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BDJ InPractice

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BDA
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NHS dentistry facing recruitment crisis

A recruitment crisis for NHS dentists is imminent, and set to deepen access problems across England, according to new data from the BDA.

Survey evidence suggests over two thirds (68%) of NHS practices in England who attempted to recruit in the last year struggled to fill vacancies. Half (50%) of the NHS practices who attempted recruitment reported issues in the previous year.

Figures reflect widespread disillusionment with England's unreformed NHS dental system, with levels of NHS commitment now a leading driver of low morale and motivation. Those with the highest levels of NHS work (over 75% NHS work as opposed to private) appeared more than twice as likely (39%) to report job dissatisfaction than those with lighter commitments (16%).

In the latest sign of emerging crisis Plymouth's Director of Public Health, was instructed by councillors to write to NHS England requesting 'urgent local action to improve access to NHS Dentists' amid 9,000 long waiting lists fuelled by staff shortages and patients facing a 70 mile journey for treatment. Recent reports for both *The Times* and BBC have highlighted access problems across England, with half of practices unable to take new NHS patients.

The BDA has previously reported that 58% of NHS dentists say they are now planning to leave the service in the next 5 years. Dentist leaders say that failure to reform the target-driven system in England and Wales, and the 35% real-terms fall in practitioner incomes continue to threaten retention, recruitment and the long term sustainability of the service. The BDA has called for the re-introduction of NHS commitment payments in all four countries to help NHS associates, who generally have a higher NHS commitment and form the vast majority of the workforce, and NHS support towards indemnity payments.

Latest workforce statistics have shown the first year on year decline in numbers in a generation.

BDA Vice Chair Eddie Crouch said: 'When patients are struggling to get access government should not be punishing dentists for commitment to the NHS.

'It is a damning indictment of current policy that the dentists who go over and above with NHS care are now paying the price in low morale. The constant treadmill of targets and pay cuts mean something has to give, and services cannot be maintained when practices are unable to fill vacancies.

'Failure to act is already leaving millions of patients across the country in limbo. We look to ministers to take responsibility and show dedicated health professionals that NHS care is not an unattractive option.'

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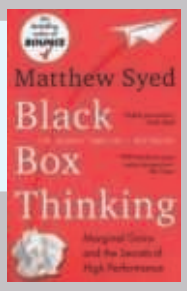
Key points: BDA evidence to DDRB

- The key challenge for NHS dentistry is recruiting and retaining dentists. The impact of morale and motivation is vital to recruitment and retention and in stemming the rates of attrition.
  - Ongoing work is needed to ensure that we attract new members to the profession but we also need to make sure that those currently working in the NHS are valued and want to stay.
  - The NHS is losing valuable dentists as they reduce their NHS commitment and seek to retire or leave the profession and this situation is causing a recruitment issue in general dental practice and the community dental services in many geographic areas.
  - We are warning of a looming and fast approaching crisis in recruitment and retention of NHS primary care dentists in the UK.
  - We have similarly significant issues in secondary care and consultant vacancies in Scotland and clinical academic posts across the UK.
  - We would like to see the re-introduction of NHS commitment payments in all four countries which would particularly help NHS associates, who generally have a higher NHS commitment than practice owners and form the vast majority of the workforce.
- As a result in this 2018/19 submission, our position is that a pay uplift recommendation must at the very least curb any further erosion of pay in real terms and, similar to other NHS professionals we are calling for an inflation (RPI) linked award plus 2%.
- In the community dental services morale and motivation have got worse since last year and there are recruitment problems, particularly to specialist posts.
  - For the first time BDA evidence suggests that the majority of CDS dentists are dissatisfied about pay
  - The role of the service is changing in all four countries to concentrate on complex specialist work with patients who can, in theory, be cared for in general dental practice being discharged back. This increases recruitment problems and does not aid retention.
- Despite the financial challenges facing dental practices and the ongoing cuts in pay, patients' expectations for high quality care are just about being met. However, the DDRB cannot allow for patient access and care to be severely adversely affected before acting on dentists' declining incomes.
- Successive below-inflation pay awards, combined with lengthy delays in their implementation, have led to very considerable erosion of dental incomes. In Northern Ireland, the 2017/18 process has still not concluded. ◆

BOOK REVIEW

Black box thinking

Matthew Syed
John Murray, 2015
ISBN: 978-1-473-61380-5
£9.99



In a nutshell

Journalist, Oxford PPE graduate and former table tennis champion Matthew Syed examines the value of failure as an unfortunate but necessary corollary to success. In his use of, often tragic, examples throughout, Syed's book echoes the findings of Atul Gawande's seminal book, first published in 2009, The Checklist Manifesto. But unlike Gawande, whose focus was on effective strategies (e.g. checklists) to obviate avoidable disasters, Syed concentrates on the paradoxically positive benefits that failures bring. He also refers to 'cognitive dissonance' being the overriding catalyst in decisions that prove disastrous. These decisions occur not just in healthcare or aviation, but anywhere and he cites important examples in law, business, technology and politics.

Who is it ideal for?

Anyone whose profession involves the potential for fatal errors should read this book. The key phrase that underlines the book's premise is lessons learned and how these lessons benefit society. As Captain Chesley Sullenberger, who successfully landed his Airbus A320 on the Hudson River, put it these are 'lessons literally bought with blood'. Additionally, Syed's book is useful for anyone making decisions that will impact on the lives of others because it examines both the causes and outcomes of what Syed repeatedly identifies as the ability to disbelieve the evidence, based on a set of fallacious beliefs but ones to which the denier fervently adheres.

Syed relates actual examples throughout to demonstrate how these errors of judgment can be obviated.

Why you should read it?

Syed's three hundred and fifty page paperback is a very readable book indeed and such is his fluid style that it's difficult to put down. The instances of failure are described in expertly researched forensic detail and often inspire righteous indignation in the reader (the prisoner incarcerated for 19 years for a crime he didn't commit). This is also a book which doesn't date, with the events described, as signal turning points and object lessons, being as relevant now as they were when they took place. As Syed states 'beneath the surface of success…is a mountain of necessary failure.' To put this another way, empirical evidence of success is often honed by myriad successive failures. As Syed summarises: 'we progress fastest when we face up to failure – and learn from it'. ◆

Dentists call for primary care services contract to be taken from Capita


©Fabrice LEROUGE/Getty Images Plus

The British Dental Association has urged government to take NHS primary care support services away from troubled subcontractor Capita.

In a letter to NHS England Chief Executive Simon Stevens, dentist leaders have called on Government to think beyond simple contingency planning, and make a decisive break in light of Capita's dismal long-term performance.

NHS dentists have been unable to work – in some cases for up to a year – owing to issues getting the 'National Performer Number', which is required to provide NHS services. Services to patients have therefore been affected by dentists being unable to work. Administration of the National Performers List used to be managed by NHS England, but was contracted out to Capita alongside other Primary Care Support services in September 2015. Before Capita won the contract the average application turnaround time was approximately six weeks.

Despite pledges to deliver compensation payments to dentists affected, practitioners have faced unexplained delays of up to four months in receiving payments. The BDA is aware of NHS practices that are risking closure as a direct result of this failure, and practitioners have been unable to meet housing and other living costs.

GPs and optometrists facing similar challenges have also raised concerns.

BDA Chair of General Dental Practice Henrik Overgaard-Nielsen said: 'We have reached the stage where we can no longer ask NHS England to seek greater efficiencies from Capita or make contingency plans. Continuity of care now requires that these contracts are taken back in-house by the NHS, so dentists can get back to work.

'This isn't a request to plan for what ifs, but to act on facts. Capita has demonstrably failed, and our members should not have to suffer as a result of its grotesque mismanagement. The financial impact on some of our members is now reaching critical levels, and the fact that compensation for past failures is not being delivered only adds insult to injury.

'Paperwork that once took six weeks to process is to taking up to a year. Patients are suffering. Systems critical to delivery of care have been contracted out for no gain, and our profession should not have to keep paying the price.'

Read the full letter online at www.bda.org/news-centre/press-releases/Documents/henrik-overgaard-nielsen-letter-simon-stevens-capita-060218.pdf. ◆

Richard Graham elected Chair

Richard Graham has been elected Chair of the Northern Ireland Dental Practice Committee (NI DPC).

He has been NI DPC vice chair for six years, BDA NI Council vice chair and was BDA NI Branch President in 2010.

Accepting the position, Richard said: 'I am honoured and privileged to be elected chair of the NI Dental Practice Committee. This is a pivotal time for dentistry and the challenges facing dentists have never been greater.

'As a Committee, we will continue to argue for government to recognise the rising costs and complexity involved in providing safe, quality dental care. The ongoing pay restraint which has seen all general dental practitioners' incomes fall by over a quarter since 2008 is unsustainable. The disproportionate rise in expenses cannot continue to go unrecognised. This inevitably affects dentists' ability to care for the nation's oral health, at a time when demand for dentistry is high. It's time for real investment in oral health.' ◆

Faculty rejects regulator proposal

The Faculty of General Dental Practice UK (FGDP(UK)) has responded sceptically to proposals to cut costs by amalgamating the UK's health regulators.

In response to a consultation by the Department of Health, it says it is not convinced that combining dental regulation with that of other professions could save money while retaining the required understanding of the dental professions, and that in the absence of evidence to the contrary, the interests of patients and the profession will best be served by the continued existence of a regulator dedicated solely to dentistry.

FGDP(UK) also expresses concern over proposals to create a single adjudication body for fitness to practise, a single register of all health professionals, and a single set of standards *in lieu* of profession-specific ones, and rejects the suggested use of mediation in regulatory proceedings and proposals for employers to be represented on the General Dental Council (GDC).

However, FGDP(UK) agreed that the currently statutorily-regulated professions should be reassessed to determine the most appropriate level of oversight, and that the regulator should be accountable to the Scottish Parliament, National Assembly for Wales and Northern Irish Assembly in addition to the UK Parliament.

Dr Mick Horton, Dean of FGDP(UK), said: 'While the GDC itself acknowledges that there are improvements to be made to the way in which it regulates, it has nonetheless developed specialist knowledge of dental patients and the professions that treat them, each of which exhibit characteristics and contextual factors which are not necessarily the same as those of other medical professions and their patients. For these reasons, the onus is on the government to produce convincing evidence that its own stated objectives for regulation – public protection, performance management, and professional development and support - would not be all the harder to meet if dental regulation were to be amalgamated with that of other professions.' ◆

Scottish Government must tread carefully in shakeup of dental services

The British Dental Association has urged ministers to proceed with caution following publication of the Scottish Government's Oral Health Improvement Plan, which could lead to the biggest shakeup of NHS dental services in decades.

The Association has expressed concern that changes to the range of care available on the NHS could undermine the viability of practices across Scotland.

Dentists' leaders have accused the Scottish Government of spin, launching the Plan off the back of statistics claiming 'record breaking' numbers of registered patients.

Actual attendance at NHS dentists has reached a record low. The percentage of patients who saw a dentist within the previous two years has shown a steady decline from around 98% between September 2006 and March 2008, to 84.1% in September 2010 and now 70.7% in September 2017, the lowest reported rate.

David Cross, Vice Chair of the BDA's Scottish Council said: 'This programme represents the biggest change to NHS dentistry in the last 50 years, but it will be impossible to deliver without new investment. Yes, reform is needed, but Ministers must tread carefully and avoid the unintended consequences that could easily destabilise the service.'

©Peter Dazeley/Getty Images Plus

BOOK REVIEW

Myths of management: what people get wrong about being the boss

Stefan Stern and Cary Cooper
Kogan Page, 2018
ISBN: 978-0-7494-8023-3
£14.99

In a nutshell

Myths of management is written by two management experts; Stefan Stern is a business journalist and visiting professor at Cass Business School and also Director of the High Pay Centre. Sir Cary Cooper CBE is Professor of Organisational Psychology at the Alliance Manchester Business School and Editor-in-Chief of the Blackwell/Wiley Encyclopaedia of Management. They have helpfully arranged this book into forty four neat chapters or 'myths', each one spanning an average of a comfortable three to four pages in length. So the key advantage of the book is its absolute readability. Within its pages, the authors destroy myth after myth, including ones that have been long-held and others that are newer. There are also myths that perennially re-emerge year after year and century after century. The old chestnut concerning machines taking over the jobs of people is dealt with in a chapter provocatively entitled 'The robots are coming to take your job'. As they reassuringly explain, the future will lie not so much in a mechanistic takeover, rather that machines will complement humans in their activities.

Who is it ideal for?

This is a book that's not only ideal for anyone in a management or leadership position, but also for those who wish to climb the ladder of success but are concerned about the ways in which to achieve this or that they might not have the appropriate qualifications or personalities. In this 'dip in and out of' book, the authors make it very clear that amongst the many myths they explode, there are several that might inhibit the ambitious but nervous. For example, the first myth they despatch is that there is one right way to lead or manage, which is of course nonsense. Then there is myth six which proposes that you need to be the smartest person in the room. This again is rubbish but the authors suggest that leaders and managers do need to know what they don't know. You can't know everything no matter how smart you think you are. Another fundamentally flawed fable is that leaders are born not made, but as the authors say 'leaders are not members of some obscure magical tribe. They are just people, plain you. Anyone can lead. Leaders are made not born'.

