible family is back!

It's been nearly 14 years since Disney Pixar introduced us to their Incredibles family, and now they're back on our screens. Incredibles 2 is sure to be a hit this Christmas, so why not use the motivational power of this crime-fighting family to get your younger patients focused on fighting plaque?

Oral-B has launched a NEW Power Kids Electric Toothbrush (suitable from age 3+) featuring fun and friendly Incredibles 2 Disney characters. Kids can download the Disney Magic Timer App by Oral-B to help them brush for the recommended 2 minutes. Disney's NEW Incredibles 2 characters will keep them motivated and encourage proper oral care habits that will last a lifetime.

Benefits include the magical 'brush and discover' functionality. As children brush their teeth they can reveal a secret image. The longer they brush, the more is revealed. They can also unlock fun rewards gaining stickers. What's more fun than stickers? Children can fill their very own sticker album with stickers earned for brushing.

The new Oral-B Disney Incredibles 2 Power toothbrush puts the power of a great clean in little hands.

Here to help

If you, or anyone you know within dentistry, are dealing with financial difficulties, please do not hesitate to contact the BDA Benevolent Fund.

The BDA Benevolent Fund was established in 1883 and provides financial aid to dental students, dentists and their families in need, irrespective of whether they are in training, in practice, have left the profession or are retired. You do not have to be a BDA member to request support from the Fund.

The types of financial assistance the charity can offer varies, but the Fund has recently supported people with the following:

- Regular monthly grants towards day-to-day living
- One-off assistance to meet a specific need
- Funding for those returning to work following a period of illness or because of Fitness to Practice proceedings; this may include help with retraining costs and professional fees.

All contact is confidential and if the charity can help, it will. Each case is dealt with on an individual basis and the assistance provided is tailored to each person. The dedicated team will also try to point you in the right direction to access other support services where appropriate.

If you would to talk to someone from the Benevolent Fund to see how you might be helped, please do not delay in getting in contact – simply call 020 7486 4994.

See dentistry in a different light

Precision is key when it comes to excavating caries, however, improvements in restorative materials mean that it's often difficult to see the margin between healthy tooth structure and common restorative materials.

The Fluoresce HD Dual Wavelength Coupling makes caries detection and removal easier as well as minimising the risk of removing healthy tooth structure. How? During caries removal the UV light causes porphyrins inside caries to fluoresce orange/red (and healthy tooth light green). The UV light also causes restorative materials such as resins and cements to appear a different colour. Since you can see everything as you're working, caries removal comes 'paint by numbers' simple – only remove what needs to be removed, leaving healthy structure intact.

This 2-in-1 handpiece coupling is compatible with Kavo MULTIflex turbines and is similar in price to a standard LED coupling. However, as well as performing the standard functions of an LED coupling, you'll also get a device that detects caries. The user needs to wear a yellow filter to see the caries. These are available as yellow tint glasses or as a yellow tint loupe insert if the operator prefers to use loupes. The glasses are provided free with the coupling and a small charge is made for the loupe insert.

Fluoresce HD is distributed exclusively through Dental Sky. For more information visit www.dentalsky.com.

Low investment, high protection

All equipment needs to be kept clean to function and prevent cross infection. Dürr Dental has a full range of disinfection products manufactured to the highest industry standards. Their range doesn't just protect against bacteria and fungi, it is also fully virucidal, meaning it destroys all viruses, both enveloped and non-enveloped, such as polio and the Norovirus.

The company recently launched a Hygiene Starter Pack, so that those unfamiliar with the superior functionality of Durr's disinfection range, can try it at a substantially reduced price. The pack contains their ID 212 Instrument Cleaner, MD 555 Special Cleaner for Suction Units, HD 410 Hand Disinfectant and FD 312 Surface Disinfectant Wipes. It retails at just £48, a saving of £50 off the normal price of £98.

These are just examples from Dürr's comprehensive range. All are conveniently colour coded to identify each product's application – blue for instruments, green for surfaces, pink for skin and hands, and yellow for special areas such as suction systems and amalgam separators.

For more information contact Dürr Dental on 01536 526740.

No more messy mixing

Applying adhesive to brackets can be tedious, inaccurate and time-consuming.

Avoid the messy mixing of traditional adhesive methods and achieve an accurate, strong bond with the APC II adhesive coated appliance system from 3M Oral Care.

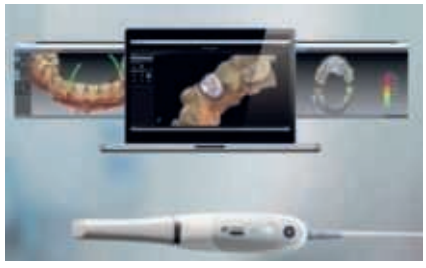
Providing a more workable adhesive than ever before, the system allows for easy positioning at the time of fitting. Though easily manageable, the adhesive is strong enough to eliminate bracket shift and has been proven to form consistently high bond strength, allowing for predictable results.

