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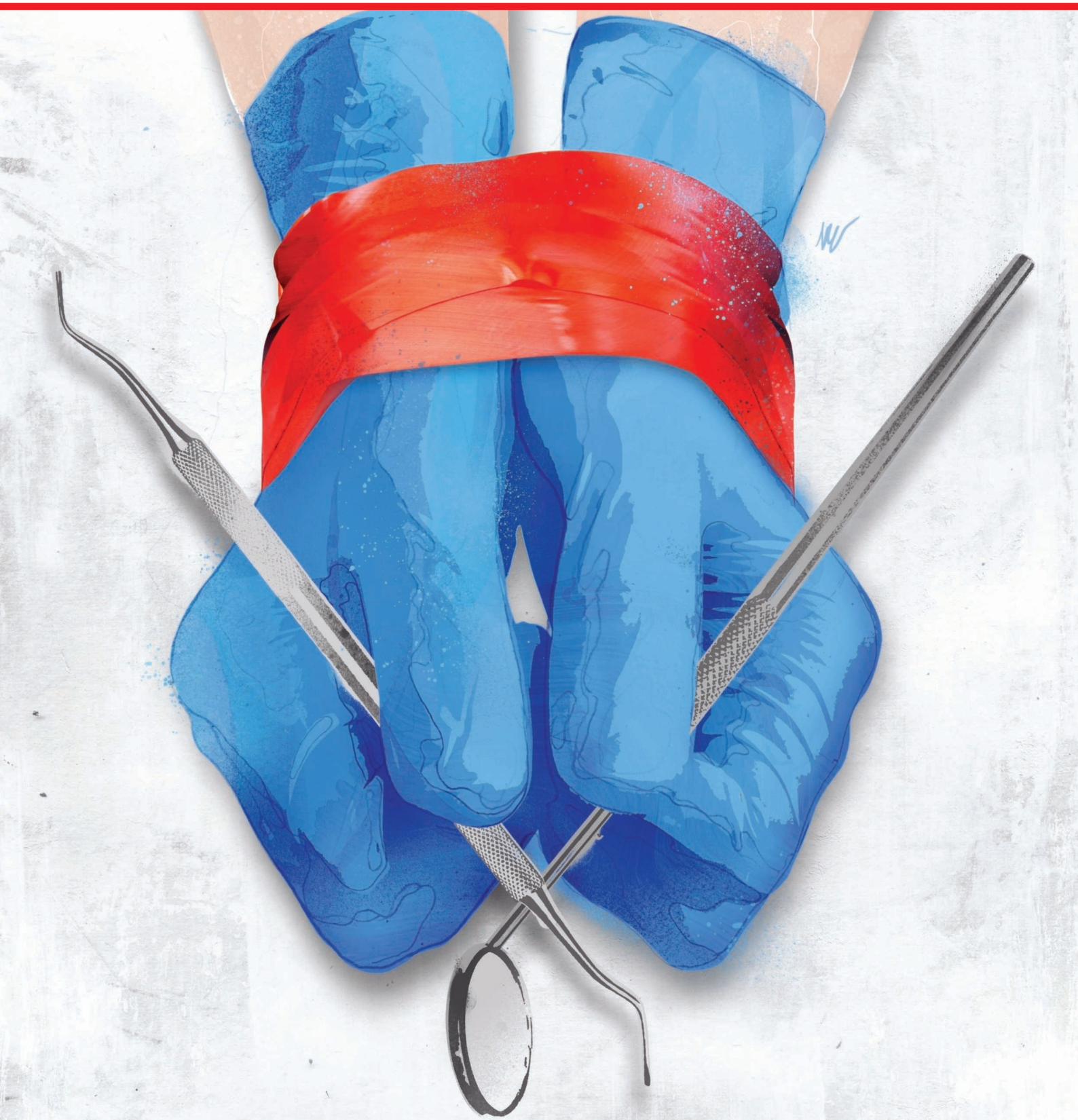

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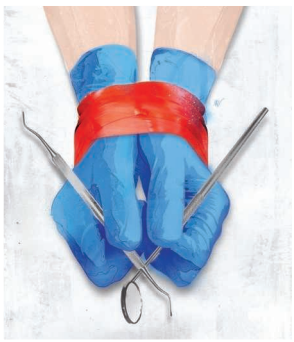

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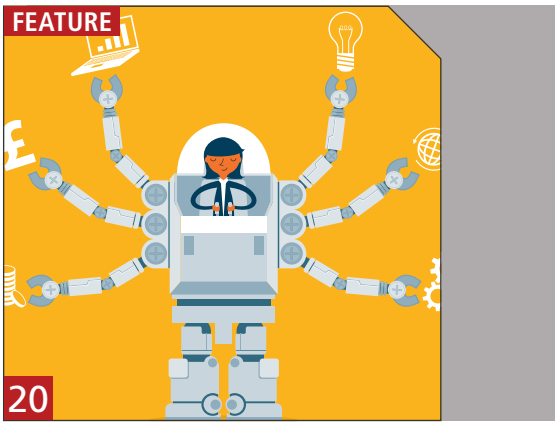
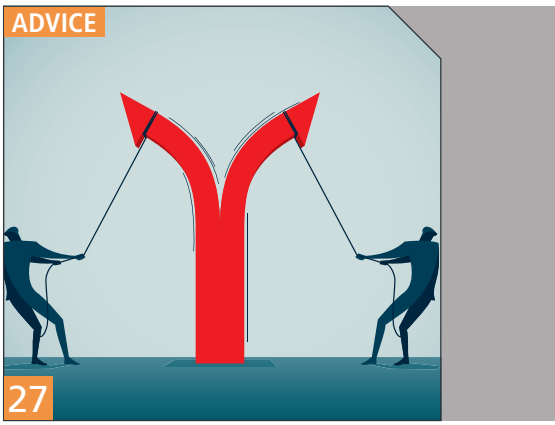




BDA
British Dental Association

Contract reform: Half-measures risk sustainability of NHS dentistry

The BDA says government must let go of failed targets, as a new report indicates mooted reforms of the failed NHS dental system could further undermine the financial sustainability of NHS practice.

The evaluation report catalogues progress on work since 2016 to prototype an updated model for the widely discredited English NHS dental contract, revealing potentially fatal flaws in the proposed business model.

1 in 4 of the hand-picked prototype practices have been unable to hit the access and activity targets, with the average practice reporting the need to work up to 10 extra hours a month to deliver on their contract.

The current contract, in operation since 2006, has fuelled patient access and staff recruitment and retention issues in a growing number of areas. Over half of young NHS dentists have indicated they plan to turn away from NHS dentistry in the next five years, with 42% stating intentions to move into private practice.

The BDA agrees with the acknowledgement in the report that the business model needs further significant examination, and said failure to make a sufficient break from the 'tick box and targets' model of care could now jeopardise needed change.

The government has pledged to reform the system in successive manifestos since 2010. Dentist leaders have called for the current reform package to be refocused away from activity targets and towards improving health outcomes, for significant expansion in the number of practices testing a new contract model, and for funding to be appropriately weighted towards high needs patients in areas of high deprivation, who routinely require more time-consuming treatment.

The BDA's Chair of General Dental Practice Henrik Overgaard-Nielsen said: 'The NHS dental system is fundamentally broken. This report underlines why it will take more than tinkering round the edges to avoid putting NHS dentistry out of business. It makes many sensible recommendations for the reform process, the government simply needs to pull its finger out and follow them through.

'A new preventive model of care is making real headway, but when 1 in 4 cutting-edge practices cannot make the grade Ministers must go further. We have practices working on their own time to make reform work, but we cannot expect goodwill or charity to form the foundation for our health service.

'The government's unwillingness to let go of targets now risks failing patients, particularly those with high needs who require care and attention the current NHS contract was never designed for. We all want to maintain access, spend more time with patients and improve their oral health, but these goals cannot be delivered against the clock and on the cheap.

'We cannot go on as we are. Policymakers must now ensure NHS patients are not left stuck between a rock and a hard place when they require dental care.' ◆

Ban energy drinks to under 16s charity urges

The Oral Health Foundation is calling for a change in the law to ban the sale of energy drinks to under 16s in the United Kingdom.

Research carried out by the charity reveals the proposed legislation is now backed by more than nine in ten (93%) British adults, with even greater support (98%) coming from those with children.

Some national supermarkets introduced a ban earlier this year on the sale of energy drinks to under 16s, with those buying drinks with over 150mg of caffeine per litre needing to provide proof of age.

However, the Oral Health Foundation does not believe a voluntary ban will be effective in reducing young people's exposure to energy drinks.

Dr Nigel Carter, Chief Executive of the charity, says there is an urgent and necessary need to protect children from the enormous health risks that consuming excessive amounts of energy drinks cause.

Dr Carter says: 'Energy drinks contain an obscene amount of caffeine and sugar, resulting in concerns around behaviour as well as health.

'Many energy drinks contain more than twice the daily allowance of sugar for a child. The potential damage caused to oral health alone is extreme and has contributed to thousands of children in the UK having rotten teeth removed in hospital every year.

'The voluntary ban by supermarkets earlier this year is highly applauded, but it is simply not going to influence the amount of energy drinks we are seeing being consumed by young children.

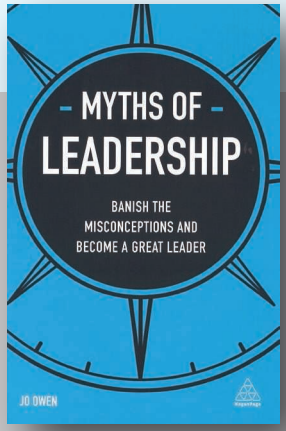
'A change in the law would immediately prevent the sale of energy drinks to children in local shops and convenience stores, vending machines, entertainment complexes like cinemas and bowling alleys, as well as in restaurants.

'These changes, along with those made by the supermarkets could have a real and tangible effect on the health of children in the UK.' ◆

BOOK REVIEW

Myths of leadership

Myths of leadership – banish the misconceptions and become a great leader
Jo Owen
Kogan Page, 2018
ISBN: 978-0-7494-8074-5
£14.99



In a nutshell

Leadership expert and London Business School educated Jo Owen already has seventeen books on the subject to his name and as the UK's number one author on the subject has won multiple awards for his writing including ones from the Chartered Management Institute Gold Medal and *WH Smith Business Book Of The Month* (six times). As Owen claims in his introduction, there are nearly 60,000 books on the subject of leadership and this book, he suggests, will save reading all the others. It also offers insight through a set of catechism-like statements or questions, thereby giving readers the opportunity to think these ideas through for themselves. The book is divided into 56 'myths' within seven broad parts. The myths are headed with such titles as 'leaders are brave' and 'leaders are reasonable'. But in the case of the first this turns out not to be a myth whereas the second is indeed a fallacy. In short, the author has forensically examined these widely-held notions and determined whether or not they hold water. Sometimes the answer is both true and false! He also discusses why these beliefs exist, occasionally providing short anecdotal examples.

Who is ideal for?

This book is actually ideal for anyone who's either in a leadership or managerial role or who is aspiring to achieve one. It can be read cover-to-cover or merely dipped into so its messages can be absorbed quite quickly. The idea behind the book is to provoke contemplation about leadership in general and how to lead better and more effectively. It also attempts to answer the basic questions that every leader will face at some time in their careers. These include big questions such as 'how do I know if I am really leading?', 'can I lead if I'm not the boss?' and 'do I need to be charismatic and inspirational to be a leader?' The reader is not expected to agree with everything this author proposes but Owen does anticipate that through questioning each proposition, the reader will arrive at a satisfactory answer. The overarching principle of the book is that it should act as a practical guide, offering clarity amid the chaos and confusion of office politics and working practices. It will help the reader to sort out the myth from the reality.

Why you should read it?

Owen emphasises the point that the defining role of a leader is to take people where they would not have got by themselves. Many conclusions that Owen reaches in discussing these putative myths are backed-up by evidence in the form of research or published papers, cited at the end of each 'myth' and entitled 'endnotes'. Owen has made a concerted effort to make his book readable and devoid of management jargon which often makes a book unreadable. He also awards each myth a 'unicorn' rating, from one to five unicorns. But in the case of the first myth, 'we know what leadership is' he wants to award it six unicorns as the most heinous myth of all, but settles for five. He contends that we really don't know what leadership is and, cites an analogy of leadership like being searching for smoke signals in fog. His solution to the question is to employ a set of four objective criteria or perspectives: common sense, practising managers, successful leaders and academic research. All this actually makes good sense with Owen succeeding in his intention of making an often opaque subject really quite clear. ◆

