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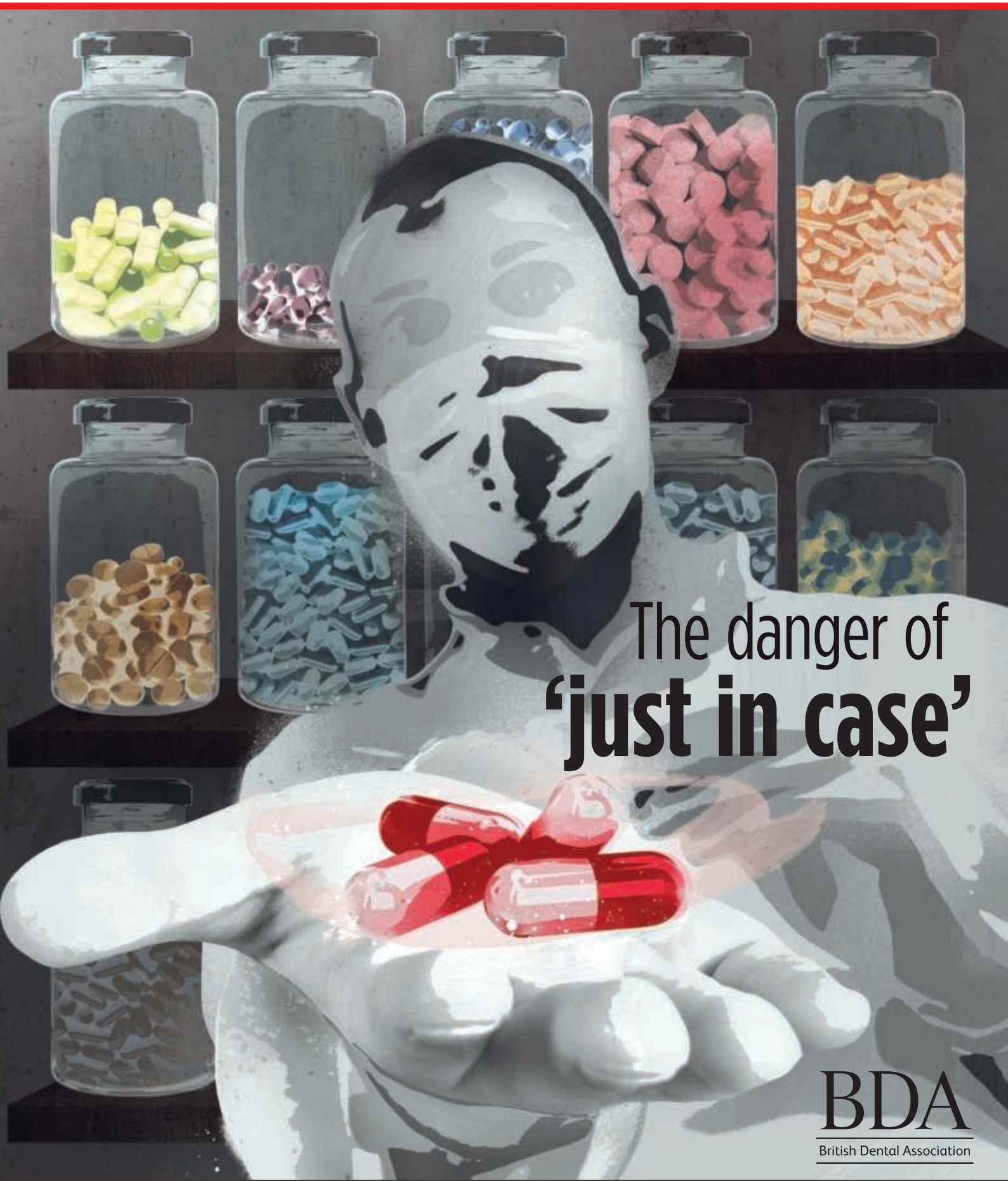

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The cost of fear

Sir, A state of anxiety when visiting the dentist is common and ranges from mild to severe. The most recent Adult Dental Health Survey suggested that the proportion of adults who are moderately anxious about dentistry is 36%, 12% of adults are severely anxious and the remaining 52% have mild anxiety which may be exacerbated when faced with potentially challenging treatments.[1]

The social, psychological and physical impact of severe dental anxiety for the patient has been described in numerous publications[2,3], however despite some studies which have identified that dentists find managing patients who are anxious about treatment stressful, there is little information on how having dentally anxious patients in the practice can impact on the practice economically.[4] Anecdotal evidence would suggest that anxiety is related to late cancelling of appointments, or failure to attend and furthermore that the anxious patient (moderately or severe) can take more clinician time for a similar operative procedure.

In an effort to provide a preliminary appraisal of the impact of dental anxiety on the productivity of a dental practice we devised a model of activity, based on the following assumptions: A dental practice of 3 dentists, with a total of 6,000 patients, working 260 days per year (minus 35 days of annual leave) performing an average of 2.5 UDAs per appointment at a UDA value of £25. It is assumed that patients without dental anxiety visit the dentist between once or twice a year, as recommended by NICE.[5] However, for patients with dental anxiety this frequency of booking will be considerably less.[6,7] The model assumes that patients with low anxiety go, on average 1.5 times a year. This reflects the fact that some patients will have annual check-ups and others will have 6 monthly check-ups patients with medium dental anxiety go once every 2 years and high dentally anxious patients go to the dentist just once every 3 years.

The table below outlines the projected turnover for a practice of three dentists, working under the above assumptions.

In a perfect world with no productivity loss due to anxiety we estimated that the annual practice turnover would be in the region of £545,625. However, we estimated that with increasing anxiety failure to attends would increase and there would be a lower completion rate of treatments. While it is difficult to ascertain the effect of anxiety we estimate that moderate dental anxiety effects productivity by approximately 20%, whereas severe anxiety would impact on treatment completion by about 50% (that is treatment would take in the region of twice as many appointments). On this basis it is estimated that turnover would be reduced to £285,905 (52.4% of the theoretical ideal).

It is highly unlikely that any practice population would comprise individuals with no anxiety at all, so the focus should be on the benefits of effective and proportionate management.[8] Again we modelled the likely impact of good anxiety management (in particular interventions which require little direct clinician time, such as creating supportive environments and directing patients to on-line resources to support coping). For example, simply by recognising a patient's anxiety through asking them to perform an assessment and providing space for emotional discussion reduced dental anxiety by on average 4 points.[9] The effect of such interventions would be to reduce the proportion of patients falling into the moderate and high levels of dental anxiety, whilst increasing the proportion who fall into the low anxiety group thus allowing more work to be undertaken. Through employing good management techniques we estimate that turnover would be £383,133 (an increase of 34%).

Practice Characteristics			
Patient Anxiety Level	**No anxiety**	**Well managed**	**UK average**
No Anxiety	545,625	272,813	174,600
Low Anxiety	0	102,000	71,400
Medium Anxiety	0	6,000	34,800
High Anxiety	0	2,320	5,105
Total	**545,625**	**383,133**	**285,905**

More information is needed on the impact of the patient's anxiety on the productivity of dental practices, and how good dental anxiety management can mitigate such impact. However, our preliminary exploration of this suggests that good anxiety management can not only benefit the health of the patients and reduce the stress faced by the dental team but may also be good for the financial health of the practice.

J T Newton, A McDougall, W Mansell
Foundation for the Effective Management of Dental Anxiety.

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Recognition from NSPCC for leading child safeguard expert

In recognition of her outstanding contribution in this area, Jenny Harris has been awarded Honorary Membership of the Council of the NSPCC.

Taken into account was her commitment to child safeguarding and 11 years membership of the charity's Health Liaison Committee on which she has represented the British Society of Paediatric Dentistry (BSPD).

For 15 years, Jenny Harris has worked to raise awareness of safeguarding issues in the dental world and beyond. The project lead for the landmark document, Child Protection and the Dental Team, she has been wholly committed to ensuring that dental neglect is recognised as a potential marker for child maltreatment.

Speaking after the presentation of the award, Jenny described her role with the NSPCC as a privilege, adding: 'It's been fascinating to work with an organisation so committed to listening to children's voices and improving their lives. What I have learned from working with the NSPCC has been channelled back through BSPD and shared more widely with the dental profession.'

Jenny, a Consultant in Paediatric Dentistry in Sheffield, works both in the Community Dental Service and at the Charles Clifford Hospital, and, in addition to her representation with NSPCC, is also Membership Secretary for the BSPD.