Why you should read it

Stern and Cooper take extreme relish in smashing some widely held shibboleths like the myth of the necessity of the annual appraisal, sometimes euphemistically referred to as a 'performance review'. They rightly point out that performance measurement should not be limited to a once a year procedure employing a highly bureaucratic methodology, rather that it should be an ongoing process. Another myth they dash is that employees are motivated by money, which as Daniel Pink established in his book Drive (2010), is incorrect, and while fair pay is important, people are far more motivated by 'a sense of autonomy, the chance to develop mastery and working with purpose'. At the end of the book there's a fifty page set of appendices comprising nine 'fireside chats' with prominent management thinkers including one of the greatest management gurus Tom Peters, co-author of In Search of Excellence (1982). Whilst this very readable paperback may give the impression of glibness, there are some very strong and useful messages imparted here. ◆

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

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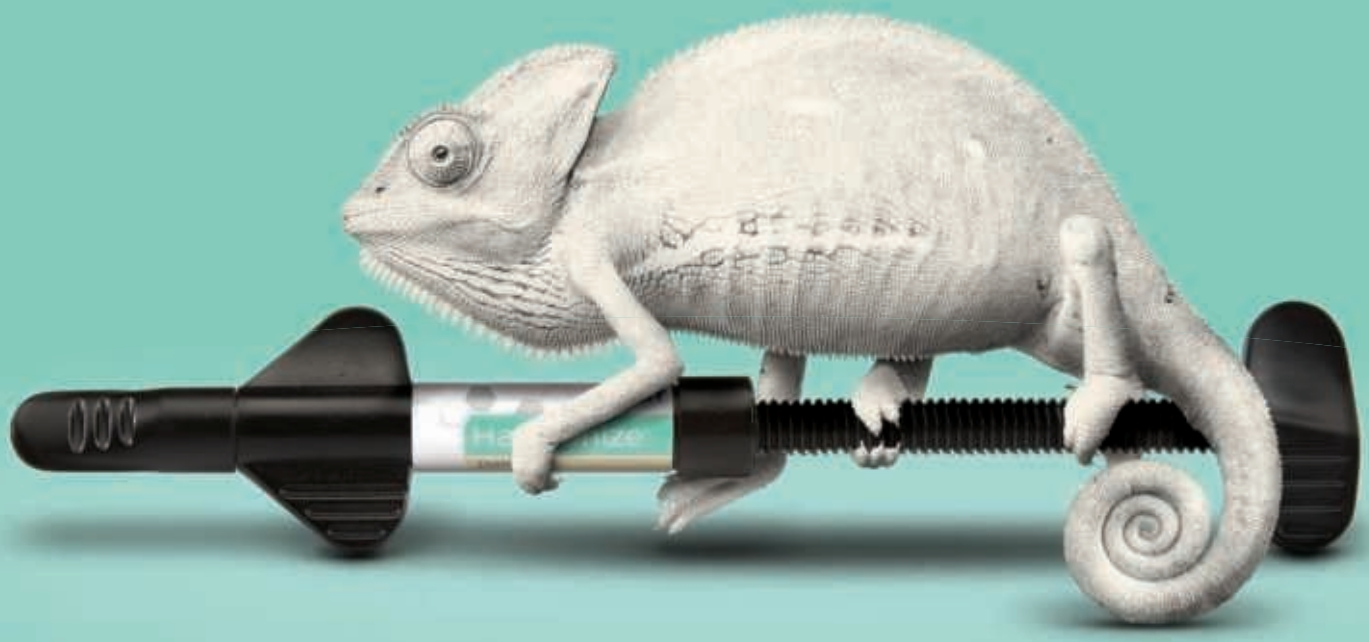

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The pink elephant in the room

Bunmi Aboaba
on her journey to redemption

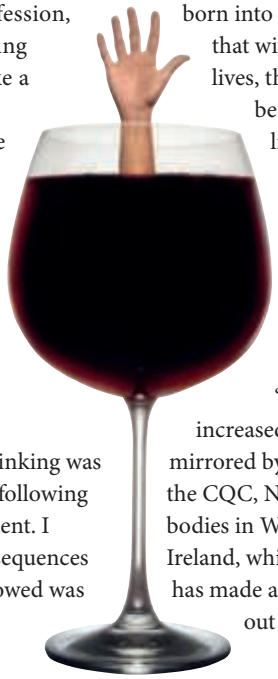
It's been ten years since my last drink. My life today is a very different story to what it was ten years ago. In fact, I would say it has turned 180 degrees. Today I am healthy, happy and a balanced human practising dentistry.

Life is exciting again. I feel comfortable in my own skin, whereas a decade ago I was blotting out the days with alcohol, living life in fear, shame and unmanageability. I couldn't control my drinking and what was once my 'best friend' had turned on me so much so that it had stopped having an effect altogether and had become a dangerous liaison. It was my horrible little secret that was damaging all areas of my life.

What I now know today which I had no knowledge of at the time was that after a while your brain rewires itself to the new habit, that it hunts for that reward. Dopamine in higher and higher levels, regardless of what you think and feel, it's that primal and it just doesn't care, willpower just melts into non-existence.

I was viewed as successful on the outside. I worked in a great profession, had a lovely family and everything going for me, but to me I felt like a failure. The more I felt like a failure, the more I tried to prove I wasn't, and subsequently the more I drank. It was the epitome of a vicious circle. I was over-compensating in other areas of my life and didn't realise that what I was experiencing was burnout, a topic the BDA have worked on substantially.

The years of struggle to quit drinking was taken out of my hands one night following an arrest after a drink-drive incident. I shudder to think what grave consequences there could have been. What followed was rehab and then facing the GDC.



I self-reported the incident. In a weird sort of way it was a relief, a blessing in disguise. I will not bore you with the details of what transpired but suffice to say I don't want any of you to go through the same experience, but it did help me to finally admit I had a problem and to take responsibility for my own recovery when the support structures were put into place.

We sometimes feel as healthcare professionals that we should be solving our own health issues, especially around mental health. First and foremost we are human with just as much need for support as anyone else. You won't be the first or the last to ask for help, so it is important you do.

Addiction has no borders – it affects every race, religion, social demographic, profession, both genders alike. There is no discrimination. Addiction could be alcohol, cocaine, heroin the opiates, food or processing addictions such as gambling or gaming.

We as dentists face so many stressors in our professional lives. New graduates are born into the world of dentistry knowing that within five years of their working lives, there is every chance they will be facing at least one case of litigation. For those working in the NHS, the UDA system has proved a challenge. Rupert Hoppenbrouwers, former head of the DDU once said: 'Dentists have had to cope with scrutiny from a growing number of regulatory bodies. 'In the past 10 years, the increased activity of the GDC has been mirrored by the Dental Complaints Service, the CQC, NHS England and the equivalent bodies in Wales, Scotland and Northern Ireland, while the Ombudsman in England has made a public commitment to carrying out more formal investigations.

'As well as meeting the GDC's ethical standards, they are expected to keep up-to-date with national guidance and changes in the law in everything from tooth whitening to data protection.

'Today's dental professionals are working under more pressure than I could ever have imagined when I was in practice.'

If you are suffering with burnout, stress and anxiety, there are so many workshops for stress and anxiety on and offline. If you feel you are suffering from depression then getting a referral from your GP or a recommendation to see a therapist would be a great start.

If you are struggling and feel you can't stop drinking or using drugs, or you fear for the consequences of your addiction/dependence, you can contact the British Doctors and Dentist group, a group I was previously Chair of. It is a safe place for confidential support. You can also contact The Dentists' Health Support Programme.

I am now a certified Professional Recovery Coach helping professionals struggling with addiction to achieve a fulfilling life in sobriety. With the right support I found my way out of the nightmare into a positive, healthy way of living.

This is why I have told my story. To any of you who are struggling with burnout or addiction: it doesn't have to be that way. There is so much support out there for you. ◆

Useful links

- → www.bda.org/dentists/advice/Pages/stress
- → www.bddg.orgt
- → www.dentistshealthsupporttrust.org
- → www.thesoberadvantage.com

Domestic abuse and the role of the dental practitioner

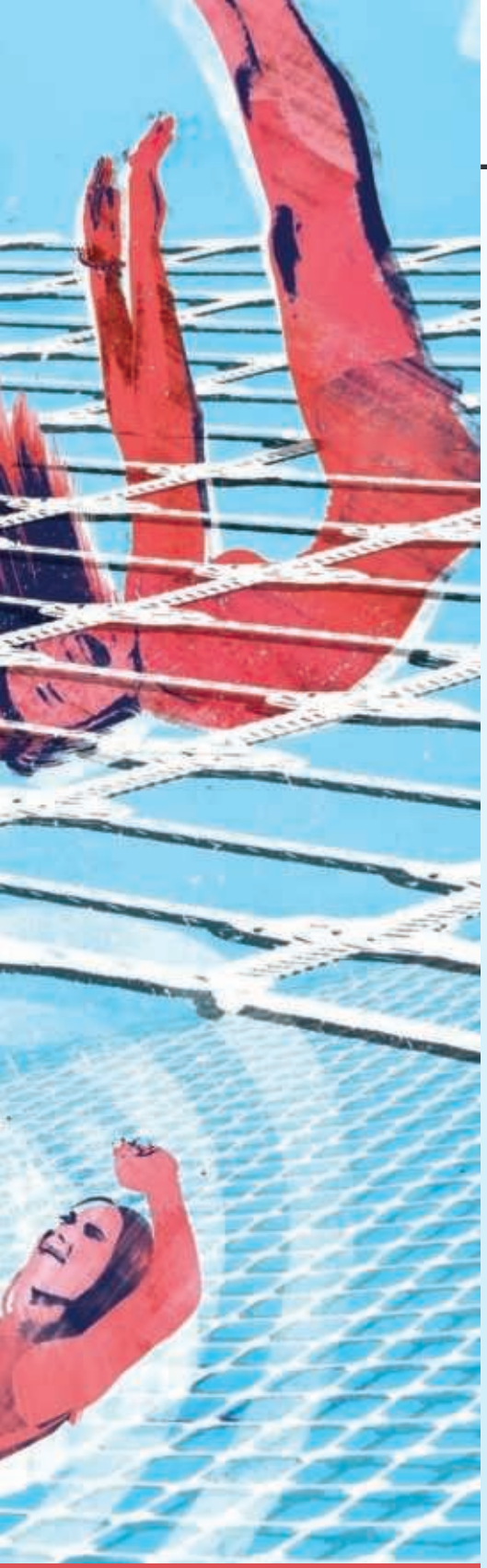
By David Westgarth,
Editor, *BDJ In Practice*

In recent years the emphasis on the profession to think about a patient's wider healthcare needs has grown spectacularly, not least in part to CDO for England Dr Sara Hurley's 'putting the mouth back in the body' edict.

While that particular emphasis has been maligned in some quarters, there is no denying that this profession has prime real estate when it comes to identifying some ailments – alcohol and substance abuse, tobacco use, poor diet and even diabetes. Yet running parallel to that is the less tangible but equally as significant discussion surrounding the profession's role in safeguarding. Having a gut feeling and knowing something isn't quite right is a different proposition to acting on it and knowing how to act on it.

Take child safeguarding, for example. Child Protection and the Dental Team was a pivotal document for providing guidance to the profession in case of doubt. There are a number of documents designed to help us through treating vulnerable patients, but there is one area that appears to have dropped through the gap.

Adult safeguarding is often clubbed in with other areas – elderly, disabled, vulnerable – for example. Within the context of vulnerable



adults, where do we find information on what to do if we suspect a patient has been the victim of domestic abuse? Who should we speak to? Should we be expected to discuss it with patients, given the myriad of services specifically designed to give survivors an outlet, or are we in the best position to help domestic abuse survivors?

The wider picture

Any figures on the scale of domestic abuse come with a warning. According to the Crime Survey for England and Wales, data can often be a fluid situation. For the year ending March 2017[1], there were an *estimated* 1,946,000 victims of domestic abuse aged 16-59 in England and Wales.

So why the emphasis on estimated cases? The same report suggests there are three ways the data are recorded, so may not be directly comparable. Some victims remain hidden. Some victims do not report the crime but seek help from a range of services. Some are reported to police.

The estimated 1.9 million adults equates to a prevalence rate of approximately 6 in 100 adults, with women more likely to have experienced domestic abuse than men (7.5% compared with 4.3%). This equates to an estimated 1.2 million female victims and 713,000 male victims. In a nutshell, for every three cases of domestic abuse, two are likely to be women, and the other likely to be a man.

In Scotland, there were 58,810 incidents of domestic abuse recorded by the police in 2016/17, which equates to 109 incidents of domestic abuse recorded by the police per 10,000. Where gender information was recorded, 79% of all incidents of domestic abuse had a female victim and a male accused.[2]

In Northern Ireland, there were 29,166 domestic abuse incidents recorded in 2016/17, which is 16 incidents per 1,000.[3] The number of crimes is far lower, and recorded at 6 per 1,000.

While these figures suggest the four nations have plenty of domestic abuse cases to deal with, it begs the question: where do the victims go for support?

Does the profession have a role?

A facial bruise in a female patient is 32 times more likely to be domestic abuse-related than any other reason. Research carried out in the United States suggests an eye-watering 70% of domestic abuse cases involved facial injuries.[4] While a visit to the dentist may not be the first port of call for victims, Jacqui Kilburn, National Training Centre Manager for Women's Aid of England, believes the profession could be the safety net victims are looking for.