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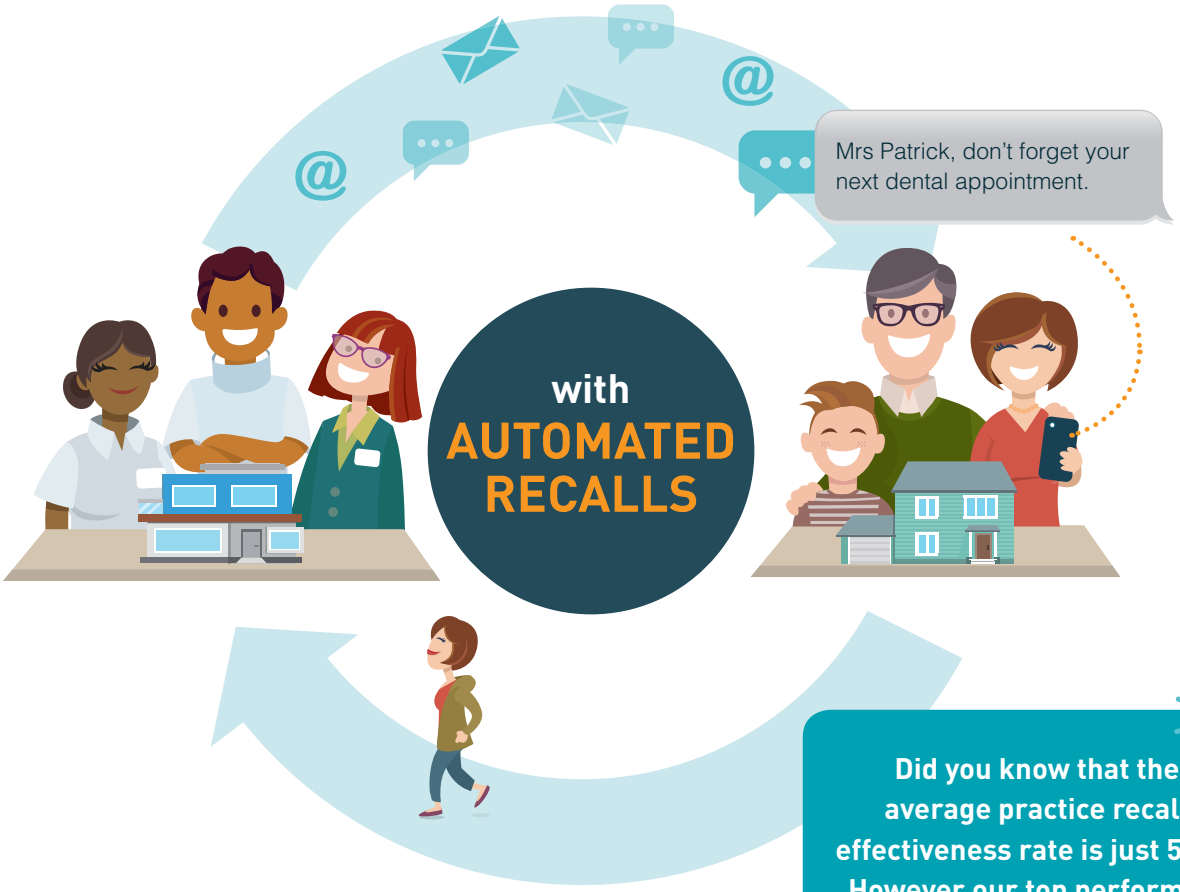

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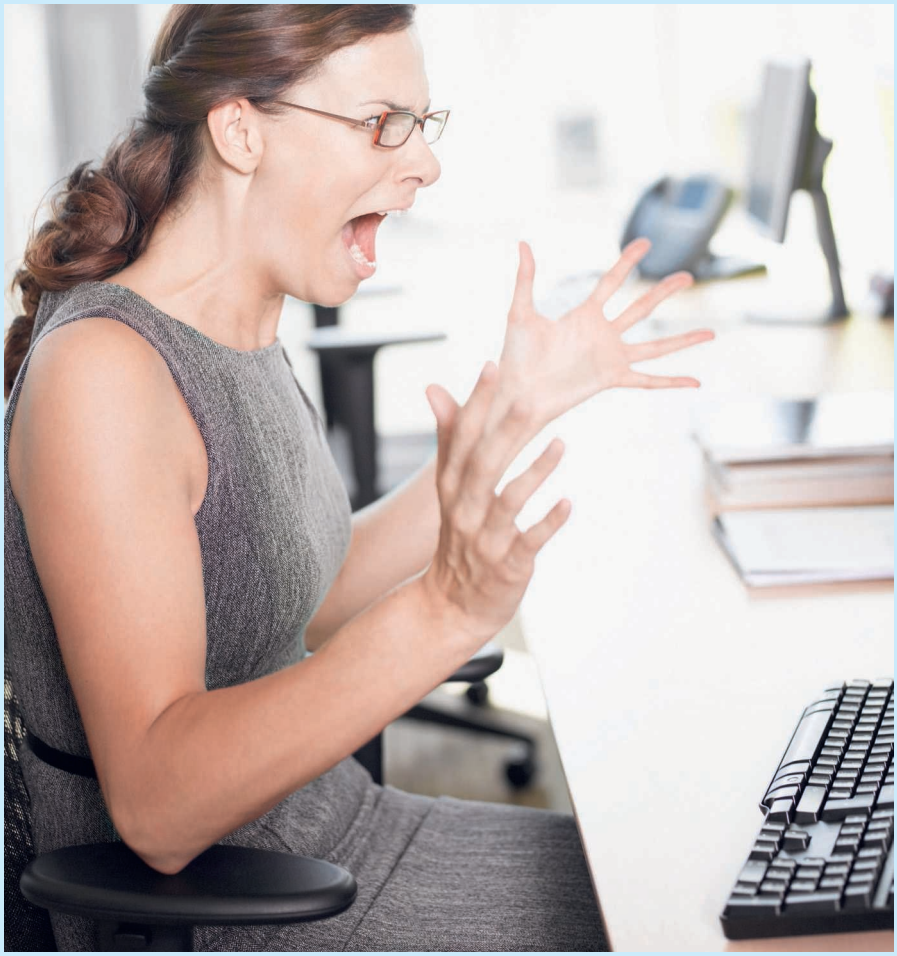
NHS England cannot pass the buck on Capita failings



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The National Audit Office's (NAO) report documenting NHS England's mishandling of the primary care support services contract delivered by troubled subcontractor Capita has been welcomed by the BDA.

Mismanagement of the National Performers List has left over 500 practitioners unable to treat patients. Turnaround times to get a performer number – which all NHS dentists are required to hold – surged after NHS England opted to subcontract out services. Before Capita won the contract an application took an average of six weeks.

Both overseas and UK trained dentists have since been left waiting for up to 12 months. The report outlines how NHS GPs, optometrists and pharmacists were all been hit by similar problems. As the report notes, service delivery continues to be poor.

The BDA has urged NHS England to take responsibility for failings borne of its failure to manage the contract, accusing it of chasing £30 million in annual savings in the Primary Care Support budget.

Following pressure from the BDA individual dentists have received limited 'goodwill payments', but many practices have been left potentially facing steep financial penalties for failure to meet contractual targets as a consequence of this blunder. Following this damning report the BDA is adamant that none of those affected should be left facing a loss because of mistakes at Capita and NHS England.

Optical Confederation Chair Fiona Anderson said: 'As the NAO points out, value for money is not just about cost reduction. Yet these poorly managed changes have been driven by the desire for savings, not the need to improve primary care services.

'The report highlights that the optical payments service is still unreliable. Indeed once again this month payments due are being delayed to hard working practitioners struggling to provide essential and sight saving NHS care.

'We hope that lessons are learned from the report; NHS England, Capita and more importantly patients cannot afford another fiasco on this scale.'

BDA calls on GDC to reduce the ARF significantly and offer flexible payment

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Plans from the GDC not to consult registrants on fee levels ever again are unacceptable, the BDA has told the regulator in response to its consultation *Clear and certain: A new framework for fee-setting.*

The BDA warns the regulator that this will do nothing to regain trust since the GDC's unlawful consultation on the ARF in 2014. It points out that the fee remains the highest of the UK regulators and continues to be used to top-up reserves that the profession deems to be inappropriate. The dentists' trade union has also insisted that before the GDC undertakes any other major work, it must significantly bring down dentists' ARF, with immediate effect from next year and make it clear to the profession how their fees are being spent.

The Association was pleased to see that the complex environment in which the dental profession operates has been acknowledged in the report, though it calls on the GDC to take a stand on the general practice contract in England, which is not fit for purpose and directly affects the ability of dentists to care for their patients. It also welcomes the scope for future work on complaint resolution, but asks the regulator to provide greater details on the plans.

The BDA calls on the regulator to allow registrants to pay the ARF by instalments and consider further ideas to support groups where the cost of registration is prohibitive, including new graduates, part time workers, refugee dentists, and those on maternity leave. The trade union also points out the value of introducing a 'non-practising' register, especially for retired dentists, who could, for instance, lend their expertise through mentoring or peer review arrangements.

BDA chair Mick Armstrong said: 'There can be no justification for keeping the ARF at its current rate. We have paid for the GDC's mismanagement in previous years – it's now time for the regulator to live within its means.

'The GDC is proposing to move away from consulting on an annual business plan to a 'high level' three-year strategy, with little or no scope to comment on the detail or the ARF. This raises questions around accountability when there is evidence that the GDC is using our fees to extend its remit.

'Co-operation has improved in some areas, but the GDC seems too willing to shut down a much-needed debate on GDC fees, efficiencies, reserves and spending of registrants' monies.'

Susie Sanderson inaugurated as BDA President

Susie Sanderson OBE, and leading figure in national and international dental politics, is the new President of the British Dental Association, succeeding Peter Dyer.

This is not the only first for Susie, since she was also the first female dentist to be elected to the high-profile position of chair of the BDA's Executive Board (this preceded the current Principal Executive Committee). She served the maximum six-year term and combined her BDA duties with working as a general dental practitioner in Yorkshire.

Susie's work on behalf of the dental profession has also been recognised internationally, on both the European and global stages, playing key roles at the Council of European Dentists and the FDI-World Dental Federation. Respected for her leadership on many thorny issues of the day, including antimicrobial resistance, amalgam, and professional regulation, last year she was elected speaker of the FDI General Assembly.

A distinguished career in dental politics has also seen her serve the profession at local level. She is a previous chair of Sheffield Local Dental Committee and in 2004 was elected chair of the annual conference of Local Dental Committees.

In her inauguration address, Susie highlighted the similarities between dentists' experience wherever they worked, be it in the UK, in Europe or beyond. Common to all, she said, are the tensions between personal professional accountability and the perverse incentives set out by health authorities.

Referring to the BDA's 2017 manifesto, Putting Prevention First, she urged governments to get a grip on the oral health agenda, and pointed out the paradigm shift in modern caries management to the minimally invasive approach which contrasts with the staggering numbers of children who are admitted to hospital for multiple extractions for tooth decay at staggering costs to the NHS.

Commenting on her inauguration Susie said: 'I am immensely privileged, honoured and not a little humbled to accept the responsibility of the Presidency of the British Dental Association.

'I see it as a responsibility which I will fulfil as fully as I possibly can during this very important year. I intend to make my Association proud and look forward to meeting as many members and future members as I can.'

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Getting a head start in the world of corporate dentistry

Neil Lloyd, *Chief Executive of Dental Partners explains why choosing to work in corporate dentistry can kick-start the career of a young dentist, and why not all corporates are made the same*

Neil Lloyd
Chief Executive of Dental Partners

A nationwide 2017 BDA survey of General Dental Practitioners makes depressing reading for any newly-qualified dentist, highlighting that young dentists have seen their real income fall as student debt levels have topped a staggering £70,000. As a result, many young dentists are looking for new ways to help them meet the challenges that lie ahead.

I quote this survey not so we can all hold our heads in our hands, but to highlight that the profession itself is at a crossroads. The opportunities presented by new technology, and improved materials are helping dentists create ever more lifelike restorations and to improve oral health, helping to meet the needs and wants of an increasingly demanding patient base. But simultaneously, increasing regulation and the challenges of running a successful and efficient small business are bringing their own trials and tribulations. Therefore, it is incumbent on all those with an interest in dentistry to start to do tangible things that can promote its positive aspects and make the lives of those working within the profession as fulfilling as possible.

Corporate dentistry is one sector that often comes in for criticism. Yes, it is true that the rising corporatisation within the market and the expansive growth of the so-called 'mini-corporates', is changing the dynamic within practices and altering the way in which dentistry is delivered. These headlines only tell half the story and we are far from announcing the death of the 'high street' practice.

Corporate dentistry has been through several evolutions since Boots first entered the market 20 years ago. Supermarkets including Tesco and Sainsbury's have also dipped their toes in the waters, but none has made any impact worth noting. The reason for this in my mind is down to trust, or the lack of it. The invasive nature of dentistry means the relationship between dentist and patient is very particular and once trust is built it is hard to destroy. It might be that the failure of these organisations to gain any significant traction in the market is down to their inability to make their offering personal enough to meet patients' expectations. The corporate sector in dentistry needs a 'makeover' and there are now big changes on the horizon that are delivering a new and refreshingly different outlook to this sector, bringing beneficial career opportunities for those who care to take a closer look.

> 'The invasive nature of dentistry means the relationship between dentist and patient is very particular and once trust is built it is hard to destroy.'

So how can we create a new dental marketplace in which the challenges of running a business and the headaches caused by the issues stated above are not mutually exclusive from clinical independence and career progression that is so desirable by today's young dentists?

This state of affairs should be considered an achievable aim for those leaving university or finishing their Foundation Year and in my view corporate dentistry is in the prime position to deliver on all fronts.

Commercially, corporates have been successful precisely because they take away the administrative headaches that are part and parcel of running a dental practice (or indeed any small business). They have centralised services which mean they benefit from economies of scale that are beyond the reach of a single high street practice, but many argue that they achieve these things at the expense of the clinical independence that dentists as healthcare professionals hold so dear. Anecdotal stories of material and equipment downgrades have added to the professional perception that in dentistry, 'corporate' is a dirty word.

As CEO of the newest dental corporate I have been in the enviable position of being able to look at the market from afar and we are now putting in place an organisation that is learning from the mistakes of those that have gone before, with a mission to change the face of corporate dentistry.

The dental team is the heartbeat of any practice and when we acquire a practice we always hope to maintain the team and culture that has already made the practice successful. Good dentistry can only thrive in the right environment and that is why we put a strong emphasis on clinical freedom and personal development through internal and external learning opportunities to help meet CPD requirements and to push the boundaries of what dentistry has to offer.

Dentistry is an exciting profession and one on the cusp of a digital revolution. At Dental Partners we want to encourage dental professionals to make the most of their skills and work in a collaborative, fulfilling environment that takes their career progression seriously.

We completely trust the judgement of our dentists and are committed to their clinical freedom – we simply provide the supportive framework needed to practice ethically and safely. Of course, actions speak lounder than words, but in the 30 or so practices that are already part of the Dental Partners' network, I am confident that we are proving how serious we are about providing an 'alternative' model for corporate dentistry. ◆

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

Is over-regulation failing special care patients?