Liz Roebuck, BSPD President, said: 'This recognition is hugely deserved. Jenny's work has helped build awareness both within the dental profession and beyond, stimulating cross-profession collaboration. Through it, some of the most vulnerable in our society have been protected and we hope that on behalf of them, and BSPD, Jenny will continue to champion work in this area.' ◆

Pre-filled adrenaline syringes in dental practices – an update

The Chief Dental Officer for England has sent a letter to dentists in response to the disruption in the supply of EpiPen and EpiPen Junior adrenaline auto-injectors. Practices are requested to re-stock with ampoules, needles and syringes when renewing the adrenaline in their anaphylaxis kits.

In October's *BDJ In Practice*, the advice article titled 'Medical Emergencies…are you prepared' included recommendations for prefilled adrenaline syringe use. This was the case prior to the below advice issued by the CDO:

'You will be aware of the recent DHSC Supply Disruption Alert on EpiPen and EpiPen Junior adrenaline auto-injectors (AAIs) that advises conserving supplies for patients who truly need them. Some healthcare professionals, including dental practitioners, may be holding EpiPens or other AAIs, in preference to adrenaline ampoules, to treat anaphylactic reactions; this should not be necessary.

All healthcare professionals providing services where anaphylaxis treatment may be required should have the competency to draw up and administer adrenaline from ampoules with a normal syringe and needle.

Due to the shortage, we ask that when you renew the adrenaline in your anaphylaxis kits, you alert all your staff to please stock ampoules (ensuring you also include dosing charts, needles and syringes) and not AAIs. This will reduce the reliance on AAIs and therefore preserve essential EpiPen stocks for patients, parents, carers, teachers, etc. who, as lay persons, cannot be expected to administer adrenaline via a needle and syringe.

The Green Book and Resus Council guidance provides additional advice to healthcare professionals on the use of adrenaline in response to anaphylaxis.

Supplies of adrenaline ampoules are currently available and there is an expectation that dental practitioners should use these in preference to the EpiPen or similar devices.

All enquiries relating to this issue should be sent to the DH Supply Resilience Team at supplyresiliencemd@dh.gsi.gov.uk.

We are working to resolve the EpiPen® and EpiPen Junior® shortage as fast as possible. Thank you in advance for all your help.'

The BDA advises that practices should follow the advice given by the CDO on this matter until the shortage issue is resolved. ◆

Time to take down barriers pushing dental patients to GPs

The BDA has called on government to urgently take down the barriers facing patients with dental problems, as new research reveals the struggles they face with cost and access.

Based on interviews with GP attenders, the study, published in the *British Journal of General Practice*, found issues around greater accessibility of GP services, previous experiences of dental care, including dental anxiety, and willingness and ability to pay for dental care.

Patients with urgent dental problems (including toothache and abscesses) typically require some form of operative intervention, which GPs are neither trained nor equipped to provide. These patients are usually referred on to a dentist. The study reports many respondents were simply unaware of the existence of emergency dental services.

The BDA estimate that the 380,000 GP consultations referenced in the study cost the NHS £20.8 million. Previous research has estimated 57% of all patients with dental problems are provided with antibiotics - which are not a cure for dental pain.

BOOK REVIEW

50 top tools for employee wellbeing

Debbie Mitchell
Kogan Page, 2018
ISBN: 978-0-7494-8218-3
£29.99

In a nutshell

Subtitled 'a complete toolkit for developing happy, healthy, productive and engaged employees' this two-hundred-and-fifty-page paperback might be misconstrued as another trendy bandwagon-jumping exercise. However, as author Debbie Mitchell contends, there is a convincing case for the tangible benefits of ensuring that employees are well cared for, not just emotionally or psychologically but also materially and remuneratively. Also, she emphasises that despite money being tight in almost all businesses, many of the top tips that she advocates are low or no cost items. Over its 250 pages, Mitchell divides her book into six discrete parts covering leadership and advocacy, careers, physical and mental wellbeing, social and community interests, financial aspects and finally, a short appendix of supporting information.

Who is it ideal for?

The notion of wellbeing at work may seem to be idealistic or utopian at best, but this simply is not the case. All employers should consider the catch-all concept of wellbeing as one that will bring benefits not just to the individuals working within the company but to the company itself. The book is ideal for forward-thinking managers and Human Resources personnel alike. Mitchell confidently asserts 'The approach that leaders take to wellbeing in organisations can be a wellbeing factor in itself' and, by way of explanation, she expands on this thus 'If leaders demonstrate an interest, commitment and active involvement in activities or interventions that promote wellbeing, employees will respond positively.

Why you should read it

Wellbeing covers a wide range of benefits to the company, some extrinsic, some intrinsic but all, ultimately, beneficial. From the most tangible benefits encompassing financial elements (in addition to salary) such as gym membership or medical insurance schemes to flexible working arrangements or addressing the physical environment of the workplace with an improved and relaxing staff room. Equally important is the mental welfare of staff; seeking to avoid workplace stress is a key element of wellbeing and whilst being able to notice tell-tale signs of stress is important there must also be a willingness to act on it when suspicions are aroused, perhaps by involving specialist support. All these measures will, ultimately, contribute to a reduction in staff turnover, absenteeism and lateness and conversely, will engender loyalty. This well-written, clear and concise guide will act as a change-catalyst for those willing to take wellbeing seriously. ◆

Nearly 1 in 5 patients have delayed treatment for reasons of cost according to official surveys. NHS Charges have increased by over 23% in the last five years, while the Government's direct spend per head on NHS dentistry has fallen £4.95, from £40.95 to £36.

Dentist leaders had recently warned that low income patients are turning away from NHS dentistry, with official figures revealing a fall of two million treatments delivered to patients exempt from NHS charges since 2013/14 – a fall of 23% in 4 years – in the face of an increasing aggressive campaign on 'misclaiming' free dentistry. Access problems in NHS dentistry are becoming everyday across England, with patients in the South West facing up to 80 mile round trips to access services.

The BDA has repeatedly called on the Chief Dental Officer and NHS England to commission more in-hours urgent care slots to relieve pressure from dental patients on both GP and Accident and Emergency services, and to give NHS 111 staff a clear sense of which dental practices have capacity.

Earlier studies from Newcastle University have estimated that 135,000 dental patients attend A&E per year at an annual cost of nearly £18 million. ◆

Are you ready to test your antimicrobial prescribing knowledge?

The British Association of Oral Surgeons (BAOS) has launched a new Antimicrobial Stewardship e-Learning resource for oral health professionals to test their knowledge of antibiotic prescribing.

Free to complete, it consists of three modules of clinical scenario-based quizzes, each of which provides an e-certificate of one hour's verified CPD upon successful completion. Feedback is provided along the way, with the aim that by the end of the modules, participants will be able to demonstrate application of the principles of sound antimicrobial stewardship to the clinical scenarios.

The modules were developed by Tara Renton, Professor in Oral Surgery at King's College London, Greg Gerrard, Council Member of the BAOS, Dr Noha Seoudi, a Specialist in Clinical Oral Microbiology representing the Association of Clinical Oral Microbiologists (ACOM), and Dr Nick Palmer, Editor and co-author of Antimicrobial Prescribing for General Dental Practitioners.

Since 2015, healthcare providers in the UK have had a statutory duty to reduce the risk of antimicrobial resistance by ensuring appropriate use of antibiotics. Whilst the aim of the modules is to promote responsible use of antibiotics in oral surgery, the educational content is of relevance to all dental prescribers, including those who place dental implants, undertake minor oral surgery or practise in special interest areas, and has been endorsed by the Faculty of General Dental Practice (UK) and ACOM.

Speaking on behalf of the development team, Professor Renton said: 'Every year, 25,000 people across Europe, and 700,000 worldwide, die from antibiotic-resistant infections. Dentists issue 7% of all antibiotic prescriptions in the NHS, and the new modules can help both primary and secondary care dentists play a vital role in keeping antibiotics working.'

To access the e-learning resource visit www.baos.org.uk/elearning/ ◆

BOOK REVIEW

Great at work

Morten T. Hansen
Simon & Schuster, 2018
ISBN: 978-1-4711-4907-8
£14.99

In a nutshell

Morten T. Hansen is Professor of Management at the University of California, Berkeley. He's also the author of three best-selling business books. He obtained a PhD from Stanford Business School, where he was a Fulbright scholar and is ranked as one of the world's most influential management thinkers by Thinkers50 and was also a manager at the Boston Consulting Group, where he advised corporate clients worldwide. *Great at work* isn't reliant on arid academic studies but was the result of a huge survey undertaken by Hansen on individual performance at work.