Jacqui said: 'It is still very much a taboo subject throughout society. The dental practice probably isn't the first place a victim would think would be able to assist them – dentistry is still seen very much as a 'fixing' profession.

'While there is no doubt that GPs, hospitals and midwives are in a better position to be able to help, much of that comes down to the environment they operate in. A nurse can pull around a curtain and buy them some time with a patient. A GP can do likewise, albeit in a more confined space. A dental surgery is often an open room with little privacy for the patient. If a partner is present, getting separation to give the patient an opportunity to talk could be difficult.

'If a dental practice is to respond to suspicions of domestic abuse effectively, they will need to think broadly about how they operate. During my time working in dental practice, receptions used to be open, which meant the receptionist had more opportunity to talk to a patient about any concerns they had before they were seen. Now it is very formal, it isn't as open, waiting rooms are more crowded and you're actually lying there with your mouth open for a large proportion of your visit, so it can be very difficult for a patient to find an opportunity to raise a concern privately.'

'A nurse can pull around a curtain and buy them some time with a patient. A GP can do likewise, albeit in a more confined space. A dental surgery is often an open room with little privacy for the patient. If a partner is present, getting separation to give the patient an opportunity to talk could be difficult.'

Christine Goodall, Senior Clinical Lecturer and Honorary Consultant in Oral Surgery at Glasgow Dental Hospital and School and Founder of Scottish-based Medics Against Violence believes the perceived number of missed opportunities shows how important dental professionals could be.

'Medics Against Violence was formed in 2008, but really took on the domestic abuse side of things with allied healthcare practitioners in 2010 when I realised I had received no training as a dental professional about what to do if I suspected a case of domestic abuse.

'I have been working in maxillofacial for 12 years and can recall numerous incidents where patients presented with facial injuries. When you look at the statistics regarding facial injury and domestic abuse, the vast majority of women presenting with facial

Estimated victims of domestic abuse aged 16-59 in England and Wales[1]

In England and Wales, an estimated 6 in 100 adults have been victims of domestic abuse

For every 3 cases of domestic abuse, 2 are likely to be women

Composite: ©ma_rish/iStock/Getty Images Plus and ©appleuz/DigitalVision Vectors/Getty Images Plus

injuries in Scotland will be victims of domestic abuse. For men it is a slightly different story.

'It is only now I realise many of the cases I have previously treated were more than likely cases of domestic violence. For me, it was talking to medical colleagues that really drove home the need for a better approach. Many of them were in the very same boat as me, so something needed to change.'

Given the very nature of domestic abuse, victims are often reluctant to raise concerns with healthcare professionals for fear of repercussions. So does that make dentistry well-placed to have a conversation other healthcare sectors just will not have?

'A visit to the dentist might be the only place a victim goes to', Jacqui suggested. 'For example, if the victim had a tooth knocked out, to fix it, the dentist would be the first port of call. At that exact point the victim would have had no other health service touch point – and potentially no intention of visiting another – which theoretically gives the dentist a golden opportunity to be able to support the person.

'One interesting piece of feedback throughout training courses is that professionals right across the healthcare sector are wary about the knock-on effects of acting on their instinct. They don't necessarily want to open a can of worms, but their duty of care to the patient has to come first.

'In the case of a dentist, they have to remember that they will be able to tell if what they are being told matches up with the clinical issue they are seeing. If there are any discrepancies, dental nurses, hygienists, therapists and reception staff should be made aware and try to make themselves available to follow up on it and possibly have a private conversation.'

Clinical implications

The simple fact is that dentists and oral surgeons have better chances of identifying domestic abuse-related injuries because the face is a common injury site.[5] Domestic violence is one of maxillofacial fractures' aetiologies, as common sense dictates the face is an accessible target for perpetrators. As a result, dental concussion, mandibular fracture, and tooth loss are the most prevalent domestic abuse-related injuries. American researchers collected data from 236 emergency room admissions and discovered[6]:

- The majority (81%) of victims presented with maxillofacial injuries
- The fist was a favourite means for assaults (67%)

- The middle third of the face was most commonly involved (69%)
- Soft tissue injuries were the most common type of injury (61%)
- Facial fractures were present in 30% of victims
- The average number of mandible fractures per patient was 1.32
- The majority of facial fractures (40%) were nasal fractures
- Left-sided facial injuries were more common than right sided.

However, as Jacqui stressed, what the patient says and what the practitioner sees may be two totally different things. So how do you see past the words and focus on the clinical?

> 'As a result, dental concussion, mandibular fracture, and tooth loss are the most prevalent domestic abuse-related injuries.'

As a starting point, by noting the patient's age and the location of injuries, dental professionals would be in a better position to determine whether the trauma was caused by abuse or by accident. This information can be useful, primarily to police officers who must make judgements based on the information presented to them, but also to support services. The information may also be used should a case reported go to trial.

Jacqui added: 'There is perhaps a lack of understanding about how the system works which unwittingly presents these opportunities.

'I think there is a feeling that patients see GPs as more powerful than a dentist, and by powerful I mean more options and more contacts to report something. There is the impression that victims and perpetrators don't see dentists in the same way, and that can be an opportunity to give that patient and victim some advice and information they previously have not received.'

A safety net

Jacqui's suggestion that dentists aren't viewed as a threat to acting upon a victim's circumstances presents an interesting question – if dentists are seen that way, which area of healthcare is the first touchpoint for victims sharing their abuse?

'There are several areas', Christine said. 'It could be when a woman is pregnant, so ante-natal care. It could be A&E, as many victims have severe injuries that require urgent treatment. It could be the GP – not necessarily for a physical ailment – bur for a mental health problem. Others – regardless of the severity of their injuries – simply do not go.

'Responses are also conditioned by previous experiences. Studies have shown domestic abuse victims have attended the dentist in the hope they would be asked how it happened and for someone to reach out, but that has not happened.

'Unfortunately this only reinforces the belief in the victim that they are worthless. It also means they would be less likely to visit that healthcare professional again.'

Jacqui agreed, and added: 'Maybe a victim has had two teeth knocked out and does not immediately seek help for fear of the repercussions. However six months down the line they develop an abscess, so they will go for treatment, thinking the dentist will not put two and two together. The hidden element of domestic abuse is one we will never have a full picture of, which makes every contact with a healthcare professional absolutely vital.

'As a healthcare professional you soon get a grasp of whether the patient is giving you the full picture regarding the nature of their injuries. It does come with experience, and it is knowing what to do and giving the right response from thereon in that makes a difference.'

It is a subject that Jacqui can speak with some authority on, having previously experienced that very scenario in her career as a dental nurse.

'Whilst I was a nurse we saw a number of facial injuries at the practice, and at the time I did not really relate them to domestic abuse', she said. 'At the time I knew something was not quite right, but did not really know what it was. Now I know what I know, I can look back on those cases knowing they were extremely likely to be domestic abuse.'

Coercive behaviour

In 2015, The Crown Prosecution Service were given new powers to bring charges, even if abuse fell short of physical violence. This included, but was not limited to, a pattern of threats, humiliation, intimidation, controlling social media accounts, dictating what their partner wore and stopping them from socialising.

Another classic sign of a controlling intimate relationship is one partner's reluctance to answer and another to answer on their behalf.

'If a partner comes into the appointment with their significant other, what you might find is that they do the answering for them', Christine explained. 'It isn't difficult to see this for what it is on the surface – the patient may not be able to talk as they have a gumshield in their mouth, or may be in some significant pain.

'As a healthcare professional there are signs to be aware of to differentiate between a supportive partner and a controlling one. A supportive one may back up what their partner is trying to say, or may be reassuring them everything will be fine, particularly if they are dental phobic.

'A controlling one may interject where they feel they may be caught out, or where there is any possibility of their partner revealing what has happened to them. It is at this point a co-ordinated approach to providing an opportunity to get the patient on their own is vital. You can – quite legitimately – tell the partner they cannot be present during an x-ray. It's also unlikely they will be aware of regulations regarding intra-oral scanners, for example, so you could ask them to step out of the room while you are scanning – chances are they will be none the wiser.

'Creating these opportunities to give a suspected victim of domestic abuse the chance to talk to you and for you to pass on some information could be the difference between a lifetime of abuse and a step change in their life.'

Jacqui added that the wider team also has a role to play.

'If, like in Christine's example, you explain that the patient needs an x-ray, a signal, prior agreed with the reception team, would give them a heads up just to be mindful of the partner's behaviour in the waiting room. If they become anxious or start to look agitated because they have been separated from them, the dental nurse could step in and say they're going to get their results, and pass something onto the dentist.

'Midwifery tackles this area particularly well. If they suspect a pregnant lady may have been a victim of domestic abuse, they will ask them for a urine sample, and in the toilet they will have a note on the wall saying if they would like to talk to someone, put a red sticker on the bottle when they return it.'

What next?

You may think at this point a dental professional would know how to react,

having read advice and guidance on raising concerns. While principle 8 of the Standards for The Dental Team sets out expectations that dental professionals will raise concerns if 'patients or colleagues are at risk and will take measures to protect them', the GDC's document Advice for Dental Professionals on Raising Concerns[7] appears to be more focused on regulating the profession rather than protecting patients, a delicious irony given part of their motto. Even in the sources of advice and useful contacts section, nowhere does it give the reader any indication of where to go if they need to raise a concern of this nature.

> 'Even in the sources of advice and useful contacts section, nowhere does it give the reader any indication of where to go if they need to raise a concern of this nature.'

Compare this to their Nursing and Midwifery Council colleagues, whose comparable document[8] gives clear guidance on what to do if one of their registrants found themselves in that position – on the second page.

Make what you will of that comparison, but one thing is abundantly clear: dentists need more help on what to do if they want to report suspected domestic abuse.

'Dentistry is taking a little bit of time to realise its role as a wider bastion of healthcare', Jacqui said. 'Some of that dates back to the very hierarchical feeling with a practice. That has changed beyond recognition.

'Every member of the dental practice has a social responsibility. That means every member of the practice needs to have training on how to handle suspected cases of domestic abuse. It extends beyond the care of the mouth, and training absolutely needs to be standardised across the board.

'Much of it boils down to confidence – the confidence to put a poster up, the confidence to have an empty room in the practice for if a patient needs privacy, the confidence to approach the subject with patients. It isn't an easy subject, but it's one that cannot be ignored.'

According to Christine, part of the problem lies in domestic abuse being tied to vulnerable adults.

'Guidance on domestic abuse is often found in advice surrounding vulnerable people', she said. 'The problem with that is it does not particularly relate to the vast number of people who are affected by domestic abuse. It is not happening to vulnerable people, as per the medical definition of vulnerable. It is happening to everyone, and we believe that is an issue, given how common domestic abuse is.

'NICE have produced guidelines across the medical and healthcare spectrum on what to do, but I feel the GDC could do more to support the profession. It would add a sense of legitimacy in being able to discuss concerns with patients. It would give a sense of direction and almost a sense of permission without the fear of what might happen to them for doing so. If some guidance was to come from the regulator, it would only be a good thing, both for the profession and patients.'

It is clear that the profession could do more. Perhaps with the a new generation of dental professionals coming through who have a greater concept of a wider social responsibility, we will see the profession doing more. Until then, dentistry will continue to act as a safety net for those who fall through it – both from other healthcare areas, and from itself. Perhaps one day, the mouth really will be put back in the body. ◆

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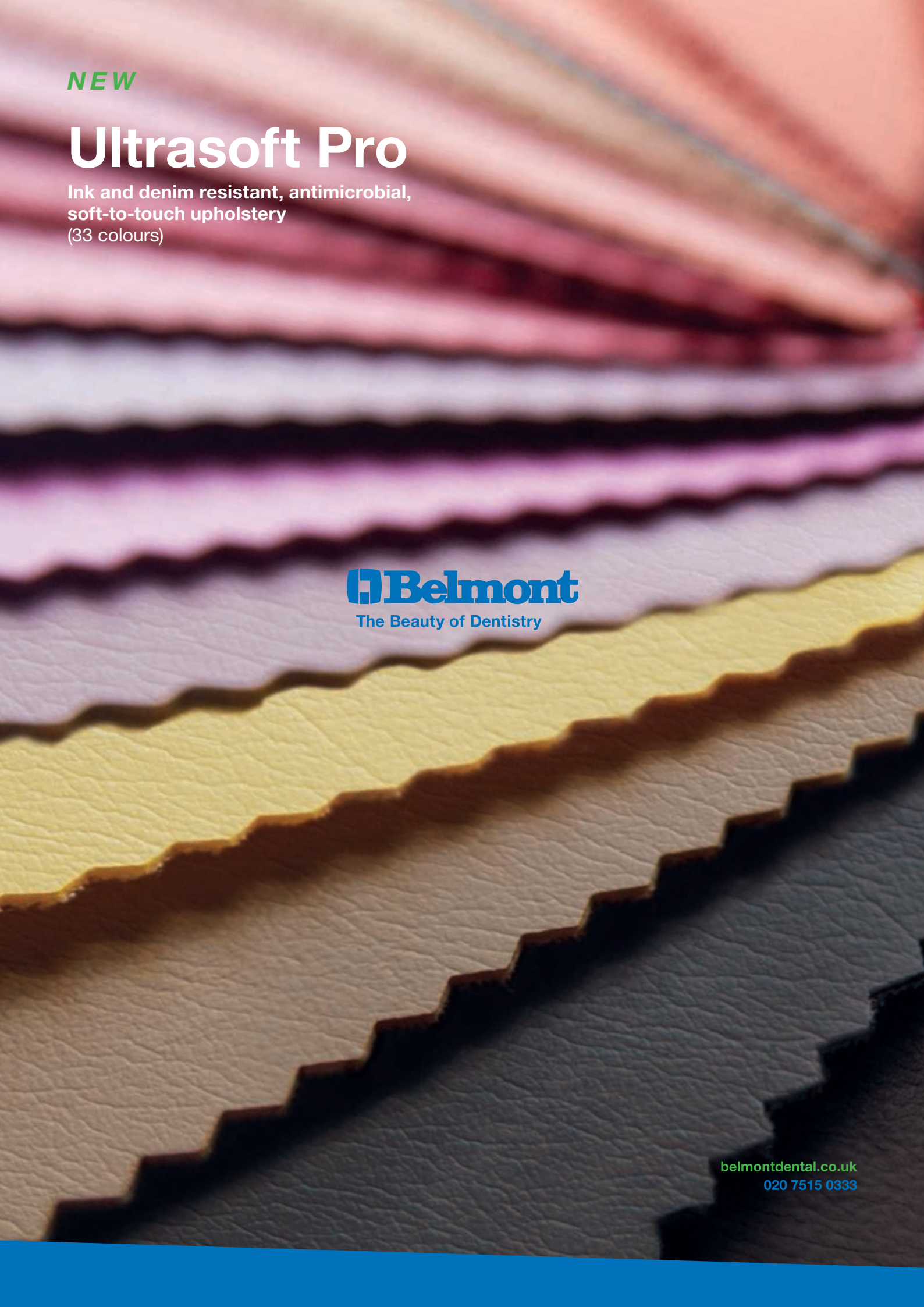