See how the APC II adhesive coated appliance system can streamline your orthodontic services by contacting 3M Oral Care on 0845 873 4066 or visit http://solutions.3m.co.uk/wps/portal/3M/en_GB/orthodontics_EU/Unitek/

A better way to take impressions

Many patients find the use of traditional impression material unpleasant – from its taste to its gloopy texture, there's a lot to dislike. For patients with dental fear this can escalate from being an unpalatable experience to a traumatic one, as they may feel the material may gag them.Banish these concerns with the latest and greatest handheld intraoral scanner from Carestream Dental – the CS 3600. Using cutting-edge technology, this device will make impression taking as quick and unobtrusive as possible.

For further information please contact Carestream Dental on 0800 169 9692 or www.carestreamdental.co.uk.



All you could need and more

When it comes to decontamination in your dental practice, your infection control procedures might be faultless, but if the equipment that you're using is substandard you're wasting your time, because the success of the cleaning, disinfection and sterilisation processes will always dictate your compliance.

Only by investing in quality, reliable products will you be able to ensure consistent sterility and provide a safe, compliant environment for both patients and staff. The Lisa steriliser from W&H offers everything you could need and more, with the additional benefits of unrivalled customer service and ongoing technical support.

Amongst other things, Lisa provides an exceptionally fast B cycle of just 30 minutes for an average load of 2kg and a 13-minute fast cycle for unwrapped instruments, taking efficiency to the next level. Along with the intuitive interface, user oriented menu structure with programmable cycle start, and innovative Lisa app for Real Time Remote Monitoring, Lisa saves you valuable time and effort allowing you to focus on delivering excellent patient care.

Thus, if it's top results you're after, you really can't go wrong with Lisa.

To find out more visit www.wh.com/en_uk, call 01727 874990 or email office.uk@wh.com.

ADVISORY SERVICES

BDA
British Dental Association

Our Advisers are here to answer your questions on various topics including...

Employment
- Associateships, disciplinary, dismissal, disputes, tribunal representation

Setting up in practice
- Buying and selling a practice, tendering, business planning and incorporation

NHS contracts and regulations
- NHS charges and claims, performers lists, information governance

Compliance
- CQC, HIW, RQIA, infection control and waste management, radiation, tooth whitening, practice inspections, clinical governance

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bda.org/upgrade

020 7563 4550

Dentist to Dentist

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

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HAPPY KIDS DENTAL
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Happy Kids Dental
74–78 Seymour Place
Marylebone London W1H 2EH

Tel: 020 7078 0822
Email: info@happykidsdental.co.uk

Dr. Sarah Tukmachi
Specialist in Paediatric Dentistry
BDS, MJDF, MClinDent, MPaed (RCS)
GDC No. 191816

Dr. Amrita Singh
Paediatric Dentist
BDS, MClinDent
GDC No. 255623

Dr. Malihe Moeinian
Specialist in Paediatric Dentistry
DDS, MSc, MClinDent, RCS (Eng), RCS (Edin), PhD
GDC No. 231760

Dr. Stephanie Oiknine
Specialist Orthodontist
DMD MSc MOrth RCSEd
GDC No. 195243

Dr Prabhleen S Anand
Consultant in Paediatric Dentistry and Specialist in Oral Surgery
IQE, BDS, MMedSc, FDSRCS(Eng) MPaedDent, FDS (Paed. Dent)
GDC No. 81513

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

AYUB ENDODONTICS
www.ayub-endo.com

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

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
Specialist Prosthodontist - including implants for adults
Consultant Orthodontist
Oral Surgeon
Dentist with special interest in Periodontology
Clinical Psychology

Midlands

MOUNT VERNON DENTAL SPECIALISTS
www.mvdentalspecialists.co.uk

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

THE PRIORS DENTAL PRACTICE LTD
www.thepriorsdentalpractice.co.uk

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

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

Mr Rehan Ullah BDS, MFDS (RCPSG), MPhil, MOrth (RCPSG), FDSOrth (RCPSG)
Interests: Specialist Orthodontics, Temporary Anchorage Devices (TADs), 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.

ST GEORGE'S DENTAL PRACTICE
www.stgeorgesdentalpractice.co.uk

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

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
Ian Pearson
Wail Girgis
Cyrus Nikkhah
Nick Williams
Philip Taylor
Assad Khan

Interests: Restorative Dentistry, Dental Implants, All-on-4®, Aesthetic Dentistry, Crowns in a day, 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

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C Recruitment drive
D All of the above

Q2: Why can you not make any reference to a patient's visit when responding publicly to a complaint?

A It's unprofessional
B Breaches confidentiality
C Mistaken identity
D All of the above

Q3: What consideration must you make when it comes to selecting images online?

A That they reflect the practice
B That they have images of staff in them
C You have the correct permission(s) to use them
D There are no considerations

Q4: Which licence is required in England, Wales and Northern Ireland for a premises?

A A1
B B1
C C1
D D1

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