Inspired by his puzzlement that a previous work colleague had done a better job than him, by putting in far fewer hours he was really testing the cliché 'work smarter, not harder'. From this survey Hansen conceived his 'seven key practices' on which this book is based and which he regards as complementary to Stephen R Covey's much-vaunted book, 7 habits of highly effective people, but updated to reflect the realities of work today.

Who is it ideal for?

Hansen's clever book is aimed at anyone who needs inspiration in order to achieve better results at work. They will take comfort from these insightful pages, studded with anecdotal evidence of incidence of high achievement where this was previously considered just a hopeless dream. The case of a Detroit High School principal is one such prime example. Faced with perennially large numbers of badly performing students whose exam results were abject failures, he underwent a 'road to Damascus' moment when he observed his son's baseball team improving by watching instructional YouTube videos to help their game. He used this model to persuade his staff to record their lessons so that pupils could watch them outside of the classroom.

This meant they could flip the process, with the classroom at home and the homework at school so that lecturers could assist the students with their problems in lessons. This idea was so successful that it transformed the ailing school's fortunes, making the principal a national hero. But this book, in a lateral thinking sense, offers solutions to problems encountered with an individual's ability to cope with their own work, working with others and achieving a work-life balance.

Why you should read it

In addition to a lengthy bibliography and a thirty-page research appendix, providing a detailed explanation of Hansen's survey, the book is populated by factual vignettes comprising case studies where the protagonists have prevailed against the odds. Interspersed amongst its three hundred pages, Hansen has, in addition to the text, included pertinent diagrammatic examples that illustrate his theories, such as the purpose pyramid, depicting a person's ability to systematically contribute to the team. This is a key element of his chapter entitled P-Squared (Passion and Purpose) in which he contends that a combination of both passion – a key driver – and purpose, the ability to contribute to the business, society and the world, are combined.

Hansen's philosophy is essentially a holistic one, but one that is based on practical examples. His mantra might be paraphrased as quality over quantity and obsessing over the details. This is how his notion of working smarter, not harder, becomes a reality. ◆

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

9 in 10 dentists fear being sued by patients

A survey of over 1,100 dentist members reveals that nine out of ten (89%) are increasingly fearful of being sued by patients. Of those, three quarters (74%) feel that the fear of being sued impacts on the way they practise.

This fear is not without foundation as 43% of the public believe there are now more marketing campaigns by 'No Win No fee' firms compared to five years ago, according to a YouGov survey of 2,000 people.

The survey by Dental Protection found that three quarters (74%) of dentists feel that the fear of being sued is affecting the services they believe they are able to offer, while 64% of respondents feel that the fear of being sued has resulted in them making more referrals.

Nearly all respondents (98%) believe that we live in an increasingly litigious society and 79% of them are concerned about the impact this is having on their welfare and the way they practise, with 77% of respondents admitting that the fear of being sued has caused them stress or anxiety.

Raj Rattan, Dental Director at Dental Protection said: 'It is worrying that three out of four full time general dental practitioners fear being sued by patients and understandably this will undoubtedly impact on the way they practise and add to already high stress levels.

'Without proper consent and comprehensive, well organised records, a dentist will be severely disadvantaged in defending any allegations that may surface at a later date. Inadequate clinical records will make the case less defensible and often compromise the final outcome.

'We always encourage dentists to explain the costs, risks and benefits of all the treatment options and ensure that the patient has a clear understanding of the planned procedure so that patient expectations can be met. Where a patient expresses dissatisfaction about any aspect of their care, dentists should take this as an opportunity to resolve the issue promptly to the patient's satisfaction.' ◆

The danger of 'just in case'

By David Westgarth,
Editor, *BDJ In Practice*

If I had £1 for every time I heard the phrase 'I'll set a second alarm, just in case I sleep through the first one' or 'why don't you bring a jacket, just in case it gets cold later', I'd have many, many pound coins. One theory behind the idea of 'just in case' is to protect against something bad that could happen. It is the filter gamblers lack, and it involves the use of judgement of a situation.

The very nature of a judgement call is that the outcome will vary according to circumstance. There is no one-size-fits-all approach, and there's a 50% chance your judgement of a situation will be wrong. Sleeping through an alarm, getting a bit chilly in the evening and calling black rather than red may seem trivial, but the threat posed by antimicrobial resistance (AMR) is not.

The warning cannot be louder, nor more serious – antimicrobial resistance is a growing threat to public health worldwide and jeopardises the ability to treat infections such as MRSA and Malaria, not to mention affecting the success rates of major surgery and chemotherapy. A government-commissioned report on the significance of AMR chaired by ex-Goldman Sachs economist and finance minister Lord Jim O'Neill discovered the cost of inaction could be 10 million lives lost through resistance to antibiotics worldwide by 2050.[1] Getting global figures on the problem is difficult but some experts suggest 700,000 are already dying each year – one person a minute. Whichever way you slice it, it's a problem now.

Dental too

According to data from NHS Digital, dentists are responsible for 0.5% of all prescriptions but prescribe 8.3% of all antibiotics in primary care in England.[2] Antibiotic prescriptions make up 63.6% of all prescriptions by dentists, and overall, 3,198,564 prescriptions for antibiotics were written by dentists in 2016. Table 1 highlights the prescribing patterns in England between 2007-2016.

So when did the penny drop that resistance to antibiotics would be a serious issue? Devika Vadher, Clinical Fellow Dental Public Health, suggested it goes back around seven years.

'As part of the Chief Medical Officer's annual report in 2011[3], Dame Sally Davies issued a specific report on antimicrobial resistance and the rise of infections. The report provided 17 recommended areas for action. The CMO made particular reference to 'antimicrobial stewardship' and the need for combined efforts with industry and other countries to tackle AMR. The report was a call for action and prompted a national response including 'The 5-year Antimicrobial Resistance Strategy 2013-18'. From there, people started to take notice and uncover the complexities of the problem we faced.'

Anna Ireland, Consultant in Dental Public Health, told *BDJ In Practice*: 'Globally it is now accepted that AMR is a crisis issue. Increasing resistance to antimicrobials and a lack of new drugs means a greater risk of infections that cannot be treated. This will make routine medical care riskier and result in more deaths.

If the issue of AMR is not addressed then procedures which we currently view as minor could, once again, become life threatening.'

Life threatening. Approaching 10 million lives. Not exactly statements and statistics plucked from thin air. Maybe I'm missing something here, but why do dental professionals still prescribe antibiotics to patients 'just in case', even though they're fully aware of the risks? Wendy Thompson, School of Dentistry, University of Leeds, suggested it's about relatability and accountability.

'There is an issue about personalising the agenda', she said. 'What I hear when I'm lecturing this to dentists is that they understand antibiotic resistance is a problem for society – see also global warming – but they don't relate it specifically to their own patients and practices. Many see reducing prescribing as just putting off the resistance time bomb which is inevitable – they think bacteria will win at some point, so why shouldn't my patient benefit from the best that's on offer now?

Table 1 The five most commonly issued dental prescriptions in England between 2007 and 2016. Numbers in brackets are the % of all dental prescriptions in the same year[2]

	2007	2008	2009	2010	2011	2012	2013	2014	2015	2016
Antibacterial drugs	3,706,014 (81.1)	3,669,862 (79)	3,731,080 (76)	3,850,773 (74.8)	3,935,698 (72.9)	3,924,400 (69.9)	3,805,256 (68.2)	3,696,109 (66.4)	3,437,561 (64.7)	3,198,564 (63.6)
Drugs acting on the oropharynx	475,386 (10.4)	481,149 (10.4)	509,545 (10.4)	506,564 (9.8)	519,116 (9.6)	516,000 (9.2)	492,569 (8.8)	476,706 (8.6)	431,161 (8.1)	377,839 (7.6)
Minerals	154,063 (3.4)	268,284 (5.8)	426,084 (8.7)	546,325 (10.6)	707,684 (13.1)	953,300 (17)	1,075,479 (19.3)	1,197,507 (21.5)	1,263,797 (23.8)	1,274,447 (25.5)
Drugs used in rheumatic diseases & gout	126,122 (2.8)	122,918 (2.6)	136,435 (2.8)	133,455 (2.6)	127,024 (2.4)	115,200 (2.1)	100,576 (1.8)	90,464 (1.6)	75,285 (1.4)	59,920 (1.2)
Analgesics	71,359 (1.6)	69,314 (1.5)	70,132 (1.4)	68,783 (1.3)	67,394 (1.2)	66,400 (1.2)	64,021 (1.1)	61,025 (1.1)	55,053 (1)	47,993 (1)

'What many still don't understand is the direct risk to their patients from anaphylaxis, antibiotic-related colitis and of course the risk of them selecting for resistant bacteria across the body every time they take antibiotics. And in fact, there is no quantification of those risks that I'm aware of, and so until we can characterise that risk for clinicians there will be those who find it hard to be confident in sharing them with patients.'