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GDPR – what you need to know

The General Data Protection Regulation (GDPR) is presented as a radical shake up of the law on how you deal with patient records but in practical terms hopefully you will find it is more straightforward. Presuming you are already looking after your records carefully and maintaining patient confidentiality, the GDPR generally just means you have to be more rigorous in being able to show that you are being careful.

The principles that you have to comply with are more-or-less the same. There are a few slight differences, but they do not affect the care that you need to take to ensure that personal data remains confidential. The law applies to all personal data that you hold, including staff and associates as well as patients. You can only use the information that you take in certain specific circumstances – these cover all the legitimate uses that you would have for patient records and staff records but you need to be clear about these. Known as your lawful basis for processing data you will need to identify a reason (or reasons) for your general record keeping and a special reason for handling sensitive data.

Lawful basis for processing data

GDPR sets out two lists of circumstances in which you are able to take, store and use information about people. One of those lists applies to all information; one for special information, including information about health.

Like current data protection law, GDPR says that you can use information if it is necessary to meet your contractual obligations, such as your employment contracts or your contracts to provide dental care to patients. You can also use information if necessary to comply with a legal obligations, such as complying with GDC rules and standards, NHS regulations and tax law.

GDPR says you may use special information, such as patient records, if necessary for the provision of healthcare. There are other grounds, such as for teaching or research purposes, but these are less likely to apply. For the most part anything related to the provision of healthcare is covered as this ground includes the use of data for preventative reasons and management of healthcare systems. Its use could also be justified on the basis of public health purposes or scientific research. Nevertheless for these extra uses data should be anonymised so individuals cannot be recognised.

You may also use information about people if you have their consent. The difficulty with relying on consent is that GDPR allows people to withdraw their consent. It is not appropriate, or necessary, to rely on consent to keep and use patients' healthcare records in connection with the provision of dental treatment.

Consent would be appropriate if you are proposing to use their information for marketing purposes, say sending them emails about other services that you offer (routine re-call messages are an ordinary part of preventative dental care, so are covered under the provision of healthcare reason). If you intend to do any direct marketing to your patients you need to explain thoroughly what you intend to do, what information you will be using and get them to actively opt-in to you using their data in that way.

Privacy notices

Transparency requires you to provide detailed information to be the people you hold information about. This means giving each person – all your staff, associates and patients – their own notification. The GDPR calls these a privacy notice. Send everyone a message telling them what information about them is held by the practice, why it is held and how it will be used. One of the major things in this will be your reasons for the lawful processing of their data.

Confidentiality and accountability

Personal data, of course, is covered by an overriding duty of confidentiality. Have procedures in place for handling data within the practice carefully, keeping it secure and taking precautions if you need to share it, for instance for referrals or with NHS officials or a private capitation scheme. This is now underpinned by the GDPR's principle of accountability, which means that you need to show how you have complied with the law. Data protection rules are overseen by the Information Commissioner's Office (ICO), there are a number of actions it could take against organisations, including: compulsory assessments to check whether it has failed to comply; formal notices compelling it to stop using data in a certain way; and prosecutions. In serious cases the ICO can fine data controllers up to £17 million or 4% of their annual turnover (whichever is larger).

Proving compliance could entail showing the ICO copies of the policies and procedures that you and your team follow – on confidentiality, data management and security.

To prevent personal information being accidentally or deliberately compromised through unauthorised access, disclosure or deletion, you must have appropriate physical and technical security measures in place. Special care must be taken when considering the appropriate security measures for electronic data to protect it from hackers or malware. Often it is necessary to get professional help from an IT expert. For all external IT providers such as a software supplier or cloud storage you need to make sure you are happy they comply with the security requirements of the GDPR. Your contract with them should include clauses which cover these obligations.

You also need a log of how you change or update people's data and have an audit trail of these changes. Generally, you will record these in each person's individual notes but if you are introducing an overall change you will need to record this elsewhere, say by updating the relevant practice policy or the privacy notice that you give to patients or staff.

If a serious breach does occur, you must report this to the ICO within 72 hours, unless you can show that the breach is unlikely to result in a risk to your patients.

Data protection officers – a major new obligation

You are expected to have the proper procedures and safeguards for looking after personal data and maintaining confidentiality built into what you do. Things that it has been suggested by the ICO that you could do, if appropriate, are: making sure you only record the minimum amount of information necessary; only share information with fellow healthcare professionals on a need-to-know basis; where possible anonymise data or use a pseudonym so that individuals cannot be directly identified; and be transparent about what you are doing with people's records (by giving them a privacy notice as described above).

In some situations you may need to do an impact assessment to determine the most effective way to comply with your data protection obligations. An assessment will need to identify the flow of data in your practice, ask if it is necessary and proportionate, list and assess the identifiable risks, and outline how to address or manage those risks.

One major new obligation is need to appoint a data protection officer (sometimes referred to as a DPO) if you see NHS patients. If you are a purely private practice you may also need to appoint a data protection officer if you handle a large amount of health data; there is no definition of large scale but guidance states that a hospital would be considered large scale but a single-handed medical practitioner would not). If you are a private practice you need to document that you have considered appointing a DPO and why you have or have not appointed one (that is why you consider yourself to be large scale or not).

A DPO is a person appointed by organisations to help them ensure that they comply with their legal obligations. They should report to the highest level of management at the organisation but not be the managers or owners of the organisation or a person who can be easily coerced by those managers or owners. The DPO should also have expert knowledge of data protection laws to do their job. Practice owners may feel it is appropriate to appoint someone external. Data protection officers can act on behalf of a number of organisations and it is understood that this service is offered professionally. They will need access to your filing systems so you must have a robust contract in place with them covering the service that they will provide and their obligations under the GDPR.

To do

Much of what you need to do to comply with the GDPR you will be doing already but you may need to take steps to ensure that you can prove this if asked by the ICO – so assess what personal information you have about patients and team members, how you get it, how you use it, who handles it, how you store it. Also:

- Give out privacy notices to patients and team members
- Check your systems for keeping data secure and ensure you have robust contracts in place with IT providers and other appropriate suppliers
- Engage a Data Protection Officer (DPO)

See www.bda.org/advice for our updated advice on Protecting Personal Information. Templates can be found at www.bda.org/expertsolutions ◆

Data protection principles

The law sets out six data protection principles that, in summary, require personal data to be:

1. Processed fairly, lawfully and transparently
2. Obtained only for specified, explicit, legitimate and lawful purposes
3. Adequate, relevant and not excessive
4. Accurate and up to date
5. Kept for no longer than necessary
6. Kept secure

Data protection privacy notice for patients

Your privacy notice for patients should help them to understand how you deal with their personal information, it should include:

- A statement that the practice keeps and processes patients' personal information
- The type of information that you hold
- The identity and contact details of the data controller and data protection officer
- The reason why you hold personal information
- How you use the information
- How long you keep the information
- How the information is stored and an overview of the security arrangements
- Who the information may be disclosed to and the circumstances in which disclosure may occur
- How patients can access their information
- How the patient can complain about the use, storage or disclosure of their information.

Contracts with suppliers

Contracts with software suppliers, cloud storage firms or any other organisation that handles practice data must include clauses which cover the following:

- What data are being processed
- The duration of the processing
- The nature and purpose of the processing
- The type of personal data processed
- The categories of people whose data are being processed
- Your obligations and rights as the data controller
- That the processor can only act on your written instructions
- That the their staff are subject to the duty of confidentiality
- That appropriate measures have been taken to ensure security
- Only use sub-contractors with your consent
- The obligation to assist you with subject access to their data
- The obligation to assist you to meet your obligations under the GDPR
- Deleting and returning all data to you as requested at the end of the contract
- The obligation to submit to audits and inspections

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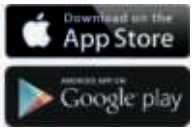

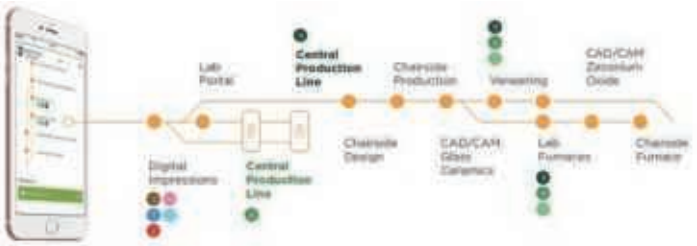

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Making the most of what you have

If that analogy doesn't work for you, take a look at the NHS across the board. £20bn of savings here, a further £6bn to be found in efficiencies there. All done at a time when more and more people are using the service, and those delivering care are expected to provide it with less resources. It is not a sustainable model, and the story is only going to end one way.

The natural tendency to seek savings when finances are tight is one most people will resonate with. When the crash hit in 2008, the natural instinct was to make cutbacks. Overheads, staffing costs, consumables – all vulnerable to a financial haircut. Investment would also take a back seat until the storm passed.

A decade later, you could question whether we're on the other side of the eye of the storm. NHS dentistry is expected – like all areas of the NHS – to provide the same service to a growing number of patients with less money to do so. Which begs the question, how do practitioners survive in the financial climate we operate in?

Ben Atkins, Principal Dentist and owner of Revive Dental Care, talked to *BDJ In Practice* about how to make the most of what you have.

'It's an interesting theory', Ben said. 'When austerity began a decade ago, it meant everyone from top to bottom in the practice had to understand the business. The fat around the practice had to be trimmed in certain areas.

'NHS dentistry is expected – like all areas of the NHS – to provide the same service to a growing number of patients with less money to do so.'

'There was also the well-documented public sector pay freeze, and that resulted in quite a lot of demotivated staff. It all added up to a period of stagnated practice growth. The reality is we're still very much in austerity, regardless of what those in charge of the coffers tell you. As a practice owner, it meant I had to be extremely vigilant about the finances of the practice.'

For practice owners across the UK, 2008 was a watershed moment. Perhaps understandably, many cautious decision-makers decided to seek cut backs and reduce their overheads. However, for those with aspirations beyond short-term survival, Ben suggested a different mindset was necessary.

'If you think seeking savings is the way to operate, there is every chance you will run out of options on where you can make them. Logically you will find yourself in a position where you have made too many savings, which endangers both patients and practitioners.

'If you control your finances properly and understand what you already have on the premises, then it isn't cost-cutting – it's being efficient. You wouldn't make a weekly shopping list without looking in the fridge to see what you have, so why would you continually order consumables blind without knowing stock levels?'

Planning

Planning may sound obvious, but against a backdrop of rising patient expectations, higher stress levels and continuous targets, is it something that all practice owners and practice managers engage in?

'We have a policy where we ask 'what's in the drawers?' We have all been there – a patient has arrived late, you're already behind schedule and you've got a challenging case. Rather than search for the instrument you need in the drawer, you open a brand new packet that's at hand. It's easily done, but done repetitively it can be costly.

'We do regular stock takes and have a search to see what we have. Things can fall down the back of drawers. They can be hidden under other items. You can borrow what you need from a surgery next door and not replace it, forcing you to think you need to order more syringes – for example, when the stock is in the next room.

'I recently purchased a practice and they had £20,000 worth of out of date stock in their drawers. That's a salary.'

Ben's point about reflecting on how the practice is operating is often looked upon as a method of improving the patient journey rather than from an economic viewpoint, but it does highlight the perceived lack of 'wider thinking' in the profession. There is a tendency that the only reflection comes in the treatment plan process. So how does this affect what goes on in practice?

'You have to understand your limits', Ben explained. 'That's not necessarily a negative thing – in fact it can be quite the opposite.