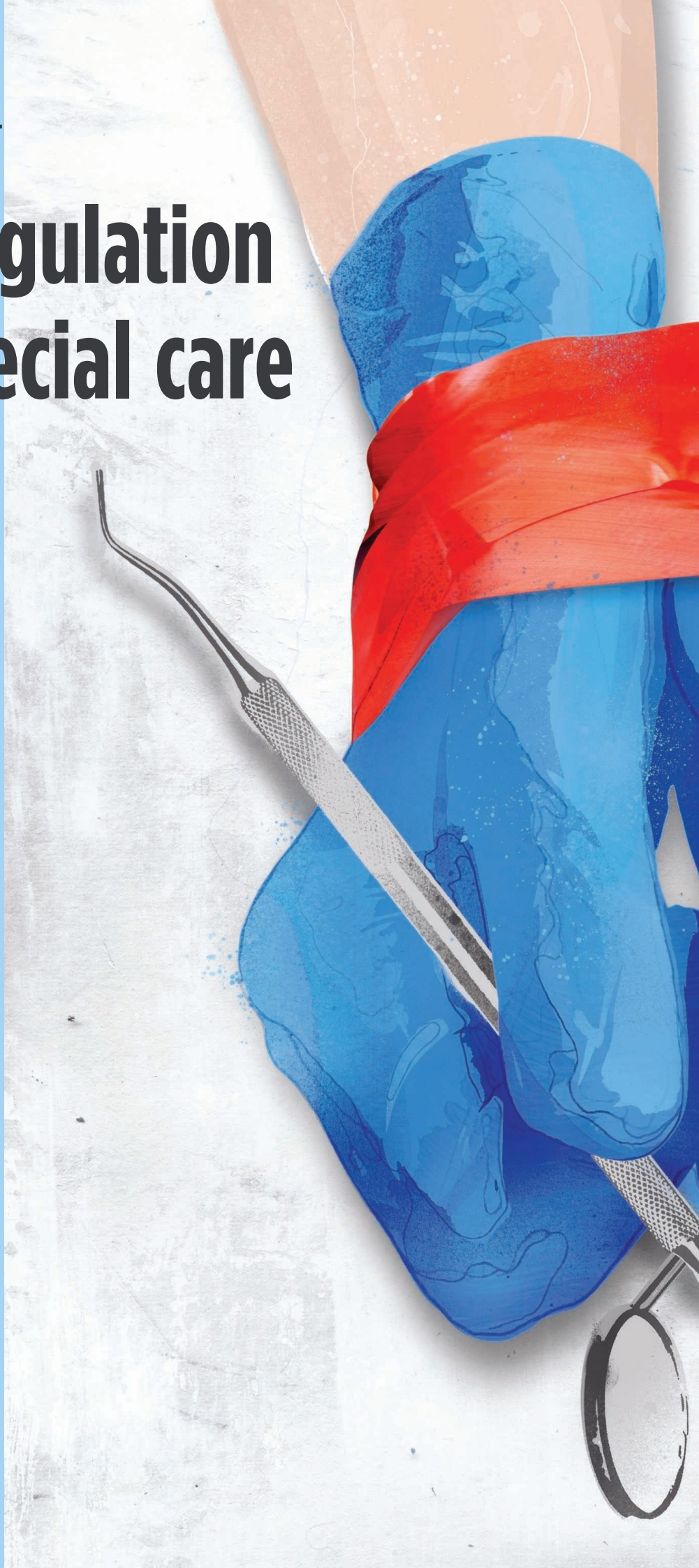
Leader by
Charlotte Waite,
Chair of the BDA England Community Dental Services Committee

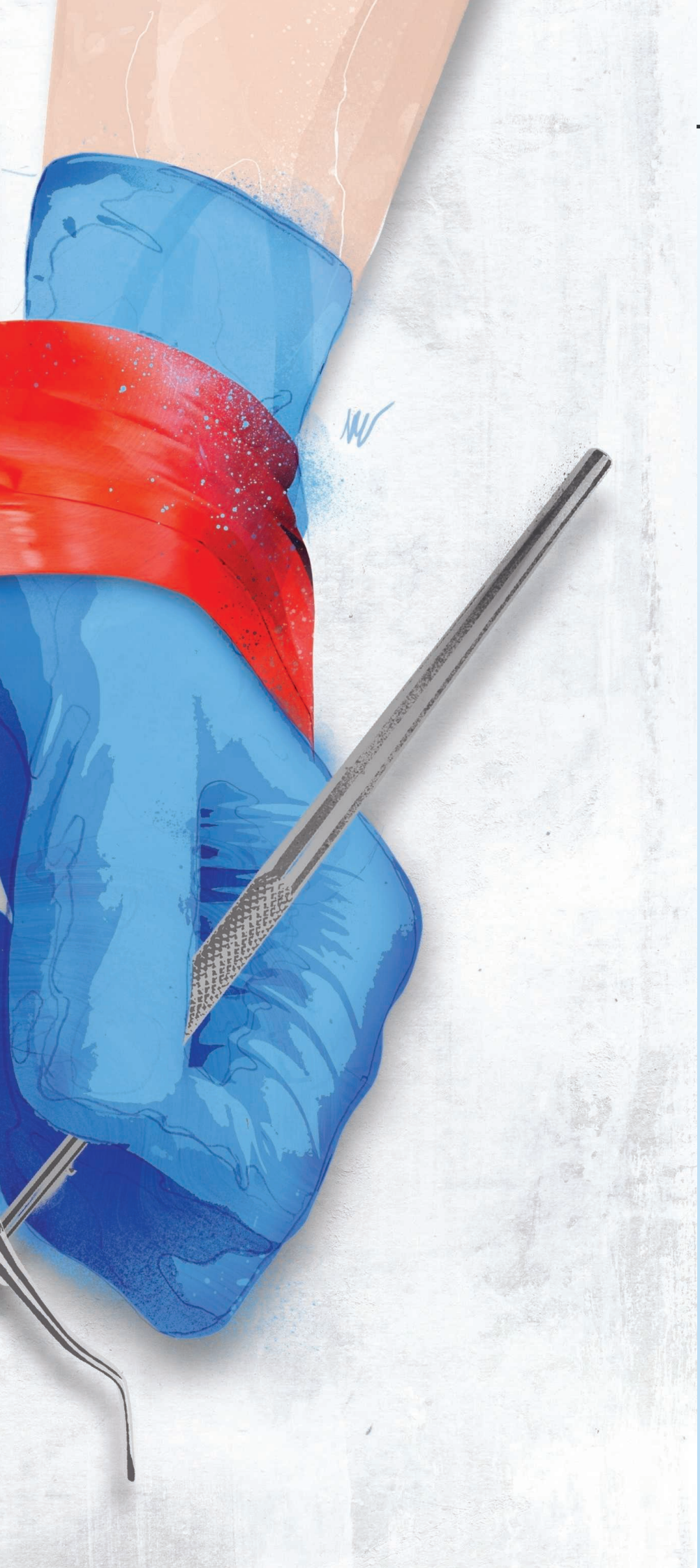
Article by
David Westgarth,
Editor, *BDJ In Practice*

Almost 10 years ago the GDC opened the specialist list for Special Care Dentistry. It is a unique specialty in that it is defined by the needs of the patient rather than by their dental needs:

'Special Care Dentistry provides preventive and treatment oral care services for people who are unable to accept routine dental care because of some physical, intellectual, medical, emotional, sensory, mental or social impairment, or a combination of these factors.

It requires a holistic approach that is specialist led in order to meet the complex requirements of people with impairments.'[1]





With this there came a formal recognition of the complex care delivered by special care dental teams and in 2015, NHS England published 'Guides for commissioning dental specialties – Special Care Dentistry'.

Much of the dental care for this group of patients is provided by community dental services but it is not exclusive with general dental services and hospital dental services (including dental hospitals) also providing care.

But 10 years on, are NHS dental services in England commissioned appropriately to provide Special Care Dentistry, which will meet the needs of an ageing population and the most vulnerable patient groups in society? Are sufficient specialist posts being funded and are sufficient numbers of specialist training posts available, to meet the requirements for services to be specialist led?

> 'The tragic consequences are that people with learning disabilities die, on average, 15-20 years sooner than people in the general population, with some of these deaths identified as being potentially amenable to good quality healthcare.'

On the 10th birthday of the specialty these questions are important and we must ensure that there is appropriate commissioning, along with investment in specialty training for Special Care Dentistry. Without a doubt the specialty is now well established but there is still work to do if we are to meet the increasingly complex needs of the population.

Barriers to care continue to be an issue and need to be addressed. Health inequalities persist and are well-documented. The tragic consequences are that people with learning disabilities die, on average, 15-20 years sooner than people in the general population, with some of these deaths identified as being potentially amenable to good quality healthcare.[2]

The Learning Disabilities Mortality Review (LeDeR) programme was established in 2015, to support local areas to review the deaths of people with learning disabilities, identify learning from those deaths, and take forward the learning into service improvement initiatives.

The most commonly reported learning and recommendations were made in relation to the need for:

- inter-agency collaboration and communication
- awareness of the needs of people with learning disabilities
- the understanding and application of the Mental Capacity Act (MCA).

Specific recommendations are listed in the report. I have listed the recommendations, which I feel are of most importance to dental services:

- Strengthen collaboration and information sharing, and effective communication, between different care providers or agencies
- Push forward the electronic integration (with appropriate security controls) of health and social care records to ensure that agencies can communicate effectively and share relevant information in a timely way
- Health Action Plans, developed as part of the Learning Disabilities Annual Health Check should be shared with relevant health and social care agencies involved in supporting the person (either with consent or following the appropriate Mental Capacity Act decision-making process)
- Providers should clearly identify people requiring the provision of reasonable adjustments, record the adjustments that are required, and regularly audit their provision
- Mandatory learning disability awareness training should be provided to all staff, delivered in conjunction with people with learning disabilities and their families
- Local services strengthen their governance in relation to adherence to the MCA, and provide training and audit of compliance 'on the ground' so that professionals fully appreciate the requirements of the Act in relation to their own role.

It is my belief that these recommendations should impact on the delivery of dental care, for people with learning disabilities. Efficient and accessible ways of sharing information is urgently required and electronic integration would be a huge step forward. Access to Summary Care Records could go some way to addressing this. Patient experiences and outcomes could be improved with better collaboration and information sharing and would improve clinical efficiency, by reducing non patient facing activities.

Pertinent items of legislation for all those providing Special Care Dentistry are the Mental Capacity Act (MCA) and the Equalities Act and these will continue to influence how we deliver care for our patients with disabilities, both now and in the future.

Best interests vs the rules

A best interest decision for an adult is required if the patient has been assessed as lacking capacity for that specific decision under the Mental Capacity Act (MCA) 2005.[3]

The first stage of assessing capacity under the MCA states the person has an impairment of, or disturbance in the functioning of their mind or brain. This could be for example due to a learning disability, advancing dementia or an acquired brain injury.

When working in the best interests for these patient groups the MCA advises certain factors should be considered:

1. Consult as far and as widely as possible, including family members, friends and carers
2. Take into account the individual's past and present wishes, or any beliefs and values likely to have a bearing on the decision
3. Will the person regain capacity? If so, can the decision be delayed?
4. Take into account all relevant circumstances
5. Involve the individual as fully as possible.

> 'What may be seen as seemingly straight forward dental treatment may require sedation or a general anaesthetic (GA) to complete. Reasonable adjustments need to be considered.'

Consideration of the factors above will often take place during a best interest's meeting which is held by the dentist and/or the wider team, with whom the decision ultimately lies. Part of this will be considering pros, cons and risks of all treatment options available to the patient. The least restrictive mode of treatment should also be taken into consideration.

Jessica Mann, Str in Special Care Dentistry at Bristol University Hospital Trust, believes straightforward isn't always the most likely course of action.

'This group of patients often have special care needs when it comes to dental treatment', she said. 'What may be seen as seemingly straight forward dental treatment may require sedation or a general anaesthetic (GA) to complete. Reasonable adjustments need to be considered e.g. desensitisation visits, shorter or longer appointment times or use of a pre-med. A multidisciplinary team input can be required where the dentist will liaise with other health care professionals, or community learning disability teams to make the dental visit as successful as possible.'

Gemma Allen, also an Str in Special Care Dentistry at Bristol University Hospital Trust, thinks the two approaches aren't compatible.

'Your typical 'gold standard dentistry' may not be in the patient's best interests.

'For example, when planning to remove teeth in a patient who is only able to accept dental treatment under GA, a best interest's decision also has to be made surrounding replacement options. On occasions no tooth replacement options are viable, any advanced restorative work which cannot be maintained carries a risk of failure. This may then put the patient at risk of complications, mortality and morbidity risks from a repeat GA. Quite often this causes more distress for the family members than for the patient and can lead to difficult conversations, managing expectations and the need to bring the emphasis back to the best interests of the patient.

'These decisions are not easy and different for every patient, which is why there are no set rules but instead guidance which can be applied. It can be difficult to judge each situation on its merit.'

Treatment planning

With Jessica and Gemma's assertions that best interests and regulations don't always see eye to eye, I asked how that affects the wider treatment-planning process for special care patients.

'Treatment planning for these patients is often complex for a number of reasons', Gemma added. 'Patients requiring special care fall into six main groups: Medically compromised, physically disabled and the elderly, learning disabilities, dental phobic, and those suffering with mental health issues. Each group requires a unique approach, and each patient within the group requires bespoke care.

'For example, medically compromised patients often require a multidisciplinary input and work up prior to treatment. Dental work may need to be timed around their medical treatment (for example if the patient is undergoing chemotherapy).

'Some medical treatment can leave patients with lifelong risks of mortality/morbidity from dental treatment. Those at risk of infective endocarditis following cardiac surgery come to mind. Some of these patients will require dental screens to ensure they are dentally fit prior to this medical treatment. Or the dental

treatment will pose a future risk, i.e. patients undergoing head and neck radiotherapy which leaves a lifelong risk of osteoradionecrosis of the jaw (ORN) from dental extractions. Treatment planning for these patients has to include an assessment of future risk of dental problems. Again, you may have to understand that the treatment you want to deliver which is clinically the right decision is no what is best for the patient.'

The growing number of elderly patients with complex dentitions is something most practitioners are all too aware of. Jessica explained: 'Elderly patients – and those with physical disabilities – often cannot access a dental setting and require domiciliary care. If they are able to access the dental surgery they may not be able to transfer to the dental chair, and require a hoist or other method to transfer. If they have a movement disorder they may require sedation for treatment.

'For patients with severe cognitive deterioration such as dementia, one struggle is whether to intervene if there is an unrestorable tooth. The patient may not be able to say or show you they are in pain, further complicating the situation. Guidance suggests that dental interventions should be kept as non-invasive as possible, but as Gemma has already said, it may not be the treatment you feel you have to deliver, but rather the treatment that is in their best interests.'