Like sweets?

The problem with the approach hypothesised by Wendy is the apparent ease at which some practitioners dispense prescriptions. These may or may not contain antibiotics of course, but the danger of handing out prescriptions like a candyman dispensing sweets to children is one that should cause great alarm to anyone within the dental profession.

But what about the profile of the prescriber? Is there such a thing, or are we too focused on pinning responsibility for over-prescribing on an individual or groups of individuals to see the bigger picture?

A team lead by Anna Ireland at Thames Valley scratched the surface of the demographics of a prescriber. In a clinical audit[4], and of the 57 participants that completed two cycles, they discovered that those who had qualified in the UK had the highest proportion of prescriptions which complied with guidelines (56%) compared to those that qualified in the EU (45%) or the rest of the world (45%). Further analysis revealed dentists registered with the GDC from 2010 onward had the highest proportion of appropriate prescriptions (60%) compared with those registered earlier.

Devika – part of the audit project team at Thames Valley – suggested there are a number of reasons for the variation in prescribing habits.

'Depending on their awareness of national FGDP guidelines, dentists may or may not be prescribing in accordance with the most current evidence base', she explained. 'It goes further than that, with a number of nuances and complexities.

'The findings of the audit – albeit from a small sample size and participant group – showed demographic differences play a role in prescribing habits. Dentists who were registered with the GDC earlier and those that qualified outside of the UK had a lower proportion of prescriptions in line with FGDP guidelines at the end of the second audit cycle.

> 'Depending on their awareness of national FGDP guidelines, dentists may or may not be prescribing in accordance with the most current evidence base'

'While understandable caution should be exercised with the results, they raise some interesting questions about how we level the playing field when it comes to training and education on AMR. The NHS is a multi-cultural society in its own right – people from all walks of life work within NHS dentistry who will have had differing patterns of education at university and throughout their early years in the profession.

'As Wendy mentioned earlier, this is both a positive and negative, and we need to ensure every professional knows the current regulations and has the clinical freedom to make decisions within those guidelines.'

Many of the above observations surrounding the interpretation of the audit results carried out by Thames Valley focus on the individual habits and knowledge of dentists. There is little doubt these can be discussed, and opinion dissected, given the individuality of the findings, but there is one area Devika believes is not open to interpretation.

'We absolutely have to look at the possibility dentists may be prescribing due to the pressures of time', she suggested. 'Time pressures – particularly for those in general practice – restrict the ability to either reach a definite diagnosis or provide the clinical treatment necessary, such as incision and drainage. Yes, the type and dosage of antibiotics prescribed will inevitably be different, but the appropriateness of the prescription in light of the diagnosis and clinical need in this scenario is one we must be more aware of as a risk.'

Guidelines or guidance?

Red tape, regulation and bureaucracy are phrases used over and over again when it comes to dentistry and allowing freedom of clinical decision-making. But is this one area where over-regulation works in both patient and practitioner's best interests?

'Each individual patient is a different case, and rarely is any case a 'text-book' scenario', Devika added. 'Medical professionals including dentists, assess all necessary factors when providing personalised patient care. Guidelines are in place to support and provide the professional with the evidence base for the treatment choices they are or are not considering pursuing. An informed treatment choice based on current best practice and evidence which takes into account individual patient factors would be considered as delivering good patient care.'

That guidance isn't confined to following a text-book – or not, in this case. At the BDA's Scottish Scientific Conference, Dr Alexander Crighton Consultant in Oral Medicine, NHS Greater Glasgow and Clyde and Honorary

Senior Lecturer in Medicine in Relation to Dentistry, posed the question 'is over-the-counter advice a form of prescribing?'

One could argue that prescribing relates to prescription-only medicines. Being prescriptive and offering tailored advice may not be, by definition, prescribing, but if you recommend ibuprofen and paracetamol without writing that down, are you still prescribing it?

Javeriah Mahmood, Clinical Fellow Dental Public Health, added: 'Yes, I think it is a form of prescribing. 'The practitioner providing the advice still needs to do exactly what they would do if it were a written prescription. You would still need to consider their medical history, the chances of the condition flaring up, the potential side effects to the patient. Simply because the final prescription isn't in writing – the patient could buy ibuprofen or paracetamol cheaper at the pharmacy or supermarket rather than through a prescription, for example – it doesn't change the process.'

Encouraging change

It's widely acknowledged that bringing about attitude change in society is one of life's great tasks.

So how do we encourage change within the profession?

Wendy explained: 'Successful behaviour change needs us to understand the factors influencing antibiotic prescribing in the first place, and then to address those factors. We'll know we've achieved change when dentists are as confident declining antibiotics as they are declining to extract healthy teeth.

'My fear is that this will only happen once the ambulance-chasing companies realises the potential market. All it will take is for one of them to turn around and say 'my client suffered harm and a prolonged hospital stay/death as a direct result of you giving an antibiotic when none was indicated.' And if the patient dies – as happened with the chlorexidine death in Penrith as few years ago – then it will be a different conversation with the coroner if the drug was being administered to a person presenting with a condition for which it wasn't even indicated. It is a harsh reality and a sorry state of affairs, but until practitioners realise the potential severity of their prescribing habits, nothing will change.'

But will that really change the way a dentist will prescribe? Does it have to get that severe for change to happen?

'The bedrock of our practice is what we learned as undergrads, and for those dentists who qualified before FGDP first published its guidelines in 2000, there will clearly have been a more variable base of learning experienced by dentists,' Wendy went on to say. 'One commonly quoted 'rule of thumb' from the older dentists – which may be characterised as 'traditional clinical teaching' – is the 3Ps of urgent dental care. When I'm lecturing the older dentists usually snigger – when I ask the audience if anyone has heard of the acronym.

> 'Successful behaviour change needs us to understand the factors influencing antibiotic prescribing in the first place, and then to address those factors. We'll know we've achieved change when dentists are as confident declining antibiotics as they are declining to extract healthy teeth'

Sometimes one of them will enlighten the rest of the mystified audience.'

Javeriah added: 'Behaviour change in dental professionals is no different to behaviour change in other people. NICE have published guidance on behaviour change and the Alliance for Useful Evidence[5] describe the COM B method which says that there are three requirements for health professionals to put evidence into practice. These are:

1. Capability – they must possess the skills and knowledge to use the evidence
2. Motivation – they must have the desire to use the evidence
3. Opportunity – they must have access to external systems and processes that make evidence work.

'For dentists, this could mean looking into the way the system works and creating a system whereby dentists are encouraged to treat rather than prescribe by providing them with adequate time and remuneration to carry out the necessary treatment. Devika suggested time constraints earlier, so we have to look at the system dentists operate in.

'One of those ways is to look at the support team around the dentist. Extending the scope of prescribers to hygienists and therapists – as the BSDHT and BADN campaigned for – could be a positive thing by improving access to care for the public. However, all prescribers need to adhere to prescribing guidelines and be adequately trained and competent to make prescribing decisions to ensure there isn't an increase in inappropriate prescribing and to safeguard patients and the public.'