'You cannot realistically perform a 3D scan on an NHS endodontic case. The costs do not justify it. It's about understanding your patient, your equipment and the ramifications of the decisions you make. If you're an associate, talk it through with your practice owner. You might work in multiple locations throughout the week with practice owners who have different opinions. It is important to know what they are.

'It all comes back to the NHS contract, which is completely unfit for purpose. If the UDA value is low, decisions will be different than those in a high-value area. Patients should not be subjected to that kind of lottery, but as a practice you have to make those sliding adjustments.'

> 'If you work out how many procedures it will take the pay off the equipment, you can plan accordingly. If you don't know those numbers, how are you ever supposed to understand how your business is operating?'

Going digital

So how can you make improvements with a backdrop like that?

'I brought in the Wave One Gold', Ben said. 'I saw an opportunity to save more teeth than we were. In any area where prevention can be done on high levels of the population, you have to take it. I felt this was the best way of doing that.

'Digital dentistry has made a huge difference to the way we approach patients. The equipment itself isn't cheap, but it goes back to my earlier point about planning. If you work out how many procedures it will take the pay off the equipment, you can plan accordingly. If you don't know those numbers, how are you ever supposed to understand how your business is operating?

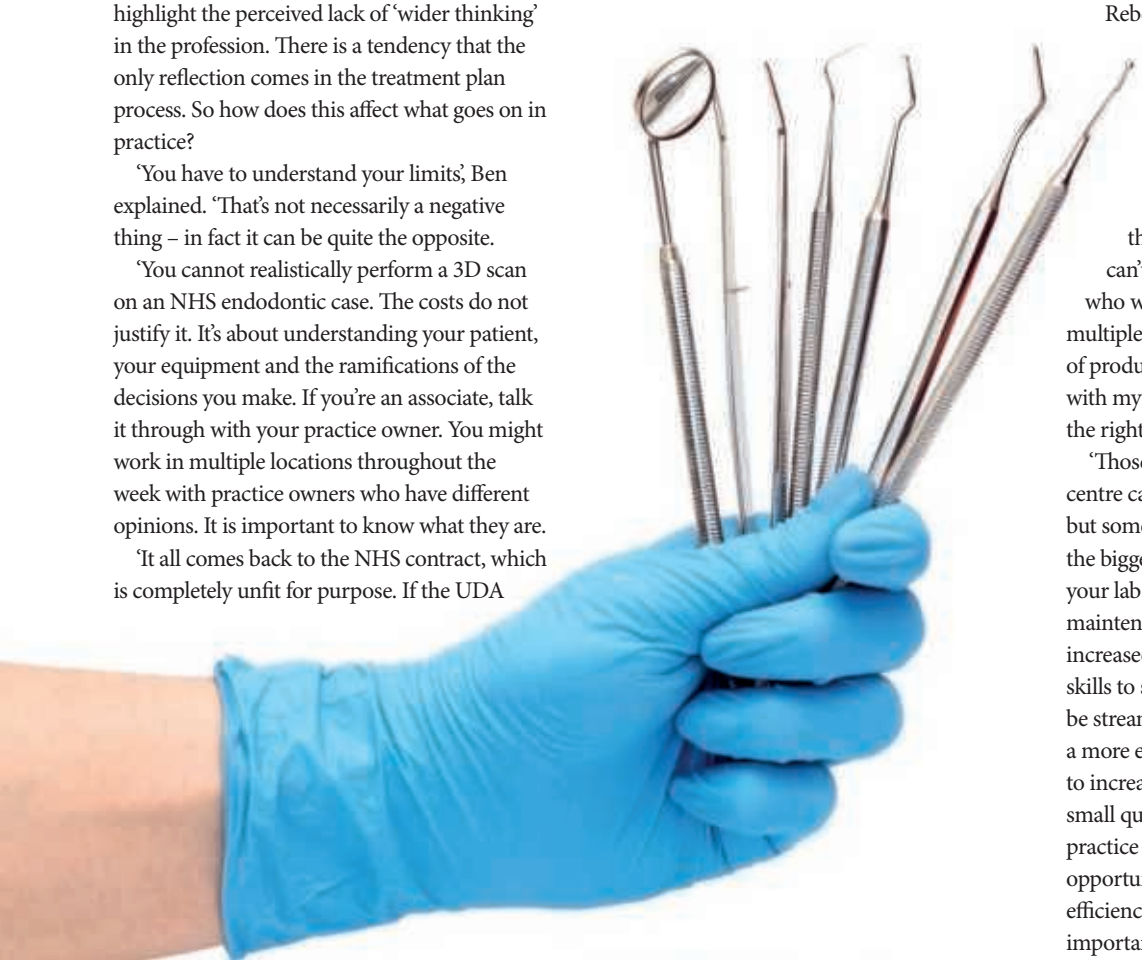
'To that end, I think it's really important to have an open communication policy, both within the practice and with suppliers. Everyone knows suppliers and account managers have a bottom line and targets to hit, so you have to understand your business inside and out. If you don't, how are you ever supposed to work with them effectively for the benefit of your practice?

'If you understand your business, they will understand your needs, and you will find you can have a great relationship. They can act as a safety net if they feel you're over-ordering on products. For example, I used to have a policy of having two of everything. To me, this made sense, but it turned out I had £40,000 of stock in the cellar gathering dust. I could clear that out and make another surgery, which benefitted the practice and our patient base.'

Rebecca Buglass, Key Account Manager at Dental Directory, believes it is more important than ever practice owners and account managers work together rather than having a transactional relationship.

Rebecca said: 'I see it as my job to understand the needs of the practice and the direction in which they want to go. Without that relationship I can't say to Ben he needs to order more face masks in line with his glove order as the ratio should be the same to be compliant. Without it I can't understand the needs of an associate who works in many different locations with multiple needs. I need to understand the types of products they prefer to use in surgery and with my industry knowledge guide them to use the right ones for their patients.

'Those who make cutbacks left, right and centre can save pennies on cotton wool, but sometimes this means you aren't seeing the bigger picture, what could you save on your lab bill, your handpiece and equipment maintenance? Is staff training up to date, will increased knowledge provide the staff with the skills to spot things they are doing that could be streamlined to make more savings. Is there a more efficient way to make bigger savings to increase profit in the business rather than small quick wins on consumables? I help the practice operate within their means, present opportunities to save money and create greater efficiencies. In the current climate this is more important than ever.' ◆



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Culture shock

the turmoil it can cause – and how mentoring can help

In the final article in the series, **Dr Janine Brooks MBE** and **Dr John Pereira BDS** talk about culture shock

For those of us who were born and educated in the UK, it is hard to imagine what it might be like having to adapt to living in a country with a very different culture to your own. However, this is the reality for thousands of dentists working here today.

Around a quarter of the dentists registered with the General Dental Council (GDC) qualified abroad, of whom approximately two thirds trained in one of the many diverse countries which comprise the European Union. Many will, of course, have transitioned successfully, be happily settled, and are enjoying a fulfilling professional and social life. However, for some, particularly for those recently qualified, adapting to a new way of life, and coping with basic needs such as making friends and engaging with colleagues and patients, can be daunting and unsettling.

This article draws on a real case to illustrate how mentoring can support dentists who find themselves the subject of a Fitness to Practise investigation where culture shock may be a factor. Details have been altered to prevent identification of the person, however the essence remains.

The dentist who inspired this article qualified outside the UK. They moved to the UK about seven years post qualification, and within a relatively short time received a number of patient complaints which eventually led to a referral to the GDC. The initial hearing did not go well, and resulted in the dentist being suspended, the suspension being re-imposed twice. Fortunately, with the support of a mentor, the suspension was lifted and conditions were applied to the dentist's practice. This is not an unusual pathway, in fact it is rather common.

Whilst cultural shock is highlighted as an issue, there are a number of points that underpin the development of cultural shock, including behaviour/attitudes, communication, insight, professionalism and ethics.

A disproportionate number of Fitness to Practise cases involve doctors and dentists who qualified abroad, leading to much research and analysis as to why this is the case. One such report recommended 'further development of mentorship schemes during the first two years of employment', and many such schemes are currently being developed by medical and dental organisations, including Local Deaneries.[3]

For dental professionals coming to the UK to work, there are a multitude of pitfalls to be navigated. Some of the most difficult are the subtle cultural variations that can lead to misunderstanding and miscommunication. In the UK, autonomy of the individual is highly respected and promoted. A manifestation of this is patient-centred care. Patient-centred care requires the ability to engage patients actively and positively in their own care and treatment. For professionals who have been born and educated in countries where the emphasis is towards professional-centred care it can be extremely difficult to make the switch.

For many, the transition to shared decision making between dentist and patient, which is the current norm in the UK, is a huge change from the more paternalistic and didactic approach in their country of origin. This can foster a lack of engagement and trust by patients, the consequences of which can be complaints and the spectre of a GDC referral with Fitness to Practise proceedings.

Enhanced patient knowledge, sometimes termed the Google factor, due to availability of information via the internet, necessitates professionals to 'up their game' particularly when it comes to discussion about treatment options. Patients want to know about their treatment options and they want to be engaged in the decision-making process.

In the UK there has been an erosion of automatic and unquestioning respect for professionals in many fields including health. A consequence of that can be that UK patients are less tolerant of seemingly arrogant behaviour by professionals, and are more likely to complain if they feel they are not being treated as partners in their care.

Across Europe and further afield there are differences in the organisation, management and regulation of dentistry. These differences can be difficult for dental professionals who did not qualify in the UK to grasp. However, ignorance is not bliss in this case, and the GDC will show little or no leniency with transgressors, no matter how innocently that transgression occurs.

Outside the UK, categories of dental professionals differ, and some registrant groups do not exist elsewhere. For example, not all dentists outside the UK work with a dental nurse. This can mean that those dentists may struggle to understand and appreciate the role and responsibility of this important colleague group. Misunderstandings can lead to poor team work relationships, and possibly poor clinical outcomes for patients.

The pitfalls

Communication with patients and colleagues can present serious challenges for those not born or qualified in the UK. This includes use of spoken language, professional language, accent, body language, facial expression, tone and inflection of voice. Poor communication is very often the precursor to misunderstanding and complaints.

Dr Janine Brooks
Janine is Director of Dental Programmes at the Dental Coaching Adademy (DCA). DCA has launched two new mentoring qualifications: The PG Certificate in Leadership Coaching and Mentoring and the PG Award in Coaching and Mentoring for Advisors. Both qualifications are at Level 7. She has her own coaching and training consultancy - Dentalia and is co-founder of Dental Mentors UK.

Dr John Pereira
John is a retired senior partner in general practice and self-employed dental mentor. John has a particular interest in helping to mitigate the effects of 'culture shock' in order to assist dentists who qualified outside the UK to adapt.

The pitfalls are many and deep. How can they be minimised? One solution is for all dental professionals coming to work in the UK to be supported by a mentor. This should be a senior colleague with experience and knowledge of UK culture, rules and regulations. A mentor can provide invaluable feedback, for example by shadowing the new UK registrant for a short time. The observation and subsequent feedback can be used as the basis of mentoring conversations. This can be a good way to notice if the dentist is struggling with communication or cultural differences. It can also underpin valuable reflective thinking and practice. Clearly there are patient consent issues to be addressed when observing a colleague clinically, however these are not normally difficult to achieve.

Culture shock is a fascinating concept. The term was defined and used in the 1950s by Kalervo Oberg, an anthropologist, to describe the problems that can arise when an individual moves from their home culture to another, new culture. He describes it as:

'anxiety that results from losing all of our familiar signs and symptoms of social intercourse' and *'psychological disorientation experienced when migrating to a radically different cultural environment to live and work'*.[2]

Since the 1960s, the number of doctors and dentists working in countries other than their country of birth has increased dramatically and this has led to the recognition of the term 'Double Culture Shock', whereby many health professionals have the additional stress of having to adapt to a new professional and regulatory framework.

This type of culture shock and the factors that underpin the concept often will act in combination.[1]

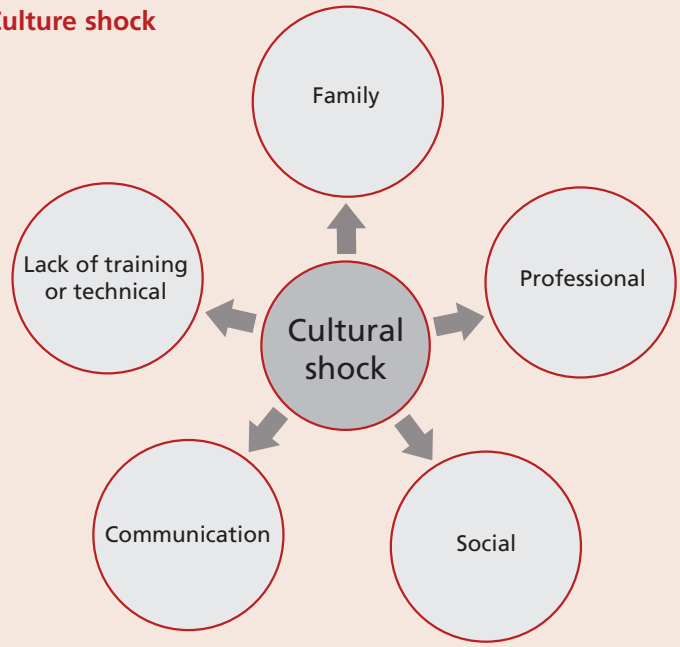
Adjusting to new patterns of cultural behaviour and the absence of familiar cues and symbols can lead to emotional turmoil. Culture shock can be intense for dental professionals as they need to adjust not only to the social setting of the UK, but also to the differences in the professional dental framework, and particularly the standards expected of dental professionals. Often these standards are substantially different to where the professional qualified. In the case that underpins this article the dentist displayed anger, denial, indifference and misunderstanding of her predicament, all classic signs of culture shock.