Nicola Gallacher, an LDFT in the Yorkshire and Humber Deanery, agrees that the textbook often is the last place to seek guidance and advice on how to proceed with special care treatment plans.

'When I began working with patients with special needs it was initially challenging and I did find it more difficult to create treatment plans', she said. 'There are a great number of factors to take into consideration when making treatment decisions. In all fields of dentistry treatment planning isn't a 'textbook' exercise and working with these patients has taught me the importance of tailoring your treatment to the individual patient's needs.

'Patients can be dependent on others to bring them to the appointments. They may require reasonable adjustments to their dental treatment which needs to be incorporated within the planning. These aren't things you see often in general practice – albeit my experience to date in that setting is limited.

'I often see patients in my community setting that are anxious. I love the behaviour and patient management aspect of community-based care, so I see it as my goal to make any kind of progress with them. Patients may not be able to tolerate dental examinations or treatment, they may require sedation or even general anaesthetic for dental treatment. If, by the end of the session, I have made some progress, I'm happy.'

A special challenge

It is well-documented how challenging general practice is. Not just in the current climate, but for the best part of a decade. The current contract, the financial crash, a squeeze on public sector pay. They have all added up to make working in practice rather challenging. And that's even before I mention UDAs and targets.

> 'The current contract, the financial crash, a squeeze on public sector pay. They have all added up to make working in practice rather challenging.And that's even before I mention UDAs and targets.'

Special care patients require a tailored, flexible approach to dental care with reasonable adjustments. This is hard to provide within the constraints of the current NHS contract – of that there is little doubt. But is it at all possible to treat special care patients in general practice?

'As I have worked in a dental practice and a community centre I can see the limits and restraints from both sides', Nicola said. 'The current climate does not always provide GDPs with the opportunity to have lengthy appointments for scales/ basic restorations but on the opposite side, due to the number of referrals there are increasing waiting lists for care within CDS. It's far from ideal.'

'The contract comes with targets, which impact clinical time for patients, remuneration issues coupled with a high patient demand', Jessica added.

'The current NHS contract does not recognise treatment need in its remuneration. Special care patients can present with a higher rate of caries and periodontal disease rate, resulting in the need for multiple appointments. It also does not recognise that it can take twice the clinical time to complete the work, for example a simple restoration can take several visits to complete, especially if acclimatisation is required. It does not remunerate for non-clinical activity which can be required for special care patients – best interest meetings, for example.

'Special care patients may require more clinical time for their treatment to be carried out. They may require more appointments per treatment, may be unable to withstand long treatment appointments, even getting the patient to sit in the dental chair can take time.

'Access is a well-known barrier for special care patients. A GDP's surgery may not be wheelchair accessible due to being on the first or second floor, or is very unlikely to have a bariatric chair for patient's weighing over the limit of the standard dental chair. The GDP may not have the extensive knowledge of some of the complex medical conditions; this may be due to minimal training in Special Care Dentistry at undergraduate level.

'The demand for NHS dental treatment puts pressure on clinical time. Special care patients can be reliant on carers, relatives and hospital transport to bring them to appointments which may result in being late or missing appointments. Due to their complex medical histories they may be too unwell to attend appointments resulting in late cancellations or non-attendance. For patients with learning disability or Autism, there may be difficulty in getting the patient to their appointment if, something has gone wrong that morning or they simply decide they don't want to go to the dentist that day.'

According to Gemma, there's another factor in play affecting the decision-making process.

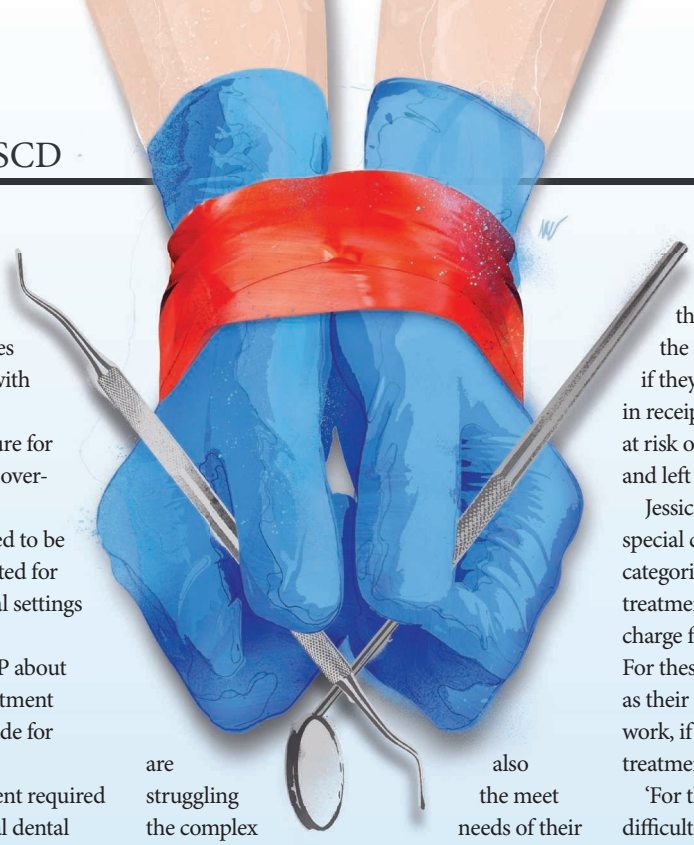
'Practitioners fear the regulator', she said. 'Fear of litigation is something that is at the forefront of many dental practitioners' minds. There is so much to consider when treating special care patients, and so much can potentially go wrong. The principle of not treating the patient according to their clinical needs and rather their best interests is one that general practitioners probably fear – after all, the number of fitness to practise cases will have something to do with that.

'All this means it's an easier option for the practitioner to make a referral.'

An easy option

So it is easy for a practitioner to refer a difficult case out of general practice, if they felt it was detrimental to achieving their targets. But is it *too* easy to make a referral into CDS/hospital for general practitioners these days, rather than treating special care patients in practice?

'Due to the current climate time is often a luxury that is not always available due to the targets set in place', Nicola suggested. 'Other patients do require specialised equipment or adjuncts to dental treatment – for example inhalation sedation or general anaesthetic. These patients – quite rightly – can only be seen within a CDS/hospital setting.



'I am aware that there are challenges out there, and these will likely only increase. General practice probably feels these pressures more than community, but I know with paediatrics things are challenging!'

Jessica believes the current structure for referrals is robust enough to stop an over-supply from general practice.

'There are referral criteria that need to be met in order for patients to be accepted for treatment within the CDS or hospital settings for special care', she explained.

'If there is uncertainty from a GDP about whether they can undertake the treatment in primary care, a referral can be made for specialist opinion.

'Generally speaking, if the treatment required is within the competence of a general dental practitioner, it is expected that the patient should be able to access this care through them. NHS Commissioning guidance for special care dentistry describes this as a Level 1 special care needs, that require a skill set and competence as covered by dental undergraduate training and dental foundation training, or its equivalent.[4]

> 'For a person who only has a set amount to live on each month, a £100 fine can have a huge impact on their financial situation. If the proof of the exemption is not provided the patient is still liable to pay a fee or be refused treatment.'

'Referral for special care dentistry is considered when Level 2 care is required. This is defined as procedural and/or patient complexity requiring a clinician with enhanced skills and experience who may or may not be on a specialist register. This care may require additional equipment or environment standards but can usually be provided in primary care. Typically, this level of care is provided within CDS.

'Level 3a/3b is where a patient requires management by a dentist recognised as a specialist in special care dentistry or holding a consultant status. Typically, these patients can be referred into the CDS for specialist input or a dental hospital for consultant input.'

However, it is not just general dental practitioners feeling the pinch. Community dental services are also overworked, over-burdened and under-funded, and with the changing demographic of the population, are also struggling the meet the complex needs of their patient. So, is the system open to manipulation?

'All referrals go through triaging to ensure they are appropriate before being accepted' Gemma added. 'In many areas acceptance criteria is becoming stricter, as special care services are being reduced through funding cuts. It is difficult, as more patients are presenting with complexities that are unable to be dealt with in general practice. In theory this will marginalise those borderline cases that often are referred.'

Exemptions

NHS dentists are highly skilled when it comes to navigating bureaucracy and cutting through red tape. We are all too familiar with the form filling which is required in order to provide NHS dental services. In this digital age most of us have computerised patient record systems. However, certain documents require a signature from the patient or their representative. In England the 'Practice Record Form- Patient Declaration' (PR form) must be signed by the patient or their representative for each new course of treatment.

The first part of the declaration is essentially concerned with consent, to allow the dental provider to examine them under the NHS and give them any necessary care and treatment that they are willing to undergo within NHS arrangements. The next paragraph is an agreement to allow the NHS BSA or other authorised bodies to examine them or their dental records. They must declare that the information on the form is correct and complete, and that if it is not, appropriate action may be taken against them.

But what about patients who can't take responsibility for checking that they are entitled to claim free dental treatment? What about vulnerable patient groups, those with learning disabilities and dementia? If they or their representative can't make the declaration because they do not know if they receive any qualifying benefits or are in receipt of an exemption certificate, are they at risk of being 'excluded, discriminated against and left behind?'

Jessica explained: 'Unfortunately some special care patients don't fall into any of the categories required for them to receive free treatment, which makes them subject to a charge for dental treatment under the NHS. For these patients the system may be flawed as their disability can mean they are unable to work, if they do not have the money to pay for treatment this can discourage their attendance.

'For those who are exempt, the forms can be difficult to fill in and the patient may be reliant on someone else to fill it in correctly for them. If the patient has a financial power of attorney (POA) the forms should be completed by the designated POA, which may not always be possible. Some carers won't sign the forms on the patient's behalf through fear that they would become liable. Some carers don't realise the impact if the form is filled out incorrectly. If this happens the patient can be charged a £100 fine.

'For a person who only has a set amount to live on each month, a £100 fine can have a huge impact on their financial situation. If the proof of the exemption is not provided the patient is still liable to pay a fee or be refused treatment. It isn't particularly fair'.

What is abundantly clear is that not all practitioners are wrapped up in red tape. Not all practitioners realise they must follow the clinical textbook for delivering care. But for those burdened by regulations and unable to see past the ghost of GDC litigation in their rear-view mirror, the story is the same – they want to be able to offer patient-centred care, but over-regulation simply does not allow for it.

And, given everything that has gone before them, can you, or do you blame them? ◆

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The bank of mum and dad

By David Westgarth, Editor, *BDJ In Practice*

It has been said that avocados are the reason many of today's millennials – and the generation before them – struggle to get on the property ladder. While I find nothing wrong with smashed avocado on sourdough with a poached egg, the reasoning is simple; we're living a life beyond our means.

The impact is that mum and dad are often the ones to bail us out. Be it in the short term, the long term or getting us onto the property ladder, according to NASDAL, it's still one of the largest sources of today's generation of dentists getting a practice. I spoke to Ajay Patel, partner at the National Association of Specialist Dental Accountants and Lawyers (NASDAL) member Elan & Co LLP in London, and Heidi Marshall, secretary for NASDAL, to find out just how reliant dentists are on the bank of mum and dad.

'Bank of mum and dad has traditionally been expected to assist with their children's first home', Ajay suggested. 'However, with high goodwill values, young buyers are unable to build up the required capital rapidly and indeed some see themselves never being able to achieve the pre-requisite capital with pressure from elsewhere, such as repayment of student loans, buying first home, marriage and other cash-heavy expenditures.

'I find parents are more willing to help because of low returns on their capital/savings. The reality is parents of many millennials are coming to an end of their own working lives, with many selling or moving on from their businesses for significant sums with no immediate answers of where to reinvest. This is the scenario where their son's or daughter's careers and fledging businesses are prime for investment.'

Heidi believes the bank of mum and dad is no longer a luxury, but rather a growing necessity.

'With ever-increasing practice values, the bank of mum and dad has been a necessity to bridge the gap between what bank lenders are willing to lend and the asking price of the practice', she said. 'Therefore, to compete successfully – certainly in some geographical locations – on practice purchases, there is a strong degree of reliance on other forms of lending. The bank of mum and dad is one of those, and a strong one.'

Ajay Patel

Ajay Patel is a founder member of NASDAL. He is a partner in Elan & Co LLP, Chartered Certified Accountants and has been in practice for over 30 years. He is responsible for advising a large portfolio of dentists and dental professionals ranging from associates to multi practice corporates.

Heidi Marshall

Heidi Marshall heads up the dental team at Dodd & Co Chartered Accountants. She is Secretary of NASDAL (The National Association of Specialist Dental Accountants and Lawyers) and acts for clients up and down the country. She has over 250 dental professional clients and therefore immense experience in this specialist area.

Ballooning

Unlike traditional ways of securing capital, parents don't put their offspring through vigorous tests to see what they can pay back. In theory, this could give access to deeper pockets – a good thing for the buyer, but is it a good thing for the market?

'The value of something is defined by what someone is willing to pay for it', Heidi said. 'In the past few years, values have been strong due to large corporates aggressively pursuing NHS practices and individuals with private lending competing with them. Part of the valuation process is to benchmark recent practice sales in the area, to ascertain a reasonable asking/sale price. Bidding wars can and do go on, which does inflate valuations. Parents will do what they can to secure their son or daughter's practice.'

Ajay agrees.

'Bidding wars ensure best value for the seller. Individuals with sufficient free capital can make bids above asking price and usually end up being the preferred acquirer. It is not uncommon for a £1m practice to go with a premium of £75K or £150K above asking price when the bidder has assistance from the bank of mum and dad. The seller will see it as having achieved market value but the buyer and banks will view it as an inflated price. It does distort the market and eliminates many bidders from the best practices.'

But is there any other way for young dentists in 2018 to be able to buy a practice?

'I advise creating a consortium for larger acquisitions by pooling resources and in the process making the bidder/s more attractive than say a corporate, for example', Ajay explained. 'Use of government enterprise funding guarantee scheme for unsecured element of loan is another avenue, but unfortunately dental lenders don't appear to be too keen on this. It can be done, but it is difficult.'

Heidi has a slightly different view.