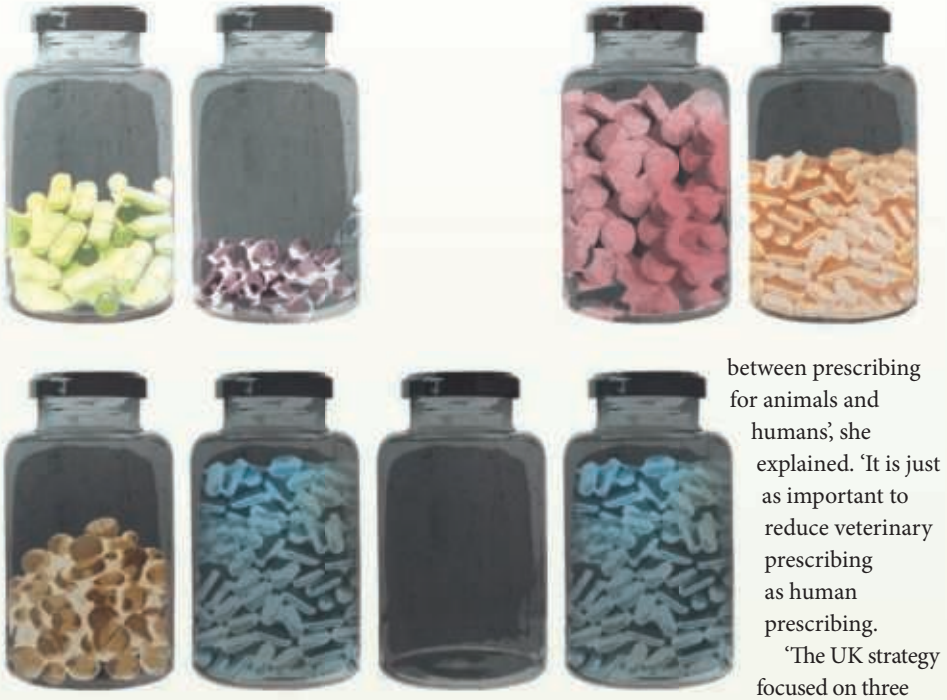
How does dentistry compare with other medical professions?

Given the global and multi-disciplinary responsibility to raise awareness of antibiotic prescribing, it's worth seeing where the profession is now to ascertain how far it needs to go. According to Anna, dentistry stacks up well.

'The dental profession's action on prescribing compares favourably with other professions,' she said. For example, the 2017 ESPAUR report found that between 2012 and 2015 the number of prescriptions by dentists fell by 21%. GPs also had a reduction during this period but it was lower at 13%.

'However, use of penicillin in the GP setting declined between 2012 and 2016 by 11.5% while penicillins prescribed in the dental practices only decreased by 9.9% over the same period.

'Dentists prescribe a significant proportion of all the antibiotics in England. In 2016 dentists in England prescribed 5% of all antibiotics, which is similar to the proportion prescribed for hospital outpatients. In 2017/18 dentists in England prescribed over 2.9 million antimicrobial drugs, which suggests that there is further scope for improvement.



'One difference between dentists and people like general medical practitioners is that dentists have a range of treatment options available to them when someone presents in pain or with an infection. GMPs may have to resort to prescribing because they have little else in the way of treatment options, whereas dentists can perform operative procedures such as incising and draining abscesses. This ability to carry out effective treatment reduces the need for antibiotics and should be the first line treatment.'

Tackling the problem?

The integrated 'UK Five Year Antimicrobial Resistance (AMR) Strategy'[6] published in 2013 was developed in collaboration with the Veterinary Medicines Directorate of the Department for Environment, Food and Rural Affairs, Northern Ireland Executive, Scottish and Welsh governments, and UK Public Health agencies. It also had input from Department for Business Innovation and Skills, the Ministry of Defence and other Government Agencies such as the Food Standards Agency (FSA) and the Medicines and Healthcare products Regulatory Agency (MHRA). According to Anna, it is this combined, integrated approach that will help to make headway in tackling the problem.

'This cross-government and cross-sector working has proved essential to tackle a problem which is cross boundary both in terms of geography, and in terms of the links between prescribing for animals and humans', she explained. 'It is just as important to reduce veterinary prescribing as human prescribing.

'The UK strategy focused on three strategic aims – improve the knowledge and understanding of antimicrobial resistance, conserve and steward the effectiveness of existing treatments and to stimulate the development of new antibiotics, diagnostics and novel therapies.

'I firmly believe the UK has a leading role in stimulating national and international action on this global issue. Public Health England exists to protect and improve the health of the nation and has the system leadership role in AMS in England.'

> 'Antibiotics, though essential in our fight against infectious disease and having contributed to increasing life expectancies over the past 70 years, have now presented with a new challenge, antibiotic resistance, and it is happening right now.'

Sandra White, Public Health England National Lead for Dental Public Health who Chairs the dental subgroup says: 'The English Surveillance Programme for Antimicrobial Use and Resistance (ESPAUR) was established in response to the UK government's five-year antimicrobial resistance (AMR) strategy. The dental subgroup of ESPAUR is led by PHE but only works through the collaboration and actions of a number of partners, all of whom bring different skills and knowledge to the group to bring synergy of action. The group has improved the granularity of reporting of antimicrobial use in dentistry, developed resources for dental practices and patients, coordinated antimicrobial stewardship activity in primary and secondary care, disseminated and worked with Local Professional Networks and worked across government and devolved administrations to co-ordinate activities.

'One of the outputs from the group is the Dental Antimicrobial Stewardship Toolkit[7] which was developed locally in Cheshire and Merseyside and then extended nationally as a result of collaboration between a number of groups, including PHE, BDA, FGDP and NHS England. The toolkit includes patient information, leaflets and posters, and clinical audit for dental practices and links to educational resources and guidelines. Current partnership work includes a secondary care audit within dental hospitals and a pain relief prescribing *aide memoire*.

'Although there is still more to achieve together, the work of the Dental Subgroup of ESPAUR should be celebrated in terms of the collaboration of its partners to address a shared goal.'

A future problem now?

If the future projections of antimicrobial-resistant related deaths are to come to fruition, it won't be the current crop of professionals ebbing away into retirement that will have to deal with patients resistant to antibiotics; it will be those at the raw end of their career – current students and young dentists – left to find a solution. Beth Bradley, 5th year undergraduate at Leeds University and student editor of *BDJ Student*, suggested unless something drastic is done, it won't be a case of if, but when.

'I am extremely concerned I'll encounter patients resistant to antibiotics', she said. 'Antibiotics, though essential in our fight against infectious disease and having contributed to increasing life expectancies over the past 70 years, have now presented with a new challenge, antibiotic resistance, and it is happening right now. The World Health Organisation have stated that antibiotic resistance is no longer a future risk or prediction but is a major, current, worldwide concern. I can say with certainty our generation of dentists will encounter antibiotic resistance.'

Based on the findings of the Thames Valley audit, I asked Beth why she thinks young prescribers have a better record than their older counterparts.

'As a soon-to-be young prescriber, having been taught a guideline-focused curriculum on prescribing and being acutely aware of the developing antimicrobial resistance issue,

I can assume that younger dentists are more likely to adhere to available guidelines for these reasons. However, I do not think this automatically renders younger dentists as 'safe' prescribers. The wealth of knowledge and experience of our older counterparts have cannot be ignored.

'Our older counterparts may face obstacles when conforming to the newly set guidelines, which we as younger graduates now learn as a baseline. These barriers are multifactorial and can be broken down – personal factors, patient factors and education factors.

'Personal barriers may be as simple as a dentist's attitude towards CPD, for example. Some practitioners may be unwilling to change how they have prescribed for many years previously – others may doubt the evidence-base behind new guidelines or disagree with the set advice in the belief previous guidelines were based on more robust data.

'As Devika alluded to, time pressures and workload may also greatly influence prescribing patterns. As younger graduates we have not yet had the time to develop 'bad habits', and it's well-documented how difficult it is to change behaviour. Studies in England and Wales found that 1 in 10 antibiotics dispensed in primary care were prescribed by dental professionals.[8] This indicates that the dental profession *are* implicated in the development of antimicrobial resistance.

'It isn't just on the practitioner though. Patient expectations can play a big part in influencing prescribing. I have found some patients when in pain have had countless courses of antibiotics before – whether justifiably prescribed or not – so when tooth ache presents they assume the only solution is a course of antibiotics.

'This attitude may pressurise a dentist into conforming to the patient's beliefs. Then again, a study into the knowledge of GDPs in England and Scotland found that the majority of them could correctly identify clinical symptoms were antibiotics were required, suggesting that it is other barriers which influence their prescribing the most.[9]

'This is where, as a younger generation dentist, our teaching and exam processes which are riddled with OSCEs, scenario-based exams and experiences of dealing with difficult patients may help us become safer prescribers by learning how to cope with patient pressures appropriately.'

But just how comprehensive is the undergraduate curriculum? Is it preparing good, all-round dentists ready to hit the ground running, or is it producing highly-skilled clinicians with little else?