The determination following the Fitness to Practise hearing stated: 'She conducted herself in a highly unprofessional manner throughout the course of the hearing'.

Exactly what that means is difficult to be sure of, however it is obvious that the panel felt that the dentist demonstrated behaviour inappropriate to professionalism in the UK.

Some individuals are able to adjust to culture shock more quickly and more completely than others. Those who are fortunate to work with a mentor are more likely to be able to adapt more easily than those who struggle without support.

Fig 1. Culture shock



How can a mentor help?

Initially the mentoring relationship needs to establish rapport and trust. Tone of voice and body language play an important role in establishing empathy. The mentor's body language needs to be relaxed, welcoming and open in order to encourage engagement. Mirroring between mentor and mentee can be helpful at this stage. It is important that the mentor is empathetic and fully focused on the mentee. Choosing a comfortable, private venue for the first meeting will help to reinforce confidentiality.

Of course, a skilled mentor offers far more than simply a source of support. Mentoring is about encouraging the mentee to reflect on and understand the situation they find themselves in. The mentor provides a safe, confidential, and non-judgemental sounding board, which encourages the mentee to work out their own solutions to their problems.

Reflection is a very useful and potentially productive way to engage the mentee with their current situation. This can be developed by encouraging the mentee to discuss their situation, and by the mentor paraphrasing and clarifying what is disclosed. At this stage the mentor should keep their own opinions to themselves. Towards the end of the meeting the mentor can give honest and specific advice, especially if there are issues which need to be urgently addressed. In the case of working with dentists undergoing remediation, that could include work on their Personal Development Plan (PDP).

With the support of a mentor, a specific action plan will be devised and a specific outcome achieved. A successful outcome can enhance the mentee's self-confidence, and lead to a virtuous circle in which the mentee may continue to develop strengths and talents they were previously unaware of.

Successful mentorship can be equally fulfilling for the mentor, and both sides can learn from the positive outcomes generated. Most importantly the mentee will have been empowered to navigate their way between hazards which could have ended disastrously, and hopefully will go forward confidently to enjoy a worthwhile and fulfilling professional life here in the UK. ◆

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Bouncing back

Dr Barry Oulton
Owner of Haslemere Dental Centre, Surrey

When bouncebackability found its way into the dictionary, I have to say I was sceptical. I mean, what sort of word is it?

Dr Barry Oulton has owned Haslemere Dental Centre in Surrey for nearly 20 years, turning it into an award-winning practice with a reputation for outstanding customer service. In 2017, he founded The Confident Dentist, a communications training company aimed specifically at the dental sector. The Confident Dentist offers face-to-face training, online courses and one-to-one coaching to help dentists and their staff improve their interactions with patients, and make their experience in the dental chair as comfortable as possible.

Fast forward 13 years, and the term has moved on from simply reflecting the ability to move on from an error in sport. With the number of Fitness to Practise cases within the profession, it could be argued it was coined thanks to the GDC.

I spoke to Dr Barry Oulton, the dentist behind The Confident Dentist, to discuss how the modern day practitioner can bounce back when things don't go their way.

'It's not simply about errors, Barry explained. 'You often find one error does not exist in silo. It is the result of a cascade of mistakes, rather like a set of dominos.

'Mistakes do happen, and, in many cases, it is as a result of circumstance. I recently had an incredibly stressful day and one particular case had me under intense time pressure to see another patient. Despite this, my nurse suggested I took two minutes out as she knows that pressure breeds mistakes and could see that I needed to take a step back.'

Wider thinking

According to Barry, there is a lot we can learn

from colleagues in the aviation industry, a sector that author Matthew Syed has already begun to learn from.

'Matthew wrote a book called *Black Box Thinking: The Surprising Truth About Success*', Barry said. 'In it he explained the process the aviation industry goes through in the aftermath of an accident. They recover the black box, do their level best to learn what happened and most importantly how to ensure it does not happen again. There are a lot of lessons the medical profession can learn from that.

'There was a case of a surgeon, who was performing a minor operation on a patient. The surgeon in question began to feel pressured, and missed that the patient's saturation levels were going down. The surgeon was not listening to their nurse, became more stressed and the patient died of oxygen starvation. This is what can happen when one minor thing can go awry – it can make you spiral out of control.

'This is why my nurse suggesting that I take two minutes out was critical. It is so important that you communicate as a team that it is OK to flag something if you think it is not right. It doesn't happen overnight, and there is still a degree of hierarchical authority in the profession, which is why building a rapport within the team is important.'

Managing expectations

In an environment where patient expectations are higher than ever, and patients know brand names rather than processes and procedures, managing expectations is one of the pillars of being able to bounce back.

'Patients come in telling me what they don't want, and straight away that's a red flag for me', Barry explained. 'Immediately I try and turn it round and ask them what they want, which is often a feeling – to feel confident in their smile, for example – rather than something tangible. It's my job to find out what that picture means to them, and I know if that picture does not match with theirs the patient will be unhappy. Everybody wants the world, and that can often put unnecessary pressure on you as a practitioner. You have to get across what is possible to achieve.'

Subconscious driver

In any walk of life, what you focus on is what you get, and it is the subconscious mind that drives you on. According to Barry, that is why we cannot process a negative.

'If I say to my nurse, 'Don't trip over that cable', they will have to imagine tripping up to understand what not tripping is.

'The very same can be said of any treatment. If you aren't fully confident on implants and have to focus on not drilling too far, you have to imagine drilling too far for your brain to process the opposite. Given that the subconscious drives you, that is going to be a real problem. You will rehearse it in your head in order to rehearse getting it right. There is a significant likelihood, in that instance, of drilling too far.'

'Everybody wants the world, and that can often put unnecessary pressure on you as a practitioner. You have to get across what is possible to achieve.'

With litigation and fear at the forefront of the discussion surrounding the GDC and Fitness to Practise, focus draws towards Montgomery. But is it simply about consent?

'The quality of the communication is defined by the response you get', Barry explained. 'If you explain the potential pitfalls to your patient in a clear way, their decision will be conditioned by the quality of the information given. If the complication you outlined to the patient prior to the procedure occurs, the rapport built up prior to that will make your ability to navigate through the aftermath somewhat easier. Rapport with patients makes having those difficult conversations easier.'

A smart problem

Many people – including myself – believe the art of holding a conversation is going out of fashion. You need to speak to someone? You send an instant text. Do you pick up the phone and chat? Not likely. So does Barry think dental students of today and the dentists of tomorrow are in a precarious situation?

'Smartphones have a lot to answer for', he said. 'The communication model states there are three strands to communicating – words, tone and physiology, or body language. Words account for 7% of any communication, tone 38% and body language 55%. How can a text message or an email possibly strike that right balance? Millennials have grown up living in the 7% – words only – given the immediacy of communication methods these days.

'We have to remember, communication is absolutely vital to our survival. It can head off problems before they arrive. It can resolve them if problems occur. Are we heading towards professionals with weaker communication skills as a result of this? It isn't beyond the realms of possibility.'

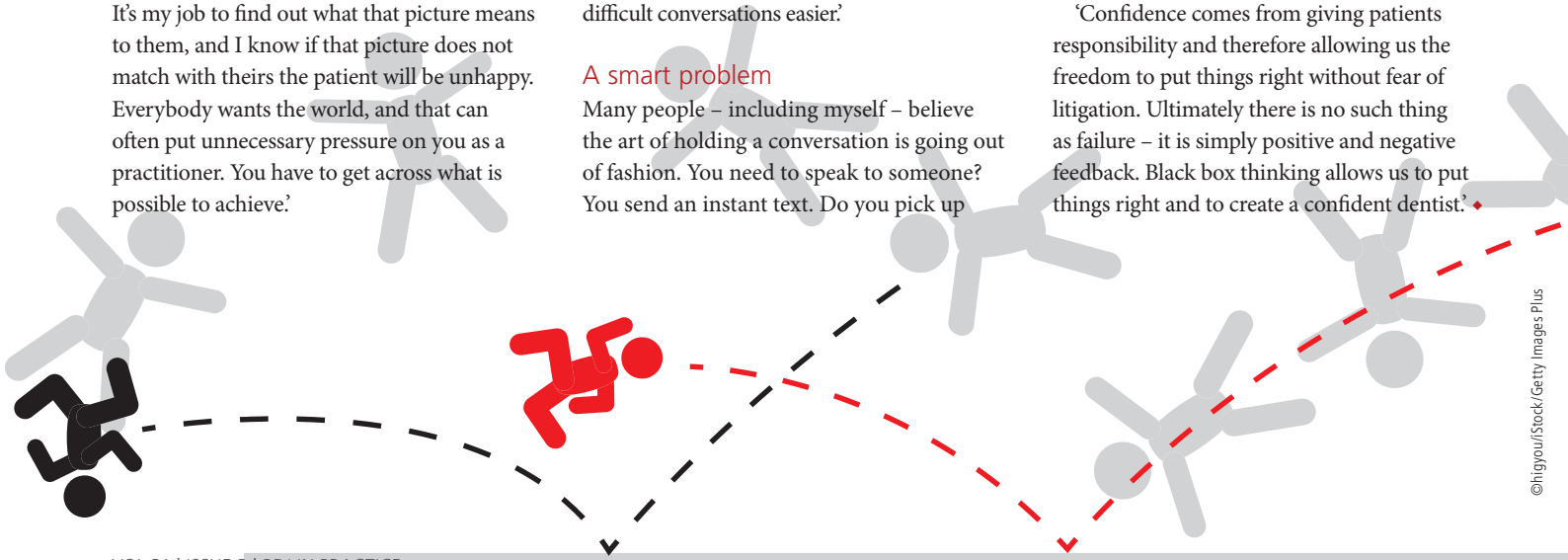
Blame culture club

The increase in ambulance chasers has given birth to an apparent blame culture. Accepting responsibility for our own actions isn't quite a thing of the past just yet, and Barry believes patients should own their own biology.

'I have patients all the time who tell me they have gum disease and it's my fault', he said. 'Where is the responsibility? It's not easy to say to those patients that if they attended appointments at regular intervals and paid attention to the information we pass on when they are here they would not have gum disease.

'I believe the profession is enabling patients to shift the blame. The regulator's approach to Fitness to Practise is helping a blame culture blossom. That has to change. How are we supposed to create confident dentists and allow them to flourish in their roles?

'Confidence comes from giving patients responsibility and therefore allowing us the freedom to put things right without fear of litigation. Ultimately there is no such thing as failure – it is simply positive and negative feedback. Black box thinking allows us to put things right and to create a confident dentist.'



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Decontamination, instrument packaging and storage

By Edward Sinclair
Edward is a dentist and a practice management consultant in the BDA Professional and Advisory Services Directorate, helping members on all aspects of health & safety law, infection control requirements, practice inspections and compliance with professional regulations.

Instruments are an integral part of dental practice; therefore ensuring a steady supply is an essential part of effective practice management. The rules surrounding instrument storage can be confusing and seemingly illogical, but aims to assist clinicians and their staff in determining the best and most economical way of achieving effective decontamination and storage.

Since health is a devolved matter, the exact guidance pertaining to decontamination is specific to the four nations of the UK. The guidance documents are in the box below.

It has been mandatory to have a decontamination room and validated washer disinfector in Scotland and Northern Ireland, since the end of 2012.

In England and Wales, it is now compulsory for all new dental practices, but the rules do not apply retrospectively. It is recognised that many premises cannot easily install a room due to space constraints – however, a theoretical plan for best practice should be in place.

However, one aspect is consistent throughout – facilities for manual cleaning of instruments should always be available. In the same way if a dishwasher breaks down in a kitchen, dishes can be washed by hand, the same applies to decontamination work.

In addition, the decontamination process should be carried out in the same way (including zoning) whether in a surgery or in a dedicated decontamination room.

Instruments are brought from a clinical treatment area in solid, lockable and leak proof containers and, ideally, instruments should be processed as soon as possible after use to avoid difficulty in cleaning later.

Where this is not possible, instruments should be immersed in water, to prevent sticking of debris; however, long periods of wet storage should be avoided and this includes leaving overnight.

The initial stage involves removing instrument debris before inspection and sterilisation; one, two or all three of the following can be used – manual cleaning, ultrasonic cleaning or a washer disinfector.

However, if a washer disinfector is present, the expectation would be that this would be used as a matter of course.

The ultrasonic cleaner is optional, but remains a cost effective option as an alternative to a washer disinfector.

Manual cleaning, as mentioned, must be available regardless, as a backup option and should always follow a recognised protocol e.g. the use of heavy duty gloves along with other PPE.

Once the debris has been removed, the instruments should be examined under an illuminated magnifier to ensure that no residue is left; if any remains, the initial process should be repeated.

Once the instruments are physically clean, they are ready for sterilisation and the types of steriliser/autoclave used is a matter for the practice to decide. There is no requirement to use a vacuum autoclave and non-vacuum types are equally permissible; post sterilisation storage times are the same for both types.