'Goodwill values are beginning to soften. A review of the most recent NASDAL sales/valuation data reveals that not all practice values have been artificially inflated. There are still deals to be had at a reasonable price.

'It is key that any potential purchase seek the advice of a specialist dental accountant, to ensure the practice they are interested in is the right one (financially) for them. In respect of lending, there is a large pool of healthcare lenders willing to lend substantial amounts, so the bank of mum and dad isn't always necessary. It's also worthwhile taking your time and saving up a deposit. Although you can attain 100% lending from banks, this is less common and will attract higher interest rates/more stringent lending terms.'

Keeping up

It's a well-documented concern that wages aren't rising quickly enough with inflation. It's difficult enough for some to get by – real term wages have fallen 30% in a decade for general dental practitioners. With wage rises sluggish, how sustainable is this way of financing?

'NHS pay rises are expected to be modest for the foreseeable future therefore with high gearing and potential rise in interest rate it should be a real worry for all acquirers', Ajay said. 'Funding from the bank of mum and dad is not always a soft loan but in the majority of cases an outright gift or inheritance, therefore for those who do not need to repay the risk is not significant.'

> 'While not geographically nor factually true, there is a growing difference in recruitment patterns depending on which end of the country you inhabit. But does this translate to how deep mum and dad's pockets are?'

Heidi added: 'Whilst it's true that practice prices have increased at a higher rate than wages, funding from mum and dad is still integral to some practice purchases. However, in our experience, funding from mum and dad is normally accumulated family wealth and therefore the recent wage rises have less of a bearing.'

Given Heidi's and Ajay's assertion that wage rises – or a lack of – aren't integral to the long-term success of a practice, can potential buyers compete with corporates?

'In one (well, two) words – very well', Heidi said. 'There are stories of dentists armed with money from their family outbidding corporates. Corporates have lending criteria and limits and approach potential purchases with an objective view, which means they can lose out when they try to bid for a practice that an individual (with bundles of cash) wants, for perhaps subjective reasons. Corporates also have to consider the cost of using associates to provide the dental work – an individual whom will be working at the practice will not need to apply this financial modelling.'

According to Ajay, a common myth is the reason many corporates complete quickly.

'Contrary to common believe corporates do not necessarily pay the best prices', he said. 'They can complete deals quicker as the banks are not involved, and consequently it is less likely that an acquisition will fail. Corporates often tie the seller in as performers for months or years which some sellers like as they are not sure of their retirement plans. I am increasingly advising bidders to offer the same options simply to make their bids more attractive to the seller.'

North vs South

There's an amusing anecdote from a number of London-based colleagues and friends who believe anyone north of Watford is classed as 'the north'. While not geographically nor factually true, there is a growing difference in recruitment patterns depending on which end of the country you inhabit. But does this translate to how deep mum and dad's pockets are?

'Due to modest prices, often there is no need for the bank of mum and dad to assist in funding in the north, as banks are happy to lend under their normal criteria' Ajay suggested. 'I have not come across bidding wars up north. My experience of funding from the bank of mum and dad in the south east of the country is that it can be as little as £50K to many hundreds of thousands, which is a phenomenal amount.'

Heidi said: 'The bank of mum and dad does seem more prevalent in the south – particularly London and the south east – as Ajay suggests.

'This may be a result of traditionally higher practice values in the south, meaning alternative financing is necessary to bridge the gap between what the asking price is and what the banks are willing to lend. With goodwill values being lower outside of this region, this gap between asking price and bank lending offers is likely to be smaller and therefore it's less necessary for the bank of mum and dad to be involved.

'Generally, prices of practices are lower in the north than the south, so we would invite young aspiring practice owners to move up to Cumbria and come and speak to us!' ◆

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Guy Meyers
Head of Customer Success at Software of Excellence

As technology becomes more sophisticated, savvy dentists are harnessing its power to help them become more efficient in their everyday practice. **Guy Meyers**, Head of Customer Success at Software of Excellence, a Henry Schein company, tells us how practice management systems can now do some of the thinking for busy practices too.

As more of the world around us becomes computerised and the digital landscape continues to innovate and produce new technologies which offer more capabilities, we are all finding that we need to be much more computer-literate in order not to be left behind.

This has been the case in the dental profession for a number of years, especially with the increasing application of digital techniques which are converting more and more dentists to the digital workflow and who as a result, are achieving greater efficiency, accuracy and predictability. CAD/CAM processes are controlled through digital software and equipment such as intraoral scanners and 3D printers integrate with and are controlled by it, so more than ever, dentists need to be comfortable working with sophisticated digital functionality.

Administrative and managerial tasks have also been digitised to a huge extent over recent years bringing greater efficiency and positive results to practice teams whose manual workload has been dramatically reduced by the benefits of centrally-held and easily-updateable data and automation. Practices have had the opportunity to embrace these efficiencies with the introduction of computerised practice management systems, some of which can automate many of the most time-consuming tasks, such as recalls, short-notice list management and online booking, thus releasing the front desk team to concentrate on patient care. They can also integrate with CAD/CAM software which enables practices to keep clinical and non-clinical data in one place.

An increasing number of practices are adopting or upgrading their practice management system each year and that can create challenges for the personnel who work in those practices. Generally speaking we might think that the younger generation of dentists and nurses in particular, would find this easy since they have grown up surrounded by digital communication and should in theory be at ease with technology. However, for an associate dentist working in multiple practices needing to use two or three different software systems throughout the week, the transition can be difficult.

Using a PMS

Whether you like a PMS or not, is usually based on personal choice, as most software systems have similar functionality around the storage and updating of patient notes, and integration with hardware such as X-ray and CBCT equipment. However, Software of Excellence's EXACT goes an extra step, and takes on some of the business tasks on behalf of the management team and also for dentists themselves.

WorkFlow

Controlling a practice workflow is an important part of assuring a seamless patient journey through the practice. For example, a system that automatically alerts the dentist to suggest a recall interval for each patient, which is then sent to the receptionist, who uses this information to encourage the patient to book a future appointment before they leave the practice provides a common-sense approach to patient management. Other alerts at 'check-out' such as for missing contact information, consent for GDPR purposes, and reminders about any outstanding patient debt simply mean that all patient information is updated appropriately; therefore communication with patients becomes easier and more efficient.

Keeping patients moving

Other automation, such as the sending out of recalls by text or email when they fall due and the filling of appointments from a short notice list, simplifies the process for the reception team but also gives the dentist peace of mind that all of the things necessary to keep patient flow moving are being done automatically.

Mypractice Cloud

Today's practice management software needs to be a smart business tool to make sure that dentists can keep track of their performance – both clinical and financial. A practice management system that gives dentists a simple dashboard of all their key performance indicators and provides in-depth performance and financial reports, along with the ability to view calendars, share documents and benchmark business results against UK averages, surely has to be the way forward for dentists who are or are likely to become business owners.

Technology has the power to make all our lives easier, but there are good and bad examples of it in every area of life. The best practice management software increases efficiency and enables targets to be met by speeding up tasks, automating manual jobs and providing insights into business performance. Well-thought-out, intuitive PMS software frees up time and provides real-time performance statistics needed to work out where you need to improve and plan how to achieve your goals. An intuitive PMS also makes it easy for any associate dentist to log in and effortlessly use it when they arrive in the practice with a full clinic ahead of them! ◆

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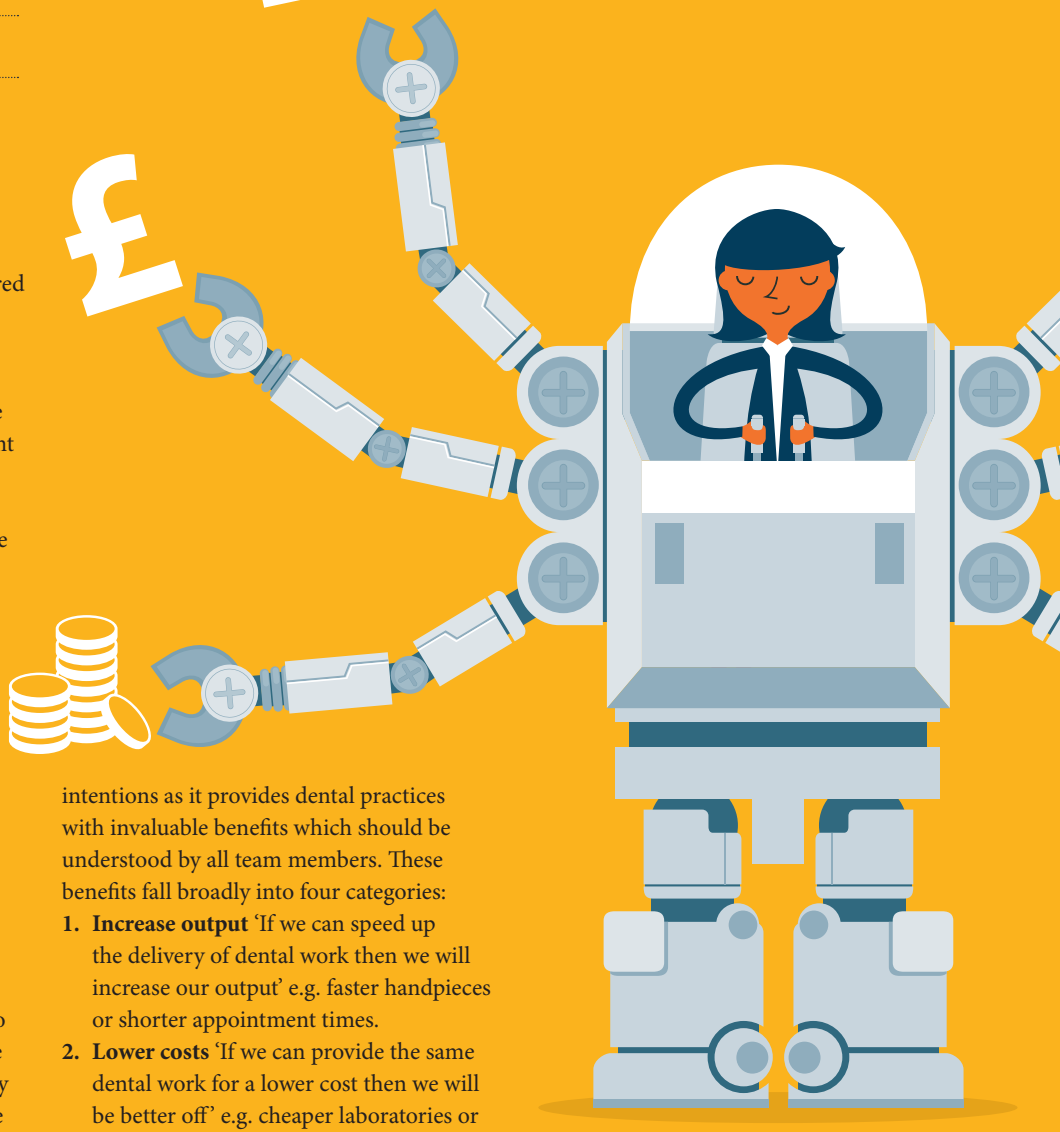
The efficiency

Asif Syed



The world is getting faster. With a quick click of a button you can find friends across the world, have Chinese food delivered to your door, access all recorded human knowledge, or watch a film on demand.

Only a few years ago this would involve leaving the house or making plans. Now we can have all these things in an almost instant timescale and with increasingly less effort.

The world has become more efficient.

Has this efficiency made us happier? There is some debate given finding friends has made us lonelier, ordering food has made us fatter, access to knowledge has made us less informed, and box sets have made us lazier.

However, these are some of the challenges we are facing in a world that is increasingly automated. Of course, these advances in efficiency will bring their own challenges to the dental profession.

One of these challenges is how dental practices across the country will cope with even more demand for efficiency.

Efficiency is not a new idea for those who work in general practice. Many NHS based practices have been encouraged to do more with less for years, and indeed private practices use the mantra of efficiency to stay competitive as they jostle for patients in the market place. When we have an industry with a predisposition for efficiency, coinciding with a world that demands the same, many practices find themselves on a runaway train of efficiency without ever stopping to examine the outcomes.

Too often 'efficiency' becomes a practice anthem in the hope of a better tomorrow. Too often this better tomorrow never arrives.

Of course, the pursuit for business efficiency always starts with the noblest of intentions as it provides dental practices with invaluable benefits which should be understood by all team members. These benefits fall broadly into four categories:

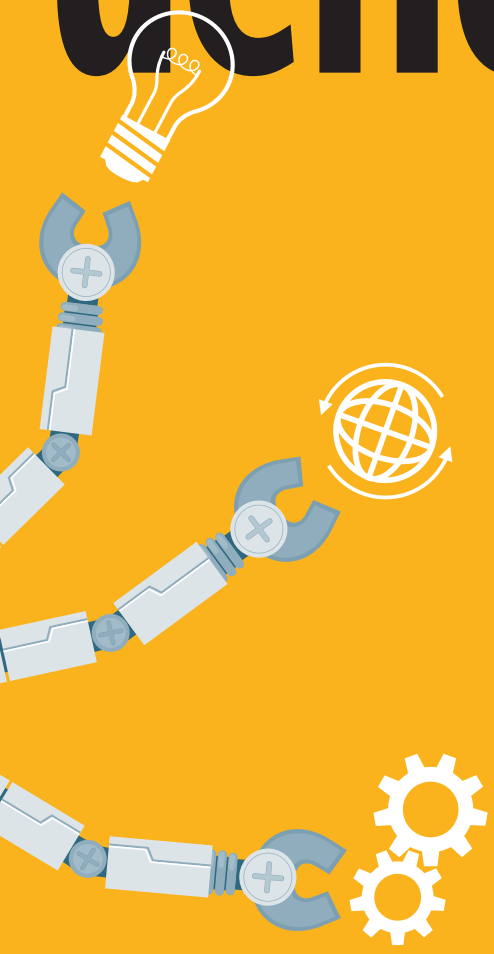
1. **Increase output** 'If we can speed up the delivery of dental work then we will increase our output' e.g. faster handpieces or shorter appointment times.
2. **Lower costs** 'If we can provide the same dental work for a lower cost then we will be better off' e.g. cheaper laboratories or capping pay rises.
3. **Reduce waste** 'If we waste less we will make more' e.g. switch off electrics or ordering fewer materials.
4. **Optimise resources** 'If we can do more with less, we are being smart' e.g. limit staff phone use or share an endodontic motor.