'Personally, as an undergraduate, I feel we rely heavily on senior colleagues for prescription advice and delivery', Beth said. 'Although our teaching is heavily guideline based and we are examined on the theory of antibiotics, I would not feel entirely confident with my own judgement of a clinical situation to prescribe a course of antibiotics. I can identify situations where antibiotics may be indicated, but would rely on a second opinion to validate my own judgement.'

> 'Prevention is better than cure and partnership working between patients and their dental professionals can help to prevent disease and reduce the need for antimicrobials. Care to reduce sugar intake and regular brushing with fluoride toothpaste can help prevent the infections which may lead to dental prescribing to begin with.'

You, me or us?

That's not to say the problem is confined to the healthcare world and ruling governments both at home and abroad. The answer also lies within the home –and this includes patients and the public. Anna added: 'Health professionals can feel pressured by patients into prescribing antimicrobials when they are not clinically necessary and part of the solution is to raise public awareness of AMR so that the demand for antimicrobials is reduced.

'Prevention is better than cure and partnership working between patients and their dental professionals can help to prevent disease and reduce the need for antimicrobials. Care to reduce sugar intake and regular brushing with fluoride toothpaste can help prevent the infections which may lead to dental prescribing to begin with.

'Dentists and their friends and families are also, at times,

patients so if they find themselves in this position they can contribute to reducing AMR by not asking for antimicrobials or by signing up to be an antibiotic guardian and fulfilling their pledge.'

Rather like Wendy's earlier suggestion about global warming, there will always be those resistant to ideas, to change. One large country seems to think climate change isn't happening, a stance set against a backdrop of every scientist worth their salt saying it is. And like antibiotic prescribing, there will always be those who cannot see past their own beliefs, regardless of the science and the consequences. It is not a judgement call, but the longer it persists, the longer we gamble with lives. ◆

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Mentors and tormentors

Asif Syed on how you can advance more by listening less

Asif Syed

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

A piece of chalk whizzed past my ear and shattered on the brick wall behind. Then Mr Atkins boomed across the chemistry lab 'ASIF...SHUT UP!' I remember the hot sting of embarrassment as twenty cherubic faces peered back with unmistakable schadenfreude: Mr Atkins was my favourite teacher and today he was teaching me a valuable lesson in the importance of being fair.

I'm sure all of us can identify our 'Mr Atkins' as that one unforgettable teacher who could effortlessly unlock potential and make success seem inevitable. However, success is smooth in an academic environment where one year prepares you neatly for the next but a little more bewildering when dentists enter the workplace and discover that undergraduate teaching does not provide all the practical skills necessary to flourish as a clinician, associate or principal.

For dentists, it seems when learning stops the education really begins as we tend to arrive at each phase of our careers as complete novices. Understandably, this can leave dentists stranded with strategies that have little chance of success. To illustrate this point let's consider some of the more common examples:

- The young dentist who signs an NHS contract based on intervention then attempts to achieve targets by earnestly practicing preventive and minimally invasive dentistry. The conflict between agreement and actions is likely to end in disappointment.
- The associate who works for seven years in a high needs demographic then risks their life savings to buy a fully private practice. Their deep experience in efficiency is diametrically opposed to the soft skills in service required to run a private facility.
- The principal whose main problem is staff compliance but invests all his funds in marketing. The patients he has spent his

money to acquire are about to meet the staff he believes are ineffectual.

Strategies that appear sensible in the present can later prove unsound in hindsight. Intuitively, ambitious dentists edge closer to the conclusion that knowledge should be acquired beforehand. But, the interesting thing is that dentists have never had easier access to knowledge. In fact, many dentists I meet are already considering specialisation, multiple practice ownership, an MSc in Implants, or a one-year restorative programme.

So, the issue for dentists is not the availability of knowledge but making sense of the flood of undifferentiated information to which they are now exposed.

In 2004, psychologist Barry Schwartz labelled this modern phenomenon 'The Paradox of Choice' in which he explains how the individual overloaded with options may suffer from lack of clarity leading to procrastination and poor choice selection. For dentists, there is not only the challenge of filtering information but also addressing the following tormentors:

- **Is this right for me?** It is tempting to follow the safety of the crowd but there is a difference between what is right for you, and what is right *per se*, as we are all on a profoundly different career journeys.
- **Does this work?** In the dental industry, success stories are always more visible than failures, meaning you may systematically overestimate your chances of winning if you don't conduct sufficient research.
- **What's your agenda?** It is natural for those pedalling a particular viewpoint to be convinced that their approach will solve all your problems, but this is only likely to be part of a wider truth.

These tormentors make it difficult to navigate the muddle. Crafting the correct career strategy is a new skill required of the modern dentist but I do believe the process can be simplified.

The antidote comes from the art world in a concept called 'curation'. The curator for the Tate Modern does not stuff the gallery with every art work in her archive but instead chooses a few pieces built around a considered theme to create an engaging and uplifting experience for the visitor.

In the same vein, your career choices should be carefully selected with the assistance of a curator. This curator is called your mentor - someone who can help separate the meaningful from the menial.

Mentors Framework

Mentor type / Level of ambition	Peer group	Sounding boards	Teachers	Role models	Classic mentors
Get through today					
Be competent					
Be good					
Best I can be					
Best in field					

Must have	Nice to have	Not needed

The idea of a mentor may sound elusive but we are fascinated by them in popular culture; Professor Dumbledore mentored Harry Potter and Yoda mentored Luke Skywalker. In non-fiction, Socrates mentored Plato, Plato mentored Aristotle, Aristotle mentored Alexander the Great who went on to conquer most of the known world. These examples repeat in the dental industry where it is heartening how often the successful pay tribute to a mentor. Indeed, many of us may have felt the warm glow of contribution when imparting wise counsel to an eager dental student at a social gathering.

For the purposes of this article I have simplified the term mentor to 'a more experienced person who you can trust to guide' so that it might include the following types:

- **Mentor Classic**: a significantly experienced person who is happy to guide for only the payment of seeing you succeed which in turn reflects well on them.
- **Role Model**: a person you admire for what they have achieved personally, how they have achieved this, and what they stand for but, you may never meet this person.
- **Teacher**: A person with vast knowledge, in a certain field, who's thinking seems to work for you. You are likely to pay for this expertise.
- **Sounding Board:** A person who is a little further along than you, who's opinion you trust, and can to call upon with some frequency.
- **Peer Group**: a group of people with whom you can share your journey and you can encourage to succeed on their own journey.

I have placed the five mentor types in a framework above so you can match the number and type of mentors you might require against your personal level of ambition.

It is my proposition that you will make smoother progress towards your personal definition of success by actively shaping your sphere of influence with mentors you trust, respect and like.

Although the concept sounds simple I see many dentists struggle to get started so I have outlined five practical tips to get you going:

- Stay away from moaners: If moaning worked we'd all be millionaires. You would be doing everyone a favour by discouraging this in both yourself and your peer group.
- Stop negatively comparing: Some will do better, some will do worse. Often what we envy in those who get ahead is not always their actual success but their personal clarity on the definition of success. Selecting a role model can help you with this.
- Respect people at the top of their game. They are busy staying at the top of their game so are more likely to be your teachers, not classic mentors or sounding boards.
- Thank Anti Heroes: If you passionately dislike a person or school of thought then resist the temptation to become annoyed and instead learn the valuable lesson of what to avoid. Aversion can be an even more powerful motivator than success.
- Keep it casual: In successful mentoring relationships, the mentor is almost never labelled a mentor and, is surprised to have been considered anything other than a friend.

I once attended a 'build your own pizza' party and watched my friends argue and laugh over which toppings made the best combination. I must confess, I am hoping you will apply this same pleasant pizza process to building your own influences. When faced with more than you can digest, don't be afraid to go on the (Mr) Atkins diet. ◆

Lessons from history:

Why you should be concerned about the GP indemnity crisis

Fenella Barnes on what the UK can learn from their Australian counterparts…

Fenella Barnes

Ms Barnes has worked within the medical and dental indemnity industry for 14 years for both insurance and mutual providers in Australia and the UK. She has held various positions within Marketing and Communications, Underwriting, Product Development and Operational Management

Crisis: defined not only as a time of intense difficulty or danger, but also as the turning point of a disease when an important change takes place, indicating either recovery or death.

It therefore seems particularly apt that this word has been used recently to describe the state of GP indemnity in the UK – and the Government has responded accordingly (details to be confirmed, of course). While the 'crisis' stamp has thus far been limited to GPs, the question must be asked: could there be a wider problem?