However, the method of preparation is different. For a vacuum cycle, the instruments must be dry and package prior to insertion in the autoclave. The autoclave should be validated and used according to manufacturer's instructions and, once the cycle is finished, the absence of machine failure should be documented.

The instruments should be removed and dried using a clean, disposable non-linting cloth.

What happens next depends on where in the UK the practice is located. (see fig 2)

Fig 1: Recent guidance

Country	Guidance document (most recent edition)
England	HTM 01-05 (2013)
Wales	WHTM 01-05 (2014)
Northern Ireland	HTM 01-05 (2013)
Scotland	SDCEP Decontamination Into Practice (2014)

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Fig 2: Storage guidance

Instrument Storage times	
England and Northern Ireland	→ Sterilised instruments can be stored for up to one working day (morning/ afternoon) unpackaged in covered trays/drawer inserts in a clinical treatment area → Sterilised instruments can be stored for up to one week unpackaged in covered trays/ drawer inserts in a non-clinical area. This can be the clean area of a decontamination room or a decommissioned surgery → Sterilised instruments can be stored for up to one year packaged. The location of the storage is unimportant.
Wales	→ Sterilised instruments can be stored for up to one working day (morning/ afternoon) unpackaged in covered trays/drawer inserts in a clinical treatment area → Sterilised instruments can be stored for up to one year packaged. The location of the storage is unimportant.
Scotland	→ Store instruments in clean enclosed cupboards, drawers or boxes in an orderly manner that avoids damaging the wrapping → Do not store any instruments on open shelving or on work surfaces in clinical areas → Use a first-in, first-out stock rotation to minimise the duration of storage.

Extra and expert members can find out more about decontamination by contacting the BDA's Health and Safety Team on 0207 563 4572 or advice.enquiries@bda.org.

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Pregnancy and risk assessment

By Lynn Woods
Practice Management Consultant, Compliance Team

Pregnancy is part of everyday life and many members of the dental team work throughout their pregnancies without any particular problems. Here we will look at what the law requires from a health and safety aspect, what employers need to do to comply and at some of the common risks in general dental practice. The requirements also cover employees who have given birth within the past six months or are breastfeeding, but this feature will look at just the pregnancy aspects.

The law – health and safety and pregnancy

Once an employer has been notified in writing that a member of staff is pregnant, the employer should immediately take into account any risks identified in their general dental practice risk assessment. If that risk assessment has identified any risks to the health and safety of the pregnant member of staff or that of her baby, then the employer must take action to remove, reduce or control the risk. If a risk is identified that cannot be removed the employer will need to:

- Temporarily adjust her working conditions/hours
- Offer her suitable alternative work; or
- Suspend her on paid leave for as long as necessary to protect her health and safety or that of her child.

Below are some of the risks that may arise in general dental practice.

Infection risks

Firstly, it is worth a reminder that all staff should be up to date with their routine immunisations, e.g. tetanus, diphtheria, polio and MMR and to bear in mind that any severe infection, whatever the cause, may be detrimental during pregnancy.

Secondly, it is important to highlight that infections caught at work are thought to be rare.

Risks in general dental practice include injuries from infected sharps and direct contact with infected blood and saliva. Protection against these risks includes the provision of suitable information, instruction and training in safe working practice (including inoculation prevention), PPE and immunisation as appropriate. Immunisation should be seen as a useful supplement to safe working practice and the proper use of PPE.

Hepatitis B is a blood-borne virus and can be transmitted through an infected sharp or through direct contact with infected blood or saliva. The virus can pass from mother to baby during delivery.

Cases of occupationally acquired hepatitis b have declined in recent years, due to increased awareness, safe working practice, use of PPE and widespread use of the vaccine.

Hepatitis b vaccination is recommended for all clinical members of the dental team, including decontamination assistants.

One common infection that can sometimes be more severe in pregnancy is chickenpox (varicella-zoster). Sources of infection include direct contact, droplet infection or recently soiled materials such as handkerchiefs. If not immune from past infection, pregnant members of staff are advised to avoid contact with known cases of chickenpox or shingles.

Chemical products/agents

COSHH requires that all hazardous chemical products should be assessed and used in accordance with the hazard labelling/safety data sheet information and instructions for use. Suitable PPE (eg gloves, eye protection, protective clothing) may be required and employers will need to ensure suitable ventilation for products with harmful vapours – which may include strong detergents and disinfectants, mercury, nitrous oxide, tray adhesives and x-ray chemicals.

Ionising radiation

Employers have to ensure that pregnant staff are not exposed to more than 1mSv during the declared term of the pregnancy. It is unlikely that the dose level in general dental practice would exceed 1mSv per year unless a pregnant member of staff personally attends more than 100 intra-oral or 50 panoramic exposures per week, in which case an RPA should be consulted.

Specific/further individual risk assessment

Although it is not a legal requirement to conduct another specific or further individual risk assessment separately from the general dental practice risk assessment (which should already have covered risks to female employees of childbearing age) it may helpful to do so to address any individual issues or concerns a pregnant member of staff may have.

It is important that the member of staff tells you (as her employer) about anything that could affect the assessment (pregnancy-related medical conditions such as high blood pressure or a history of miscarriages, for example) as this could affect the assessment and you may need to adjust her working conditions accordingly. The member of staff can request to see the outcome of the risk assessment and you should show this to her.

Aspects to consider for a pregnant employee include:

- A need to go to the toilet more often. It would be sensible to agree timing and flexibility of rest breaks as part of the risk assessment process.
- Her dexterity, agility, co-ordination, speed of movement and reach may be impaired because of increased size as the pregnancy progresses. ◆

Further information

BDA Expert has an example risk assessment for pregnant and nursing mothers. If you have any queries in relation to a pregnant member of staff you can contact the compliance team on 0207 563 4572.

The tooth about whitening

By Patrick Gamble

Patrick is a BDA Good Practice assessor and practice management consultant in the BDA's Compliance team, helping members on all aspects of health & safety law, infection control requirements, practice inspections and compliance with professional regulations.

A brighter smile is up there on most people's wish list, with tooth whitening fast becoming one of the largest growing cosmetic procedures in the UK. In recent years, this demand for the perfect 'Hollywood smile' has spawned a range of home whitening products that can be picked up online or on the high street. However, despite the growing availability of whitening strips, charcoal toothpastes, and whitening pens, professional tooth whitening remains the only way to truly change the colour of teeth.

A survey by National Smile Month revealed that 48% of the population are currently unhappy with their teeth, with 64% of those stating discolouration was the primary reason for their dissatisfaction.[1] The growing demand for tooth whitening has led to the procedure now being reasonably priced and widely available. However, there is a negative side to the growing popularity of whitening. From unlicensed traders and beauty technicians capitalising on the insecurities of their clients, to confusion from patients over who can provide whitening services and what products are actually effective.

It's not surprising then that in 2014, the GDC reported that of the 1,844 complaints they received, 1,424 (77%) of them were related to tooth whitening.[2] Historically, the legal position in Europe relating to teeth whitening has been confusing, with different interpretations of the EU Directive being applied in different European countries, but in 2012 it became illegal for anybody other than a dental professional to carry out tooth whitening in the UK; yet there remains a dangerous number of beauticians and salons carrying out the treatment.

Members of the profession have continually warned that having teeth whitened by a person not registered with the GDC could result in damage to the patient's teeth and gums. For example, last year a woman from Renfrewshire suffered third-degree burns after her teeth were whitened by a beautician, and in Lancaster a mother lost her two front teeth after receiving treatment from an unlicensed practitioner. The GDC can investigate and, where sufficient evidence is available, bring a criminal prosecution against non-registered whitening providers. However, they can, and have, taken similar action against registrants found to be carrying out whitening outside their scope of practice. One such case occurred last year when a registered Dental Nurse from Rochester appeared before a Professional Conduct Committee (PCC) after dishonestly offering tooth whitening treatments and found using products up to three hundred times the legal limit.

So who can perform tooth whitening? In the eyes of the GDC tooth whitening is solely the practise of dentistry and should only be done by regulated dental professionals. Dental hygienists and therapists can also carry out teeth whitening if they have the necessary additional skills but only on the prescription of a dentist. Similarly, the taking of impressions and making of bleaching trays are within the scope of a dental nurses, but again, are only permissible under a dentist's prescription.

With so many products flooding the market, what type of whitening agents can be used? Current regulations stipulates that products between 0.1% and 6% hydrogen peroxide can only be prescribed to persons over the age of 18 by a dentist following a clinical examination. However, due to serious concerns regarding the safety of sodium perborate and chlorine dioxide-based whitening products, these agents should not be used. There is currently no distinction between in-surgery whitening and the provision of home whitening kits, but due to the risk that a patient could swallow excess material, all home whitening kits must be accompanied by detailed instruction on fitting the tray by the prescribing dentist.

One of the most common questions that arises about tooth whitening is the subsequent provision of top-up gels. After the first in-surgery application, patients can be provided with the tooth whitening product for home use, but the dentist's duty extends to monitor the provision of top-up gels and ensuring it is in accordance with the patient's treatment plan. The dentist does not have to be present when the top-up gel is handed out, but detailed records of the examination and the instructions given to the patient should be recorded within the clinical notes to ensure what is handed out is in accordance with their treatment plan.

Importantly, a little-known fact is that once the course is complete, top-up gels should not be provided without a new clinical examination by the dentist.

Finally, with so many patients desperate to emulate the pearly-white smiles of their celebrity idols, ethical advertising of tooth whitening services can be another stumbling block. Promising patients a 'Hollywood smile' is one thing, but remember dental practices can only advertise tooth whitening procedures using products containing or releasing up to 6% hydrogen peroxide and, any advertisements should comply with the GDC guidance and the Advertising Standards Authority Codes. ◆

1. Facts and Figures – National Smile Month. National Smile Month. 2018. Available from: www.nationalsmilemonth.org/facts-figures (Accessed February 2018).
2. Reporting of illegal practice. General Dental Council; 2015. Available from: www.gdc-uk.org/api/files/GDC%20Illegal%20Statistics%20Infographics.pdf (Accessed February 2018).

Further information

For further discussion on this issue further please contact BDA's Health and Safety Team on 0207 563 4572 or email advice.enquiries@bda.org.

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Getting to the root

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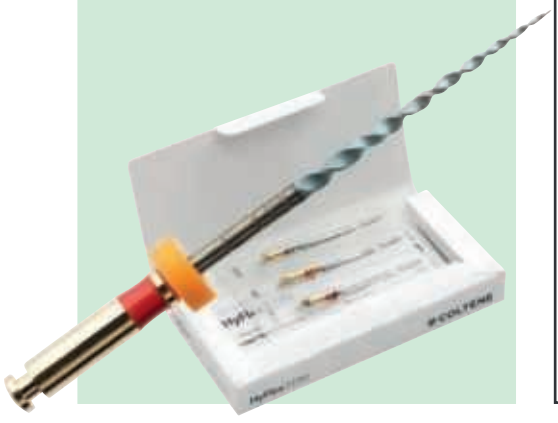
Indeed, the HyFlex EDM file allows for greater flexibility in the canal, meaning that – along with its superior strength – the file can be used with greater accuracy in minimally invasive procedures.

What's more, due to these unique properties, it is possible for practitioners to reduce the number of files they need to clean and shape the root canal during endodontic procedures – making the HyFlex EDM more cost-effective than other files.

Through intense research and development, COLTENE has been getting to the root of modern dental issues.

To find out more visit www.coltene.com, email info.uk@coltene.com or call 01444 235486.



Staying protected

Winter brings with it some harsh conditions in the wilderness, but it's the dental practice that is the toughest environment of them all. The constant threat of dangerous pathogens and need for a continuous high level of infection control is far more unrelenting than the prospect of a bad winter.

That's why you need equipment you can trust to perform, such as the Little Sister range from Eschmann that is designed to work in the most demanding of environments.

Little Sister autoclaves and washer disinfectors are the epitome of reliability in times of need, and you can rest assured that you'll be able to deal with whatever is thrown at you thanks to Eschmann's Care&Cover Protection. Unrivalled and affordable, Care&Cover is available from as little as £8.50 per week.

For more information on the highly effective and affordable range of decontamination equipment and products from EschmannDirect, visit www.eschmann.co.uk or call 01903 753322.

The ideal tool for orthodontic patients

Recent research shows that sonic brushes are particularly efficacious at reducing gingivitis, plaque and interdental bleeding compared to manual orthodontic and powered brushes.[1]

To help your patients undergoing comprehensive orthodontic therapy minimise the risk of periodontal breakdown, why not recommend the Hydrosonic Black Is White toothbrush from Curaprox?

With its hydrodynamic effect, the innovative toothbrush can help patients clean hard to reach, critical areas, helping them keep plaque accumulation at bay.

It has three modes:

- Intensive – ideal for preventing decay and getting rid of plaque
- Soft – for cleaning sensitive teeth and gums
- Massage – stimulates blood circulation in the gums.

All this is available at the push of a button. And because the Hydrosonic Black Is White comes with an extra-powerful battery that lasts for 40 minutes before having to be charged, patients don't have to worry about their toothbrush running out of power!

If you know patients with fixed braces that would benefit from the use of a high-performance sonic toothbrush, call 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.

1. Sharma R, Trehan M, Sharma S, Jharwal V, Rathore N. Comparison of effectiveness of manual orthodontic, powered and sonic toothbrushes on oral hygiene of fixed orthodontic patients. *Int J Clin Pediatr Dent* 2015; **8:** 181-189.