Dental practices have repeatedly found the above can be winning or losing tactics based on how they are explained, how they are received by the dental team, and the order in which the initiatives are introduced.

Often this can be a tough sell, given that staff rarely wake up in the morning with the goal of making the practice more efficient. Even dentists aren't motivated solely by the idea of efficiency, and certainly findings from numerous patient surveys have rarely, if ever, concluded that efficiency is a key determinant for patient attendance, retention or attraction.

deficiency

In the first part of a new series, **Asif Syed** explains how an efficiency deficiency is affecting the profession



Yet as a profession, we have an insatiable appetite for efficiency.

This blind pursuit of efficiency can set dental practices heading into dangerous waters. Often, this happens insidiously so it may be helpful to illustrate the five most common deviations made in the name of efficiency.

1. Squeezing in patients Larger numbers of patients are placed into smaller units of time. Although sometimes unavoidable, if this is deployed as an ongoing strategy this is not efficiency but maximisation. Running any system to absolute maximum capacity for indefinite periods will cause it to crash. This applies to your home heating system, your car, your computer, and also your dental practice.

2. Doing unscheduled treatment on the spot Patients agreeing to treatment at check-up find themselves staring down the business end of a blue needle to the metallic symphony of a nurse rapidly changing trays. Although occasionally justified, if this is deployed as an ongoing strategy this is not efficiency but opportunism. Repeatedly removing structure from the clinical day in this way rapidly leads to a chaotic surgical environment as no two team members know what is happening next. It is not possible to provide predictable dentistry in an unpredictable environment.

3. Doing work faster There is a tendency for dental teams to work to accepted practice norms for example, 15 minutes for a Band 2, 45 minutes for an eMax crown preparation, 10 minutes to set up the surgery. On closer examination, this norm is most often set by the fastest in the team for the slowest. When team members are pressed indefinitely in this way it does not lead to efficiency but rushing. Rushing means team members miss out steps to maintain the illusion of speed. Occasionally rushing is required but when used as an ongoing strategy in this way, missing out steps invites the practice to embrace mediocrity.

4. Encouraging only hard work Quite correctly, laziness should not be tolerated in a dental team. However, many practices over shoot this goal and focus solely on keeping team members busy. Often this can be seen in the 'best nurse' who is 'efficiently' running around the practice collecting instruments from other surgeries whilst sorting out patient payments at the desk. Certainly, some running around is part of any general practice role, but when the team become fixated by being busy in this way it does not lead to efficiency but activity. Activity means the practice prizes the existing work. It does not prize learning how the existing work can be completed better. By accidently deprioritising learning, practices can stagnate, regress and finally lose the ability to adapt to a fast, changing world.

5. The incorrect use of financial triggers The rallying cry of 'we are spending too much on materials!' is regularly followed by a stock ordering embargo. Although financial controls are important, sudden knee jerk changes to recently viewed metrics in this way does not lead to efficiency but myopia. The short-term stock bill reduction is met by a long-term shock revenue decline. This is the only possible outcome when dentists and their teams cannot count on the composite capsule being available for the planned private composite or the correct bonding kit for the freshly delivered private veneers. It is not possible to provide quality dentistry without the necessary items to provide quality dentistry. The necessary items can become lost in the haze of efficiency.

When the darker side of efficiency reveals itself, a practice is characterised by multitasking, stress, panic, and eventually burnout.

This is the 'Efficiency Deficiency' – when the pursuit of efficiency has become a deficiency. The Efficiency Deficiency can be diagnosed in this way: when a clinical facility has been created where only a few can thrive and the majority struggle.

The unlucky ones who work in this environment may recognise, moaning, complaining, frustration, and depression as markers of their daily grind. For those who experience this environment intermittently, a resolve to steer away from the Efficiency Deficiency would be heathy. For those, who are lucky enough not to work in this environment, appreciation, gratitude and personal contribution towards practice progression would be prudent.

In either case, the journey away from The Efficiency Deficiency always rests on the question of responsibility. Specifically, is efficiency the responsibility of the individual or the practice?

In theory, it is the responsibility of the practice to create an environment where all have the basic right to succeed. In reality, it comes down to the ambition of the individual.

Having dealt with The Efficiency Deficiency on numerous occasions, it may assist your own progression on a practice

and individual level to review the four rules summarised below:

1. People can't be efficient

People can't be efficient, only processes can. If someone is deemed efficient it is because they have an efficient process. Their process can be learned, but their personality cannot be plagiarised. This is useful for dentists trying to move up a level both clinically or managerially. The other dentists are not really 'faster' or 'better' they just have processes which work better than your current processes. Try watching someone you wish to emulate at work to discover the key differences in process. Don't waste energy defending your current process, or trying to reinvent the wheel by working out why your current process does not give you what you want.

2. Collaboration is cool

Often the answer you are looking for is held by someone in the practice. As a first step, always look for things that you can already see working in your current environment. Other team members are not as secretive as you think as human nature responds to authentic interest, genuine compliments, and a sincere desire to improve. Practice managers can use this to help create a harmonious work environment instead of being placed under the impossible burden of supplying all the answers to justify their pay grade.

3. Don't run six businesses

If a group of full time and part time dentists become individually efficient, the practice can fall into the trap of running six separate businesses. A dentist and nurse combination must compete against another five for the limited resources to make their system work. This is terribly difficult for the desk: two receptionists cannot deliver six different systems to a high standard. It would help principal owners to align working patterns as early as possible in their tenure. Again, dentists can be surprisingly compliant when this process occurs for the greater good and is not positioned as indulging petty personal preferences. This would be mandatory for practices which have invested significantly in developing a brand – it would be inefficient to say one thing in the market place then deliver six different things to the same market when they eventually attend the practice.

4. Preparation is profit

During the working day, clinical time is wasted when the dots don't connect: missing lab work, lost notes, incorrect payments, empty water bottles and the wrong sized gloves. This waste can be improved by robust preparation systems. Nurses wishing to get ahead and improve their standing in the practice would do well to concentrate on preparation to show their worth to those holding the purse strings.

The world is getting faster.

I hope 'The Four Rules of The Efficiency Deficiency' help you cut through the noise to propel your progression.

In the meantime, my Chinese food has arrived. ◆

Asif qualified as a dentist and is now a committed full time dental business strategist based in London. Asif runs three well respected business courses for dentists: 'The Young Dentist Course FFQ', 'The Associate Course PYP,' and 'The Principal Course KYN.' In addition, he manages a select group of dental practice clients.

Are dental labs and technicians a dying breed?

There are few things that annoy me like automated telephone calls. If they are to be believed, I'm owed enough money from PPI to buy a private island, and I'm the unluckiest person on the earth with the number of accidents I've been in. And these calls are getting smarter too.

Phillip Silver

Automation isn't always a good thing. In March the BBC ran a story asking '*could a robot replace your dentist?*' Besides the obvious lack of situational knowledge no robot possesses, it posed an interesting sub-thought; what area of the profession is at most risk of automation? I asked Phillip Silver, the UK Business Manager and Consultant at Solvay Dental 360, about where he feels technology may or may not hinder.

Phillip Silver
Phillip Silver is the UK Country Manager and Consultant at Solvay Dental 360. He is a specialist in medical technologies and materials with over two decades of experience in both implantable and non-implantable devices. Phillip has worked in a range of clinical fields incorporating digital techniques and introducing new and novel technology into restorative dentistry, replacement and reconstructive surgery and facial plastics.

Do you think dental technicians and laboratory teams are most at risk in the profession from automation and technology?

I think that those laboratories and technicians that don't embrace new technology, for example CAD/CAM and digital workflows could perhaps be at risk if they don't evolve and move with the times. We are in a situation where digital is moving so quickly that potentially, there is that danger that dental technicians and laboratory businesses could be at risk.

Judging from the way the dental lab market is right now, I would say that there are different categories of laboratories. We have the artisan labs, which produce superior quality crowns and bridges and prosthetics. I think that there will always be a need for these businesses, but not in the volume that we have now, so it is inevitable that we will see shrinkage. In another category we have laboratories that are producing very high volumes of work and you have to ask, what is the reason for that? A lot of it comes down to cost and in order to fit within the NHS system and tariffs, those labs need scale. This is where digital is exciting because it can allow all the efficiencies needed to consistently produce large quantities of high quality work.

Have we become too reliant on technology?

There is always a danger that we can become too reliant on technology and lose some of the traditional skills that we have within the industry. However, we do have recruitment issues and a skills shortage in the dental technology profession right now and often it's necessary to fill the gap by recruiting some of the well-trained technicians from overseas. However, Brexit could be a potential concern in that it might be harder to fill those vacancies, and/or it may become less attractive to come and work in the UK.

Would you say technicians have had to go through revolution or evolution of their role?

It is very much an evolution. What I have seen is that if technicians with traditional skills are able to add CAD to them, it makes them stronger. They have learnt the traditional techniques but now with the aid of digital technology, they can put them to further use. What we are seeing is that we meet highly trained dental technicians and others that only have CAD skills. For us, there is sometimes a skills gap, which we have to overcome, and that is where courses such as the Solvay Dental 360

can help to plug those gaps. It can be interesting to put those two types of individuals in a room and get them to the same level by the end of the day. The learning curve can vary for both types; for example, some individuals struggle to be able to use CAD because it just seems alien to them, whilst for others it comes naturally. Nevertheless, from the lab's perspective, there is always going to be a need for technicians that are formally trained and registered.

Would you say that those laboratories that once offered a 'full service' are now having to outsource work in order to offer a comprehensive provision to dental teams?

It's a mixture I would say; some still do everything in-house whilst others outsource. Speaking from our point of view, to fabricate a removable partial denture (RPD) from Ultaire AKP it requires a digital scanner and then CAD/CAM. Nevertheless, there are laboratories that have not been able to make that investment yet but still want to offer our solutions to their customers, so they outsource. We don't see this as a problem, it is good that they have that ability but we still ensure that these labs are trained properly and know how to finish the material correctly to produce a completed prosthetic. It is worth pointing out too, that labs have been outsourcing chrome manufacturing for decades. It just means that laboratories can offer a viable metal-free alternative.

Dentists often comment that it is impossible to keep up to date with the all the emerging dental laboratory technology and materials, so does this place more responsibility on dental technicians as part of the wider team?

I talk to a lot of laboratories and those with successful businesses are those that have a strong relationship with their customers, i.e. clinicians and patients. Clinicians are very busy people with many patients to see and very little time, so it is very important that labs nurture that relationship.

It's not uncommon for laboratories to have open days or open evenings to discuss and demonstrate new innovation, products and materials with dentists. The level of interest can vary though – some dentists just want to get on with their own work but there are a number of clinicians that are incredibly focused on digital. For instance, you often see dentists that have made the so called 'leap of faith' by getting an intraoral scanner and they are interested in ways in which they can apply that high cost investment and explore different avenues. From a prosthetics point of view, these clinicians are very interested in what we have to offer because it is one more thing where they can make use of a digital scanning device.

Do you think that some clinicians simply want consistency and affordability and are not particularly concerned about how products come into existence?

This varies between clinicians. We feel very strongly about educating right now, because by gathering clinical evidence and disseminating information we can offer clinicians a working knowledge to assist with decision-making. This knowledge can then be passed on to their patients and helps that individual make those informed decisions.

Is there a generational difference in the attitudes of dental practitioners towards digital dental technology?

It is mixed. Maybe the younger generation of clinicians that are moving into practice are slightly more open to new technologies and the efficiencies that they offer. Although having said that, just because someone is more experienced, it does not mean that they are not interested in say, milling in-house. Similarly, a newly-qualified clinician may be more interested in advancing their clinical skills rather than their technical knowledge. Nevertheless, due to the nature of society, the younger generation is always going to be more in tune with new technology. We only have to look at our children, who grow up with it. I also think that it is going to depend on how clinicians are trained too. Previously, dental schools offered very traditional training but now we are starting to see a lot more digital dentistry being introduced.

To what extent are the changes that we are seeing as a result of increased patient expectations?

Patients are far more knowledgeable than they ever used to be with access to the internet where they can undertake research easily, join forums and view social media. There is also an increased desire for improved cosmetic outcomes as well as clinical outcomes too. Consequently, patients often undertake research and see what options and solutions are available to them before discussing the possibilities with their dentist, and making an informed choice based on their budget as well as what they have been able to find out.

I would say that patients shop around to a certain extent, but it often depends on the case. If a patient is going through a series of treatments they are likely to accept whatever the clinician offers them. However, if you have a patient that is a long-term prosthetic wearer, for example, who has just read about an exciting new solution, they will often telephone dental labs or contact their clinician to find out more. In turn, those dentists and laboratories then contact manufacturers to find out more information.

> 'However, we do have recruitment issues and a skills shortage in the dental technology profession right now and often it's necessary to fill the gap by recruiting some of the well-trained technicians from overseas.'

Are we going to see more dental teams bringing their lab work in-house?

Potentially. There are various systems on the market, which enable clinicians to scan patients and to mill in-house. However, from a prosthetics point of view, I don't see that happening. The issue about prosthetics is that you really do need the skills of a good dental lab to be able to firstly, design it properly and secondly, to ensure a perfect fit. At present, the computer software is just not available to design an appliance from an algorithm or a scan or any other means in respect to our material, it needs someone who is familiar and has very specific skills.

Where do you see dental technology in the future?