The blunder down under

In the early 2000s Australia experienced a significant medical indemnity crisis of their own. Historically, Australia's medical indemnity industry mirrored the model currently operating within the UK, in that it consisted of a series of member owned mutual Medical Defence Organisations (MDOs) with an occasional smattering of commercial providers coming in and out of the market. The chain of events that led to the crisis commenced over a decade prior in the 1980s, as the first increases in the frequency and severity of medical negligence litigation began to materialise. By the mid 1990s this growth in litigation had escalated, and the number of players operating within the relatively limited market had increased to include six Australian MDOs and two UK-based indemnifiers (MPS and MDU). At around the same time, the Review of Professional Indemnity Arrangements for Health Care Professionals had identified an emergent funding issue with respect to incurred but not reported (IBNR) liabilities. The UK providers largely withdrew from the market in the late 1990s, with MDU passing their members on to the largest Australian MDO, United Medical Protection (UMP), and MPS making bespoke arrangements on a state-by-state basis for its medical members. Significantly MPS chose to remain in Australia to continue serving its dental members, for whom it was the dominant market leader, and whose claims experience had seen nothing like the deterioration experienced amongst medical members.

By the year 2000 the majority of the Australian MDOs (including UMP) had made calls on their members for an additional year's subscription to try and address their funding shortfalls, then in 2001 a series of seemingly unrelated events combined to place significant further pressure on the financial viability of the MDOs. First

was the collapse of HIH Insurance Group – Australia's second largest insurer at the time. Unfortunately for many of the defence organisations, HIH featured heavily on their reinsurance programmes resulting in a further erosion in funding position as future liabilities that would have fallen to HIH were bounced back to the MDOs. In addition, the Medical Indemnity Policy Review Panel 2005 identified the spike in medical negligence claims preceding the introduction of the Health Care Liability Act 2001 in New South Wales (where the vast majority of doctors were indemnified by UMP) and the downturn in the financial market following the September 11 attacks as having a significant detrimental impact upon the financial viability of UMP. Ultimately, the ramifications of these events led to UMP entering provisional liquidation in 2002.

The size of UMP's membership and liabilities and the existing financial pressure on the other MDOs within the market made straight forward rationalisation impossible. Government intervention followed involving a bailout of UMP, tort reform, the introduction of a number of support schemes and the requirement for providers of medical indemnity to comply with new standards in relation to both their product offering and the nature and oversight of their operations.

Caught in the net

It would be reasonable to assume that as dentists had nothing to do with the circumstances of the indemnity crisis in Australia they were not impacted by the government interventions referred to above. Unfortunately, as is often the case, dentists and dental care professionals in Australia were lumped in with their medical practitioner colleagues when the new standards were introduced. At least on this occasion they were not alone, as the indemnity needs of all registered healthcare professionals were subject to the new legislation.

While the standards were applied universally, the right to access the associated support schemes were not so collectively applied. While a number of them had little relevance to dentists and dental care professionals, such as those relating to large and exceptionally large value claims, others, such as the Run-off Cover Scheme, were of significant relevance and the exclusion of dental practitioners was a considerable disappointment.

Déjà vu?

So what lessons can be learned? That sort of thing could never happen in the UK… right? The parallels between the current medical indemnity environment in the UK and the pre-crisis environment in Australia provide some slightly uncomfortable food for thought: the costly medical negligence litigation framework in desperate need of reform; the largely unregulated medical indemnity industry that is not subject to the same prudential obligations and restraints as the general insurance market; the increased competition as MDOs move outside of their traditional markets into the 'territories' of others (with the income from the rapid membership growth of some providers flattering their financial accounts, while the growing IBNR liabilities from those new members remains conveniently out of sight); the significant increases in indemnity subscriptions leading to an expansion in the provision of state indemnity thereby robbing the MDOs of a crucial income stream.

> 'So what lessons can be learned? That sort of thing could never happen in the UK… right?'

Of course, these were not the only factors that led to the crisis in Australia, but most of it can be whittled down in to three main themes – the litigation framework, funding of indemnity organisations, and external factors.

Calls for tort law reform are gathering pace within the UK, with both the indemnity organisations and the NHS groaning under the weight of unsustainable claims costs. While the Legal Aid, Sentencing and Punishment of Offenders Act 2012 appears to have had a positive impact upon dental claims frequency within the UK, the NHS and MDOs have expressed with increasing alarm the need for further modification of the existing litigation structure.

When considering the funding of indemnity organisations (particularly in relation to IBNR liabilities) and what that says about the health of the UK indemnity industry at present, the problem is that most appear to be tight lipped on the matter. Only one of the MDOs publishes an estimated value of their IBNR liabilities in their Annual Report (and should be applauded for doing so) – although this is quickly followed by a caveat that it is not included as a reported balance sheet liability as it is subject to the organisation exercising its discretion to assist… comforting stuff. As far as the other two main players go, who knows? One thing is for sure though – the vast price differentials in dental indemnity costs between the organisations would suggest that someone is getting it wrong, and here the echoes of the Australian experience resonate most strongly.

Which finally brings us to external factors. One could argue that no one could have predicted the series of external events that contributed to the collapse of the Australian medical indemnity industry over 15 years ago, so there is no way to plan for them – and that is true. However, surely this is where financial viability comes to the fore. Would the impact of those external events have been so significant if the Australian medical indemnity industry were fully funded at the time? Even if one of the MDOs had succumbed to the wounds caused by such events, could the others have taken on the impacted members if they had been in a more stable financial position? There is a reason that the Australian Prudential Regulation Authority (APRA) now requires medical indemnity insurers operating in Australia to hold 150% of the minimum capital requirement – because while unexpected events happen, practitioners need to trust that they will remain protected and their patients will not be disadvantaged or left uncompensated.