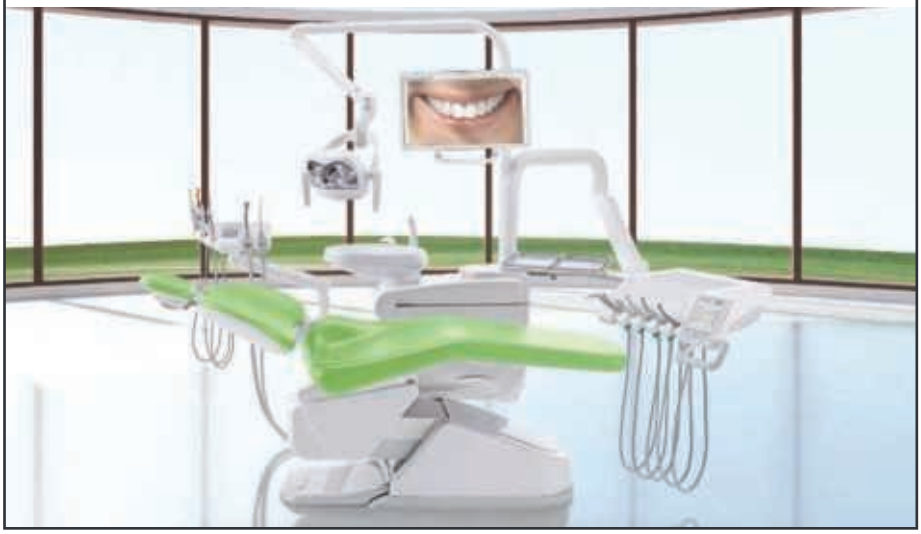
All the bells and whistles

When it comes to your treatment unit, what do you think your patients would think if they walked into your surgery and saw a basic, low-budget chair with no accessories or technology in sight? Wouldn't it be more impressive to be greeted by a top of the range dental unit with all the bells and whistles?

The Castellini Skema 8 available from RPA Dental, for instance, has a built in Full Touch control panel that lets the user save the working parameters of each individual instrument, and integrated media monitor for use alongside complimenting digital imaging solutions. There are a number of accompanying instruments, accessories and multimedia to choose from to meet your patients' expectations and suit your personal needs, all of which work in perfect harmony together for the optimal outcome.

Plus, what patient wouldn't appreciate the comfort provided by the exclusive sliding function and synchronised movement of the seat and backrest? It really is the ideal dental chair for both patient and practitioner.

RPA Dental offers the Skema 8 in a variety of striking, eye-catching colours alongside excellent customer service and ongoing technical care. To find out more, visit www.rpadental.net.



A thorough check

Most dentists routinely screen patients for oral cancer, but how confident are you in detecting an early cancerous lesion? Sadly, oral cancer is often caught in the late stages, which is why mortality rates are higher. If caught early, the survival rate is over 85% when cancers are small.

As well as visual screening, practices are also using technology to assist in diagnosing early cancerous lesions. One such device is Goccles, Oral Cancer Screening Glasses. These allow the clinician to run a simple, non-invasive and painless test using the technology of fluorescence and cell-tissue auto-fluorescence by utilising the wavelengths emitted by curing-lights, a common piece of equipment in all dental practices. This allows the user to see in a clear and accurate way any anomalies of the oral cavity. The basic principle is that the auto-fluorescence of abnormal cells lining the mouth when exposed to light, differs to that seen occurring in normal cells. Goccles glasses allow the clinician to see differences in auto-fluorescence of the tissues, with normal cells appearing green and abnormal cells dark.

The eyewear is comfortable to wear and permits the simultaneous wearing of standard glasses. The light source is held by an assistant, leaving the examining clinician with both hands free to reflect the oral soft tissues with dental mirrors to ensure that the entire oral mucosa is assessed.

Goccles are distributed exclusively through Dental Sky. For more information visit www.dentalsky.com/goccles-oral-cancer-screening-glasses.

A new premium prophylaxis system

The new premium prophylaxis brand Lunos covers a range of products that combine to form a cohesive system, offering unique advantages over existing products.

One example of this is the MyFlow powder jet handpiece. Its unique exchangeable chamber principle means the powder container can be replaced quickly and easily, avoiding the inconvenience of having to refill in the middle of treatment. Furthermore, surgeries can prepare enough powder containers for the whole day.

The powder jet handpiece also sets new standards in terms of reprocessing. All parts are thermally disinfectable and autoclavable. Together with the minimised clogging potential and ease of maintenance, this saves time, taking pressure off your treatment workload.

MyFlow works with various prophylaxis powders. The Gentle Clean variant of Lunos contains innovative new abrasive agents based on the non-carcinogenic disaccharide trehalose for gentle cleaning in the supragingival area and is available in three different flavours. Alternatively, there's Lunos prophy powder Perio Combi for supragingival and subgingival treatments. The excellent water solubility of this powder enables safe, virtually residue-free dissolution in the periodontal pocket and suction system. Thanks to this, patients no longer experience the unpleasant grittiness typically associated with this type of product.

There are also two variants of polishing paste available. The abrasive particles in the Lunos prophy paste Two in One become smaller during the polishing process ensuring that coatings and plaque are removed without interfering with the surfaces of restorations. Even gentler polishing is possible with the Lunos prophy paste Super Soft. Its low RDA value makes it suitable for sensitive surfaces, for example on children or patients with implants. The prophy pastes from Lunos are also available in different flavours.

Lunos is a new sub-brand of Dürr Dental. For more information visit www.duerrdental.com

Can you provide treatment for all?

Most people visit the dentist because they want to look after their teeth but there are also many reasons why people do not visit, such as dental anxiety.

For people with a physical disability, it can be the case that they do want treatment but they are prevented by factors that limit their access. For example, people who use a wheelchair report difficulty obtaining treatment and that they prefer to stay in their wheelchair during treatment.

One product that helps to overcome this particular limitation is the CS 8100 panoramic system from Carestream Dental.

As the CS 8100 system is height adjustable, it is suitable for patients who are standing or sitting, including those in a wheelchair. It makes the positioning of patients quick and simple, and fits easily into tight spaces. It is part of the CS 8100 family that was awarded the Dental Advisor's 'Top Panoramic Imaging System of 2014'. By using this unit, dentists can remove one problem faced by people with different needs.

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

Innovative imaging

Designed to be durable and robust, practitioners can trust in the reliability of the NOMAD Pro 2. It comes with a powerful battery handset which has enhanced the system's performance and made it a highly portable radiographic unit, capable of obtaining hundreds of images in a single charge.

Built to endure an operatory environment, the dental team will appreciate the efficacy of the full-colour LCD user interface of the NOMAD Pro 2 that is both scratch- and moisture-resistant. The reduced time required to conduct radiographic procedures also means you have more time to spend with your patients during an appointment.

Be confident in the knowledge that the NOMAD Pro 2 maintains the highest level of safety as it has been expertly manufactured with modern radiation shielding to protect the operator from prolonged exposure.

Taking intraoral radiographic images has never been simpler with the NOMAD Pro 2 from Clark Dental.

For more information contact Clark Dental on 01270 613750, email info@clarkdentalsales.co.uk, or visit www.nomadhandheldxray.co.uk.

A safe space

Supporting professional education in the field of dental implants, the Association of Dental Implantology (ADI) offers various platforms for its members to advance their knowledge and skills.

To encourage the sharing of information and ideas between professionals of all experience levels, the ADI Members-only Facebook Group provides a safe space for individuals to seek advice and guidance from peers. Cases can be posted, opinions sought about new products and recommendations for referral centres or training centres requested too.

A great platform for debate and discussion, it enables members to offer their own perspectives for improved understanding among colleagues.

The group is also the perfect place to network with like-minded peers and gain inspiration form the amazing work others are doing.

For more information about the ADI visit www.adi.org.uk.

True genius

Oral-B's Genius brush, combined with the Oral-B App, provides the world's most intelligent brushing system, helping users to achieve the best possible at-home dental care.

It does this by combining the best cleaning technology – electric tooth-brushing – with the best guiding technology. Oral-B's oscillating-rotating-pulsating brush-heads provides an outstanding clean, while Oral-B's App makes sure that users brush for the right amount of time, with the right pressure, and that all zones of the mouth are covered evenly. Even the best cleaning and brushing technology in the world cannot help if it isn't applied everywhere evenly.

The position detection capability of the Oral-B Genius is what sets it apart. Other brushes cannot detect where users brush in their mouth as Genius can. Their systems give recommendations on where to brush, but cannot track if indeed the user brushes where their app tells them to do. If the user does not follow the guidance given on the app-screen, their brushes cannot detect where the brush is, and cannot help the user to brush correctly, or to improve their brushing style.

Genius? It certainly is!

Dentist to Dentist

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

Scotland

BLACKHILLS SPECIALIST REFERRAL CLINIC
www.blackhillsclinic.com

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

266979

East Anglia

J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

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

289511

DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

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

Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

296176

North

SPECIALIST DENTAL CARE
www.specialistdentalcare.com

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

261782

South East

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

MOOR PARK SPECIALIST DENTAL CENTRE

www.moorparkdental.com

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

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

Dr Lydia Hopkins BDS MSc Ahea
Specialist in Periodontics

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

Dr Norman Gluckman BDS Rand
Specialist in Endodontics

Dr Neeta Patel BDS FDS RCS
Specialist in Oral Surgery

Dr Sheetal Patel BDS MFDS RCS MSC Morth
Specialist in Orthodontics

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

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

294230

DENTAL SPECIALISTS ST ALBANS

www.thedentalspecialists.co.uk

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

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

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

239826

TOOTHBEARY RICHMOND

www.toothbeary.co.uk

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

258051

BOSTON HOUSE DENTAL CLINIC

www.bhddc.com

SPECIALIST REFERRAL CENTRE IN THE CITY OF LONDON

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

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

Specialist services:

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

Special Interests services:

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

295045

PERIO & IMPLANT DENTAL REFERRAL CENTRE

www.perionimplant.com

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

293125

DENTAL SPECIALISTS MK

www.dentalspecialistmk.com

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

209440

ROOT CANAL DENTAL REFERRAL CENTRE

www.rootcanalcentre.co.uk

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

293124

Midlands

DENTAL SPECIALISTS MM

www.dentalspecialistsmm.co.uk

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

Interests: Periodontics, Orthodontics, Peri-implantitis

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

209439

THE PRIORS DENTAL PRACTICE LTD

www.thepriorsdentalpractice.co.uk

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

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

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

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

CT Scanner and dedicated implant suite on-site.

236739

North West

ST GEORGE'S DENTAL PRACTICE

www.stgeorgesdentalpractice.co.uk

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

261006

In Practice CPD

Health & Safety

Q1: How long can sterilised instruments be stored for in England, Wales and Northern Ireland?

A Overnight
B 24 hours
C One working day
D Two working days

Q2: What is the maximum exposure to ionising radiation throughout a declared term of pregnancy?

A 0.1mSv
B 0.5mSv
C 1mSv
D 1.5mSv

Q3: What is the minimum percentage of hydrogen peroxide a dentist can prescribe to a patient over the age of 18?

A 0.1%
B 1%
C 6%
D 10%

Q4: When did the EU Directive on tooth whitening take effect in the UK?

A 2015
B 2014
C 2013
D 2012

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Development outcome (A) (B) (C) (D)

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Uncovering the Science

behind a unique Enamel Protection formulation

As patients can miss the early signs of erosive tooth wear, the need to protect their precious enamel can easily be overlooked. This problem calls for an expert solution.

That is why GSK scientists developed Pronamel – a patented formulation carefully optimised[1] to deliver **superior fluoride uptake** into acid-softened enamel[†2,3] and **lock in more minerals**[4] for greater strength and resilience.[5,6]

Up to **3X** higher fluoride uptake* vs a non-optimised toothpaste

In vitro cross-sectional DSIMS images of the enamel surface. Adapted from GSK Data on file 161077.

Act early to help safeguard the future of your patients' enamel.

RECOMMEND PRONAMEL
TO HELP STRENGTHEN AND RE-MINERALISE ENAMEL.

No.1 Dentist recommended brand to protect enamel from erosive tooth wear[7]

Contact your local **GSK representative** for more information and/or to order samples.

And why not participate in one of the oral care distance learner modules which can contribute up to **1.5 hours of verifiable CPD** for each module? Visit **www.gsk-dentalprofessionals.co.uk** or view our recent webinar – visit **https://digital.vevent.com/rt/gskpronamel~webinar**

1.5 hours verifiable CPD

*Based on mean fluoride/oxygen ratio measured at a depth of 20 µm. **Colgate Sensitive Enamel Protect. Sourced and tested in 2016.
DSIMS: dynamic secondary ion mass spectrometry; NaF, sodium fluoride; ppm: parts per million. †Compared to tested non-optimised fluoride toothpastes.

References: 1. Layer TM. J Clin Dent 2009; 20(6): 199-202. **2.** GSK Data on File 144803. **3.** Newby CS et al. J Clin Dent 2006; 17(Spec iss): 94-99. **4.** GSK Data on file 161181. **5.** Zero DT et al. J Clin Dent 2006; 17(4): 112-116. **6.** Barlow AP et al. J Clin Dent 2009; 20(6): 192-198. **7.** GSK Data on File. MMR Research, 2016. Survey of 204 Dentists and 200 Hygienists.

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