There is no doubt digital is here to stay and it is going to develop and grow. As digital progresses, the materials that are needed to work within that space will most certainly increase and more solutions will become available. I think that 3D printing is very exciting and we are likely to see that evolve further. Due to the well-documented move to take metal out of the mouth, we are going to see more non-metal solutions, which are also more viable in terms of milling or printing. In fact, I see materials that work in harmony with digital processes, as a natural progression. ◆

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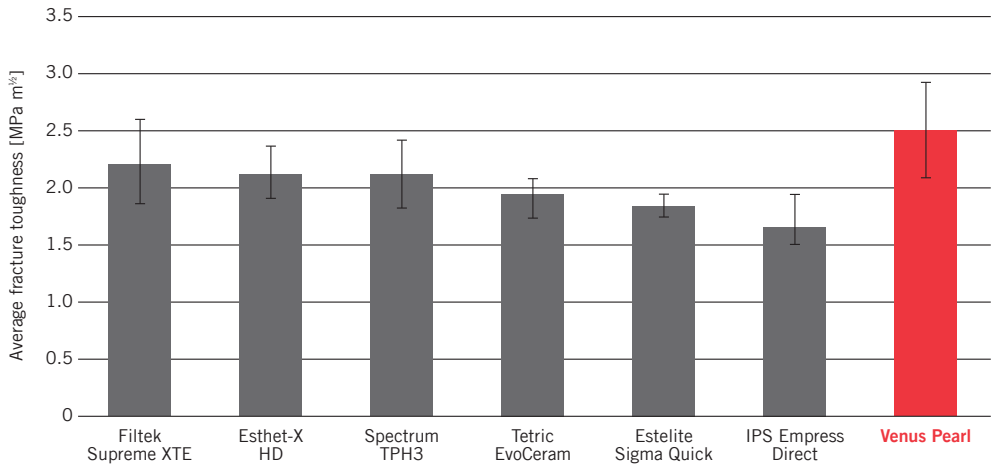

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Top tips for holding a practice open day

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

We get many members asking us about marketing and how to boost their patient numbers or introduce a new product or service. When I ask the question, have you considered holding an open day this is often something that they haven't thought of. So, why hold an open day?

An open day gives you the opportunity to present your practice to the community in an informal, yet personal, way. It gives you and your team a chance to speak to your current and potential patients outside of the clinical setting. Direct marketing such as mailshots and social media can all be effective ways of growing your business or interacting with your patients. However, creating a bond with people through face-to-face interaction at an open day is a far stronger way to build a practice-patient relationship than any letter or tweet on a Twitter feed. It can also be a lot of fun!

So, now you are considering the idea of an open day, think about the practical steps on how to go about doing this.

Planning

The first thing to do, is to make a plan!

Start with a practice meeting to ensure all of your staff know what their role will be before, during and after the event. Give your staff real responsibility and incentives so that they are fully involved and team spirit is high. Make sure that your staff are fully educated on the messages that you want to communicate on the day. An open day will create an immediate impression to patients about your practice and happy, welcoming, involved staff will greatly help with this.

Decide on a suitable day and time to hold the event. Consider events that may be happening in the local community to avoid clashing with those. Also think about a suitable time; evenings and weekends are more likely to be convenient for most people. The key thing to think about is who you are targeting and when they might be available.

Think about what you want to achieve on your open day. Is it to attract new patients? Demonstrate a new product or service? Educate parents? Think about having a 'topic' and ensure you have any relevant printed literature to hand.

Think about the practicalities of the day. Where will people park? What local transport routes are there? How many people can you accommodate? You don't want to be overcrowded as this won't create the best impression of the practice and you will want to have time to introduce yourself to everyone that attends.

Publicity

Another vitally important aspect of holding an open day is publicising it. There is no point holding an open day unless your patients or potential patients know about it. You may be surprised to hear that some people don't enjoy visiting the dentist!

There are lots of ways to promote your day: posters and leaflets, social media, advertising in the local paper, a broadcast on your local radio station or even by inviting a local celebrity? The simplest way is of course word of mouth, tell all your existing patients and encourage them to bring someone along.

Try to give people a reason to attend, for example, many parents may neglect their own oral health but are very keen to ensure that their children's teeth are well looked after. Think about going along to a toddler group or offering to speak in your local school. Hold a competition for the children that will require them to come to the practice on your open day.

Will you have an agenda for the day?

When planning your day, you will need to decide if you will have set structure or a drop in. Preparing an agenda allows you to conduct your day in a structured manner. When preparing your agenda, you should work out the timings of each section. It would also be a good idea to have snacks and drinks available at the end of the event as an incentive for people to hang around and place bookings.

If you choose to have a drop-in day with no set agenda you will still need to plan. Think about how you will deal with members of the public when they arrive, how will you ensure you have someone available to help them considering you may get a group of people all in one go?

Safety first

Practice safety is a priority for all dental practices. Having an open day comes with potential risks. It is recommended that you conduct a risk assessment prior to any open day. Potential risks should be minimised and plans put in place in the event of an incident occurring.

You should also consider data protection when taking potential patient details. Think about how that information will be handled and stored.

After the day

Once you've held your event, don't stop there! You can use the event as publicity material. If you held a competition (and got the relevant consent) you can post pictures of your competition winners. Make sure you measure your success against your targets. How many people joined as a patient? Booked a treatment? You will want to analyse any feedback received and consider the total cost of delivering the event. All of this information will help you to plan your next open day. ◆

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Practice sales and goodwill

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

Goodwill is a term bandied around by sellers, buyers and agents of any business and it is not unique to dental transactions. A lot of importance is attributed to goodwill because it is one of the assets of a practice that can vary in value considerably.

What is goodwill?

Goodwill is an intangible asset. Unlike the physical assets of a business such as the chairs or drills which you can assign a value to using a depreciation calculation, goodwill is an asset that requires an expert to consider and calculate. Some factors that will be considered are the location of the practice, the size, type and longevity of the NHS contract if there is one as well as the staff turnover and patient footfall. Good governance of a practice will also be taken into account.

Why is it so important?

Goodwill is important to a seller as a high goodwill value will give them a healthy profit on a sale, whereas a low goodwill value may impact on their happy retirement, or, in the worst of scenarios, delay the sale plans because a sale would only allow them to meet their debts. For a buyer, the goodwill value of a practice is a good indication of the health of a practice and its governance. Although some buyers will be looking for a practice with a low goodwill value so they can build on the business and make a profit, many lenders will be cautious lending to a business which does not have a healthy background and many buyers will, despite spotting a bargain, be cautious about a business that is not running at a profit.

As a seller how can you maximise your goodwill?

As a seller it is important to keep an eye on your bottom line, whether it is to get a healthy profit on sale to attract enough buyers to get a good price. Therefore, in the years leading up to sale there are a few things a seller can focus on to assist with the goodwill valuation. Depending on the type of practice you run some of the below may be relevant:

- Your health and safety records are up to date
- You are running a safe and compliant practice
- You are part of a good practice scheme such as that run by the BDA
- Your staff are happy and any issues are dealt with effectively and correctly
- Staff turnover is minimised
- You are, as far as possible, Equality Act compliant
- Where you hold an NHS contract you are meeting your targets
- Your associates are happy and performing well.

It is a good idea that a seller, if they are seeking to make any large or long-term changes in the years leading up to sale, seeks advice from a sales agent or accountant. This is because although some changes will have an enduring impact on goodwill values some will not and it is prudent to choose the investment wisely.

As a buyer what are you looking at when you are assessing a practice's goodwill?

When buyers look at a practice they want to see a healthy practice but depending on the individual they may also want to see room for growth. There is a fine balance between maximising your goodwill value for sale and leaving an attractive business for an incoming buyer to make their own. Lenders may want to see a business that will grow rather than remain static too although a well-run business will often present development opportunities. As a buyer you could consider the following:

- How well is the practice run?
- Is a compliance scheme in place?
- Are the surgeries being used to their full capacity and if not why not?
- Have private opportunities been fully explored?
- Is there scope for alternative therapies to rent space in your surgery?
- Would investment in additional or alternative equipment increase your bottom line?

As a buyer it is important to understand the market you are buying into and the location. You may have ideas for growth but you will need to understand whether these have a reasonable prospect of success at the practice you are considering purchasing.

Remember to be good and write a will

Goodwill, albeit intangible, is an asset. A practice is a large asset and arguably the biggest asset most owners will ever own. Practice owners whether actual or perspective, should absolutely draw up a will to protect the goodwill of their investment. Protecting the asset and its goodwill in the event of death is essential to any practice owner. ◆

Highlight what else your patients can do to improve their oral health

Significant changes in lifestyle mean that traditional eating habits have altered, and people are now eating on the go more than ever before. The more we snack, the more our teeth come under attack.

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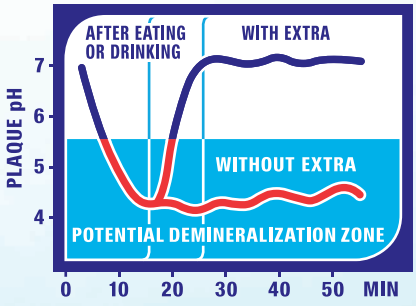

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i Alcantara E, Leveille G, McMahon K, Zibell S. Benefits of Chewing Gum: Oral Health and Beyond. Nutrition Today, Volume 43, Number 2, March/April 2008
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† Extra® sugarfree gum is beneficial for dental health as it helps neutralise plaque acids.

Fee setting

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

Almost every business you see started off at some point as someone's dream; the chance of a better life, of self-reliance, freedom, profit and good reputation. That dream never involves failure. Instead there's a feeling of self-belief, a challenge that can be overcome and it is usually considered to be worth the risk; why? Because no one ever dreams they will fail.

Clearly there needs to be some return for all the hard work. Typically the reward comes from having a successful business with happy patients, happy staff and a happy bank balance. An integral part of achieving that comes down to the fee setting process.

Fees

A fee is the charge or payment made from the customer to the business for a service. When setting a fee for the service you provide, there are numerous considerations. Therefore fee setting requires a thorough process of research and planning.

Competition

When considering what you should charge for services, the wrong and yet common thing to do is to look at what ABC Dental Practice down the road is charging. £30 per private examination may cover their costs and allow them to stand out as affordable, but it has the potential to leave you unable to cover yours.

Researching your competitors is always recommended. After all, as a business you want to stand out. If you can cover all your business costs and more with £30 per private examination, then taking into account your competitor's fee is useful, but it should never ever be the starting point. The starting point should always come from what you need to earn to cover your costs.

Setting fees

For someone who has never had their own business, it can be daunting to come up with fees. However, you can remove the difficulty once you realise that a fee should be based on business needs and any extras you want to factor in.

A good place to start building your fees is by looking at the costs required to start your practice. Start-up requires a flood of money before you even see the first patient. You have to consider the premises and make sure it complies with regulatory and best practice standards, you have to get all new software systems in place, new equipment, safety checks, recruitment fees etc. There will then be the costs of establishing all new policies and procedures that your practice will need to abide by once up and running.

Once you know your start-up costs you have your first figure that you will need to work with. You should also know at this stage about any set business expenses you will have. These are expenses that will not change throughout your first year regardless of the number of fillings you provide, for example your premises, business rates, GDC registration, insurance fees and regulatory costs. Clearly there will be others, but this gives you an idea. Knowing these provides yet another figure you can work with.

Next you have to think about delivering the service. This is where it can get mind bending. To prevent business failure, it is vital you are thorough with each step of the way. Your business plan should interlink here and really help you. If you have really done your research you will know the local demographic and their likely dental needs. You will also know that if you have only two surgeries then you are likely to have capacity for only X dental appointments through the year.

Be realistic rather than overly optimistic on the number and types of services you think you will deliver. Then work out the associated costs of delivering that. 200 appointments means 200 pairs of gloves – what do they cost? What about disposable equipment or materials and lab fees for each? And of course, your staff. Break down each of your treatment types and look at the full cost of service delivery based around that treatment. Thinking about utilities, staffing, materials, lab bills and stock. You then have another figure to work with.

Then there are the extra considerations to give you your final figure. These are, but not limited to things such as:

- The salary you wish to earn
- Future expansion
- Unplanned expenses
- Additional and often over looked expenses such as staff taxes, business taxes and pension contributions, fire extinguisher servicing, PAT testing
- Sick leave, holiday cover and additional recruitment
- Any further dreams you have such as having extra freedom, or an early finish on Friday.

You then are left with your overall final figure. You can divide this overall figure down into realistic fees that provide you with your fee list. And more importantly, the security that you can cover your expenses. It also gives you targets to work to and allows you to measure performance. And don't forget, it is a GDC requirement to display your fees.

On-going concerns

Once you are up and running, fees need to be an on-going concern. Never worry about increasing fees. If you cannot cover costs you will fail. And so, if your rent review increases your rent, or a new regulation creeps up requiring a fee, then make sure you always factor these in and review your fees. Equally, once your start-up costs are covered, you could bring down your fees or look at promotions to bring in new patients. ◆

You care about your patients: Counterfeiters don't!

You care about your patients - their safety is your top priority. Anyone selling counterfeit and non-compliant dental devices does not! These devices are potentially dangerous to patients and users, as well as putting your registration at risk.

Just like when treating your patients, care and common sense should also always be exercised during the purchasing process. Systems need to be in place to ensure that equipment is genuine, compliant and safe to use. Don't risk it – be sure that you are buying genuine equipment from genuine providers, particularly when making online purchases.

If in doubt, check, and remember if a deal seems too good to be true, it probably is. The Medicines and Healthcare products Regulatory Agency and the British Dental Industry Association strongly recommend that all purchases, however small, are made from a reputable supplier.

Download the latest tips on how to spot fake dental products and find trusted dental suppliers at www.bdia.org.uk

Report anything suspect now at: www.yellowcard.mhra.gov.uk

BDIA

CSIDI

Counterfeit and Substandard Instruments and Devices Initiative

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Medicines and Healthcare products Regulatory Agency
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T: 020 3080 6701
E: counterfeit@mhra.gsi.gov.uk

Image of counterfeit products confiscated by the MHRA 40,770 seizures were made between April 2016 - May 2017

Dealing with a new start-up nearby

By Paula Slinger

We have all seen the leader boards for big sporting events. Those at the top of the board win something of value, be it a medal, recognition, a place in another tournament. However, those at the bottom usually drop out; fade away from memory, and ultimately lose out. For some it can even be the end of their sporting career.

Competition in business has a similar theme to the leader board. A successful business is one that has outshone its competitors, won the loyal patient base and has a good reputation.

Realistic

'Another dental practice has just opened up across the street from me. Surely they can't do this?' This is one of the most common questions relating to competition received by BDA advisors dealing in business matters. The unfortunate and yet very simple answer to this is, 'yes they can'. There are no rules that prevent another dental business opening up near you.

'My associate has left and started seeing patient's two streets away. Can they do this?'

Again this is another common question and this depends. If there is no associate agreement placing restrictions on them, then yes they can set up even next door. Even if there is an associate agreement in place, they can still breach the geographical restrictions. You would need to seek legal advice before considering whether to take the matter through the courts if they did this; restriction clauses in associate agreements are only enforceable if they are reasonable.

Understanding your business

Clearly with business you need to have a clear goal. What is it you want to deliver? Usually you will have an idea of where you want to place yourself. Do you see yourself as high-end, delivering services only to the mega rich? Do you see yourself as the only practice (for now) to provide the latest no drill technology? Or do you see yourself as a high street dentist seeing Mrs Jones who happens to be shopping in the area?

When you know what your business model is, you can then build on that. It allows you to think about your location, how you will tailor your brand and services, and how you will sell yourself. It gives you a foundation to work from. You truly have to know your business and its aims.

A successful business knows their patients. They know that their services are relevant to them. It should not matter if you are a new business or more established. Your patient base can change over time. A new dental practice can open up at any moment. Therefore being knowledgeable about this information is vital.

There are many ways you can find out about your patients. You can look at local government information on the local demographics. These normally tell you things like age groups and average income and education.

The NHS will usually have an Oral Health Needs Assessment for local areas to give you an idea of areas of health which could need your focus. There are also websites that give information about geographical areas such as leading property search websites.

For established practices there is the undisputed historical evidence. What types of treatments are common? What information do you get from your patient satisfaction surveys? What do they like about you and don't like? What do you think you could improve on? What thoughts do your dental team have on your service?

Knowing your competition

Just as it is wise to know about your patients, it is wise to know about your competitors.

Unfortunately we live in a shallow world where first impressions are formed quickly – and they really do count! Even for business.

Look at how they present themselves, their shop front, their website, their team. Compare that with you. If you were a patient looking for a dentist, what would you go for? Who gives you the best first impression and why is that? What services are they offering? Does that fit with the local population and their needs? What are their prices? How do you compare?

You can find out what patients think about other practices by looking at information that is there in the public domain, such as NHS Choices comments.

Most importantly how are patients treated?

Help! A new dental practice has opened in my area!

As a business you should always be on the ball. Keeping up to date with patient demographics and looking at competitors. It doesn't matter if the competitor is new or old. Even an old competitor could come along and sweep up your patient base.

The patient pathway is important. It creates business through word of mouth. Treat your patients like royalty from start to finish. Then let them go and sell your services through word of mouth. Think about the act of seduction, when you feel singled out as the special one; made to feel amazing. That is a very powerful tool in business. Don't be cheap and shoddy. That never wins admirers.

Most importantly, go with change. Expect it. It will happen. There will be always competition. ◆

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Please send product and services news through to David Westgarth, *BDJ In Practice* via: David.Westgarth@bda.org

Forever learning

If you've a passion for learning, then Dental Showcase is the event for you. Taking place at London's ExCeL 4-6 October, here's a sneak preview of what you can expect.

Dental Update Lecture Programme – 5-6 October

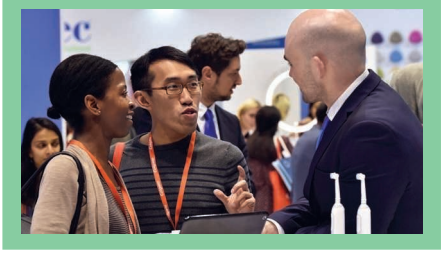
A full programme of lectures continues on Friday and Saturday, with some equally engaging presentations, covering a wide range of topics.

Louis MacKenzie will be giving practical advice on anterior composites. Paul Bachelor will explore the topic of dementia-friendly dentistry and Bob Cummings will explain some of the HMRC challenges associates face. There will also be some business-focused presentations. Frank Taylor & Associates will take delegates through the journey of a practice sale, including advice on finance.

Innovation Theatre

The application of technology is core to these lectures and this year the event will utilise revolutionary new technology, introducing an interactive element to the live demonstrations taking place each morning. The afternoon sessions will allow you to peek into 'tomorrow's world', with discussions and reviews of the latest technology accessible to dentistry. Pioneers and practitioners will talk you through its evolution and application.

To register, or for more information, visit dentalshowcase.com.



A new entry

Philips Oral Healthcare has launched its latest ProtectiveClean toothbrush range which features Sonicare's unique sonic cleaning technology at its core.

Like its predecessors it produces 32,000 brush sweeps a minute, creating the dynamic fluid activity – aerating saliva and toothpaste – for a penetrative clean, for which it is famed.

The Philips Sonicare ProtectiveClean toothbrush is proven to reduce gum disease by up to 100% and remove up to seven times more plaque than a manual toothbrush for improved oral health. It comes in two models:

- **Philips Sonicare ProtectiveClean 4300** features inbuilt pressure sensors to let patients know when they are brushing too hard. The brush includes one inbuilt cleaning mode, with two intensity settings, high and low to provide users with a tailored clean. The handle comes with an Optimal Plaque Defence brush head, charger, travel case, features BrushSync technology and is available in range of colours, light pink, light blue and black.
- **Philips Sonicare ProtectiveClean 6100** features inbuilt pressure sensors, includes three cleaning modes; clean, gum care and white, and three intensity settings; high, low and medium. The brush also includes two BrushSync features, a brush head replacement reminder and brush head mode pairing, to provide users with a tailored clean. The handle comes with two Optimal White brush heads, a travel case and charger.

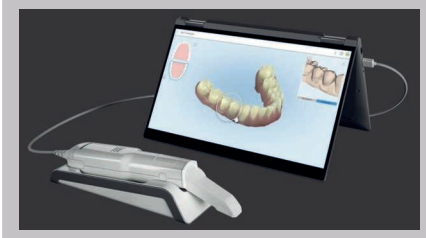
The new ProtectiveClean range also features a two-minute timer and a pressure sensor, which provides real time feedback to ensure that patients are not brushing too hard, thereby minimising their risk of gum damage and gingival recession. Thanks to its clinically efficacious Optimal Plaque Control brush head ProtectiveClean is also clinically proven to remove seven times more plaque than a manual toothbrush.

The brushhead also features new BrushSync radio frequency identification device (RFID) technology to monitor usage and alert the patient when it is time to replace it with a reviving new one and ramp up the efficacy of the brush to its full capacity again.

A strong differentiating factor of the new brush, which should appeal to dental professionals is that the ProtectiveClean range addresses multiple price points, making good oral hygiene more accessible to a far wider cohort of patients.

For more information, please visit http://www.philips.co.uk/sonicare

Bringing power and speed to your practice



Align Technology, Inc. announced it has expanded the iTero Element portfolio with the launch of the iTero Element 2 and the iTero Element Flex scanners. These additions build on the existing high precision, full-colour imaging and fast scan times of the iTero Element portfolio while streamlining orthodontic and restorative workflows. The next-generation iTero Element 2 is designed for greater performance with two times faster start-up and 25% faster scan processing time compared with the iTero Element. The iTero Element Flex is a wand-only device that transforms compatible laptop computers into a highly portable scanner that works anywhere – it's perfect for practices with multiple locations who need a scanner that is convenient and easy to transport.

The iTero Element 2 scanning system is equipped with next generation computing power that enables faster start-up and faster scan processing time. An integrated lithium-ion battery provides easy mobility from operatory to operatory without the need to plug in for power or reboot. The iTero Element 2 scanner is designed with an ergonomic, centered wand cradle for easy access.

The new iTero Element Flex wand-only configuration is a portable scanner for easy transport from practice to practice, allowing doctors to leverage the power of chairside visualisation coupled with iTero scanning precision in any location. Working seamlessly with compatible laptops, practitioners can now scan anywhere, even in the smallest of consulting rooms. The iTero Element Flex includes a convenient, custom-designed carrying case.

Visit www.itero.com or www.facebook.com/iterodigitalimpressionsystem/ for the latest news on the iTero Element scanner portfolio.

Combatting enamel erosion

Enamel erosion is increasing in prevalence and incidence and affects people of all ages which affects people of all ages. A recent study showed that in the UK, 54% of young adults (aged 18-35 years) have signs of enamel erosion.[1] Enamel erosion is a cumulative process triggered by repeated acid attacks, and the increases in prevalence have been attributed to a rise in ingestion of fruit teas, fizzy drinks, sports drinks, fruits and juices, vinegar based dressings, wines and cocktails. This daily assault on the teeth is most common in the younger generation who frequently consume acidic foods and drinks throughout the day.

Fortunately, dental professionals now have an effective product to counter this growing challenge. After conducting a Basic Erosive Wear Examination (BEWE) to determine a patient's risk score for erosive wear in the clinic, clinicians can recommend REGENERATE Advanced Enamel Serum and Advanced Toothpaste to kick start a preventative regime against further acid damage.

Inspired by bone repair research, NR-5 technology contains two unique ingredients – calcium silicate and sodium phosphate salts – which combine to form a fresh supply of enamel minerals, wrapping and integrating onto the teeth.[2] Studies showed that the REGENERATE Enamel Science system consisting of REGENERATE Advanced Enamel Serum and Advanced Toothpaste can help reverse early signs of enamel erosion.

It is proven to recover surface micro-hardness by 82% following three days of use.[3] It is clinically proven to provide superior re-hardening of acid-softened enamel in situ after three days compared with standard fluoride toothpaste.[4] REGENERATE Enamel Science is also proven to provide superior protection against enamel erosion, offering two times greater protection from erosion than a fluoride-only toothpaste.[5]

Refrerences
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2. Sun Y, Li X, Deng Y, Sun JN, Tao D, Chen H, Hu Q, Liu R, Liu W, Feng X, Wang J, Carvell M, Joiner A. Mode of action studies on the formation of enamel minerals from a novel toothpaste containing calcium silicate and sodium phosphate salts. *J Dent* 2014; **42** (Suppl 1):S30-38.
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4. Joiner A, et al. Remineralisation effect of a dual-phase calcium silicate/phosphate gel combined with calcium silicate/phosphate toothpaste on acid-challenged enamel in situ. *J Dent* 2014; **42**(S1): S53-S59.
5. Wood N J, Jones S B, Chapman N et al. Dent Mater 2017.

Helping your patients to keep their gums healthy between dental visits

Plaque control with daily brushing is key to the prevention of gingivitis. This was presented during Europerio 2017, where the importance of toothpaste was reinforced as a pivotal factor in plaque removal.

Corsodyl toothpaste is designed for patients with or susceptible to gingivitis.[1,2] Corsodyl Ultra Clean toothpaste contains 67% sodium bicarbonate, which enhances the physical action of brushing to remove plaque. Refined sodium bicarbonate particles penetrate the plaque layer, disrupting the polysaccharide matrix.[3] After six months Corsodyl toothpaste resulted in four times greater plaque removal than a regular toothpaste.[4]

That is why Corsodyl is the number one dentist recommended toothpaste brand for gingivitis.

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1. Kakar A et al. Evaluate the Efficacy of Different Concentrations of Sodium Bicarbonate Toothpastes. IADR General Session and Exhibition, Cape Town, South Africa, 2014. Abstract No: 754.
2. Data on file, GSK, RH01530, January 2013.
3. Pratten J et al. Physical disruption of oral biofilms by sodium bicarbonate: an in vitro study. *Int J Dent Hyg* 2016; **14**: 209-214.
4. Data on file, GSK. RH02434, January 2015.

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Email: enquiries@devonshirehousedental.co.uk

Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

296176

Scotland

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

266979

South East

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On Specialist List: Yes

270171

North

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261782

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Dr Nick Vyas BDS MSc FDSRCS Cert. Implantology
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Dr Neeta Patel BDS FDS RCS
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Dr Sheetal Patel BDS MFDS RCS MSC Morth
Specialist in Orthodontics

Professsor Raman Bedi BDS MSc DDS honDSc DHL FDSRCS(Edin) FDRCS(Eng) honFDSRCS(Glas) FGDP FFPH
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Dr Amanda Reynolds DDS LDS DDPH(Eng) MSc DPH Dip Endo, Cert Sed & Pain Management, CILT
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Specialists in Periodontics: **Dr Adetoun Soyombo, Dr Olanrewaju Onabolu and Dr Carol Subadan**
Specialist in Orthodontics: **Dr Ayodele Soyombo**
Special Interest in Orthodontics: **Dr Juanita Levenstein**
Special Interest in Prosthodontics: **Dr Richard Craxford**

239826

TOOTHBEARY RICHMOND

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258051

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

Specialist services:

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

Special Interests services:

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

295045

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MSc (Distinction) in Dental Implantology (University of Bristol)
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293125

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CT scanner and Zeiss microscope on site
On Specialist List: Yes, Orthodontics Dr Ayodele Soyombo, Dr Patel
Special Interest in Orthodontics: Dr Juanita Levenstein
Specialists in Periodontics: Dr Adetoun Soyombo, Dr Carol Subadan and Dr Olanrewaju Onabolu
Specialist in Prosthodontics: Dr Peter Yerbury and Dr Ulpee Darbar,
Specialist in Restorative Dentistry: Dr Ulpee Darbar
Specialist in Endodontics: Dr Neil Kramer
Specialist in Oral Surgery: Dr Tamer Theodossey, Dr Wale Towolawi and Dr Yinka Lesi

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On Specialist List: Yes

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

209439

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

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

CT Scanner and dedicated implant suite on-site.

236739

In Practice CPD

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

Q1: Which of these is *not* a set business expense you will be aware of throughout your first year in business?

A Annual Retention Fee
B Indemnity fee
C Water rates
D Rent obligations

Q2: Which of these is not applicable when considering the goodwill of a practice?

A Business rates
B Happy staff
C Health and safety compliant
D Minimal staff turnover

Q3: Can an associate work for a competitor close by?

A Yes – without any restriction
B If there is no agreement in place regarding geographical restrictions, yes
C No
D No, but it can be compromised upon

Q4: What could an open day achieve for your practice?

A Better patient/practice relationship
B To educate parents
C Drive up patient numbers
D All of the above

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GDPR

NHS practices – how to be a DPO in a dental practice

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- Understand the GDPR and regulatory framework
- Decipher the relevance of the GDPR in a dental practice
- Understand the role of a Data Protection Officer (DPO)
- Be able to perform preparatory work for GDPR compliance
- Be familiar with key compliance documents.

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