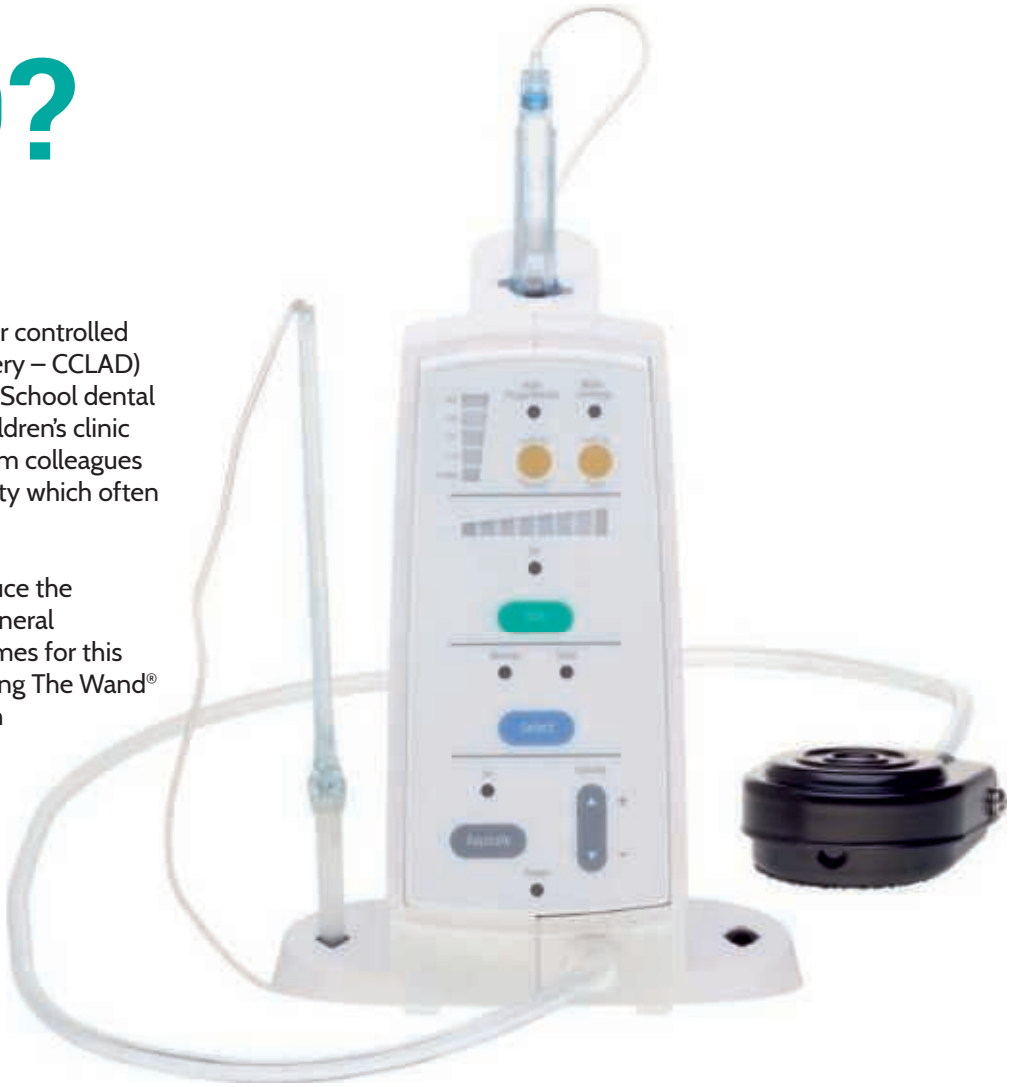
The prescription

In the years following the introduction of the aforementioned reforms, schemes and regulation in Australia, a much-needed balancing of premiums occurred as the funding requirements set by APRA were realised. While the durability of the existing government support schemes is a recurrent topic for discussion, the industry is enviably well funded – because it has to be. Most importantly, it has regained the trust of both practitioners and the public.

If history were to repeat itself (and we all sincerely hope it does not), would the UK recognise that dentists have really played no part in creating the problems, but simply happen to be minority members of the same MDOs? In recognition of that, would the UK come up with a solution that doesn't penalise dentists as happened in Australia? And what can we learn from the Ghost of Crises Past to mitigate the risk of a similar occurrence? Legal reform. Closer oversight of the MDOs, or even formal regulation with all that that entails. And above all transparency, particularly surrounding funding. Only transparency will ensure enduring trust.

We may not yet be in crisis here in the UK, but we may be approaching a turning point where substantial change needs to take place in order for a crisis to be averted. Only time will tell. ◆

PLEASE WILL YOU USE THE MAGIC WAND?



We began using The Wand® (computer controlled local anaesthetic administration delivery – CCLAD) in NHS Highland in 2005. In the High School dental unit, a Public Dental Service (PDS) children's clinic in Inverness, we accepted referrals from colleagues for children with dental fear and anxiety which often related to fear of injections.

One of our aims as a team was to reduce the reliance on inhalation sedation and general anaesthesia and provide better outcomes for this group of patients. Initial evaluation using The Wand® was very promising indeed, with much less time spent on non-pharmacological techniques and acclimatisation with a high rate of acceptance for repeat procedures. As one young patient remarked, "It's great now you don't need to get the jag".

Injection of local anaesthesia for an anxious child has been cited as one of the most stressful procedures to carry out in paediatric dentistry. According to Davidovich et al (2015) this is true for general practitioners and specialists alike, regardless of age, gender or years of professional experience.

Dental fear and anxiety is common in children and adolescents. The strongest fears are often associated with local anaesthetic injections. Children with higher levels of dental fear and anxiety may experience a higher prevalence of untreated caries. The Wand® allows the administration of very comfortable infiltrations, inferior alveolar nerve blocks (IANB) and palatal injections. Single Tooth Anaesthesia (STA), delivered via a low pressure intraligamentary approach is a very effective "intra-osseous" technique unique to The Wand®. The approach to the patient is very relaxed. The Wand® hand-piece can be reduced in size by snapping the handle to a shorter length which has a very non-threatening appearance, recognizing the importance of patient perception. Ergonomically, it is very easy for the operator to give a slow, controlled delivery of local anaesthetic using a modified pen grip and finger rest for excellent control of the needle tip. A foot pedal is used for control of flow rate and aspiration. The aspiration function is very positive and reliable.

There is a learning curve when beginning to use The Wand®. We have introduced the techniques to Vocational Dental Practitioners, Dental Core Trainees, undergraduate dental therapy students and colleagues in the trust who treat patients with dental fear and anxiety. The Wand® units have proved to be very robust and reliable with some simple maintenance and periodic

lubrication. The one-handed "docking station" design complies with safety device sharps guidance.

I have found the STA technique very useful in patients with autism for the delivery of effective pulpal anaesthesia without collateral soft tissue anaesthesia. This is also a very useful technique for providing supplementary anaesthesia for teeth with enamel hypoplasia / MIH. The ability to deliver very comfortable palatal injections has been very useful for anxious children referred in for orthodontic extractions.

A colleague in our oral and maxillofacial service has reported ongoing success with a technique using The Wand® to deliver comfortable local anaesthesia to carry out exposure of palatal and labial canines with bonding of brackets and chains (30-40 cases per year), reducing reliance on general anaesthesia for this procedure. The response of children who have experienced this is very positive.

There is a useful archive of video clips on **www.thewand.com** with instructions for set up and maintenance of The Wand® and demonstrations of different injection techniques.

There seems to be a growing evidence base and recent studies have demonstrated benefits in certain patient groups using The Wand®. Interestingly, Re at al (2017) used the "willingness to pay" index, demonstrating that adult patients, in a private dental clinic setting, expressed a preference for local anaesthetic injections delivered with The Wand® compared to conventional techniques.

Kwak et al (2016) present a critical review of studies in adults and children, aiming to provide an objective assessment of the usefulness of CCLAD in different patient groups. Baghlaf et al 2015 demonstrated that both intra-ligamental anaesthesia (STA) and IANB delivered with The Wand® were clearly associated with less pain related perception and behaviour than the IANB delivered with a conventional syringe in children aged 5-9 years. Mittal et al (2015) demonstrated significantly less pain in children aged 8-12 years using the Wand for palatal injections. Garret-Bernadin et al (2017) demonstrated that, in comparison to the use of a traditional syringe; use of The Wand® demonstrated significantly lower pain ratings and physiological indicators of stress in children aged 7-15 years. In this study, the number of patients showing relaxed behaviours was higher with The Wand®, as was the level of patient satisfaction.

There is an excellent account in Campbell (2017) of use of The Wand® as part of a wider model of practical strategies to help children with dental fear and anxiety cope with dental treatment.

European Academy for Paediatric Dentistry guidance (Kühnisch et al 2017) states that pain on administration of local anaesthetic should, wherever possible be avoided and minimised and that the use of routes which achieve single tooth analgesia may be advantageous to reduce the risk of accidental soft tissue trauma.

Ongoing research will be important to demonstrate benefits of CCLAAD such as The Wand® to investigate the cost / benefit analysis and identify patient groups who would benefit from these techniques.

Talking to patients and parents some years after referral and use of The Wand®, many say that use of The Wand® was an important part of the process of getting past earlier fears and anxieties. I also use The Wand® for anxious and phobic adult patients and many of these patients cite the use of The Wand® as an important element of their ability to accept care. In my experience, and that of my colleague, Anne Gornall, a senior PDS dentist in NHS Highland who also has extensive experience of using The Wand® for children referred into the service with dental fear and anxiety, The Wand® has proved to be indispensable. In association with a range of other pharmacological and non-pharmacological techniques, I, personally, could not do without it.

Guy Jackson graduated with a BDS from King's College, London in 1989.

Guy spent 10 years working for NHS Western Isles as the community dentist on the island of North Uist in the Outer Hebrides of Scotland.

Guy worked as a tutor at the dental school in Dunedin, New Zealand before taking up a senior role in Paediatric Dentistry in Scotland for NHS Highland.

Guy has worked as a senior dentist / tutor on final year dental outreach in Inverness and as a lecturer on the University of Highlands and Islands BSc in Oral Health Sciences course (Dental Therapy) and is an NHS Education for Scotland Remote and Rural Fellow and has completed an MSc in Primary Dental Care at the University of Glasgow.

His research project titled "Placement of preformed metal crowns on carious primary molars by dental therapy vocational trainees in Scotland", was presented as a poster at the International Association for Paediatric Dentistry conference in Glasgow in 2015 and as a paper published in 2015 in Primary Dental Care.

Guy currently works for NHS Highland as a Public Dental Service dentist / senior dentist in paediatric dentistry and is also a clinical tutor on the Primary Dental Care MSc program at Edinburgh Dental Institute.

Guy is a contributer to the chapter on Local Anaesthesia in Paediatric Dentistry edited by Richard Welbury, Monty S Duggal and Marie Thérèse Hosey (OUP 2018).

References available upon request.

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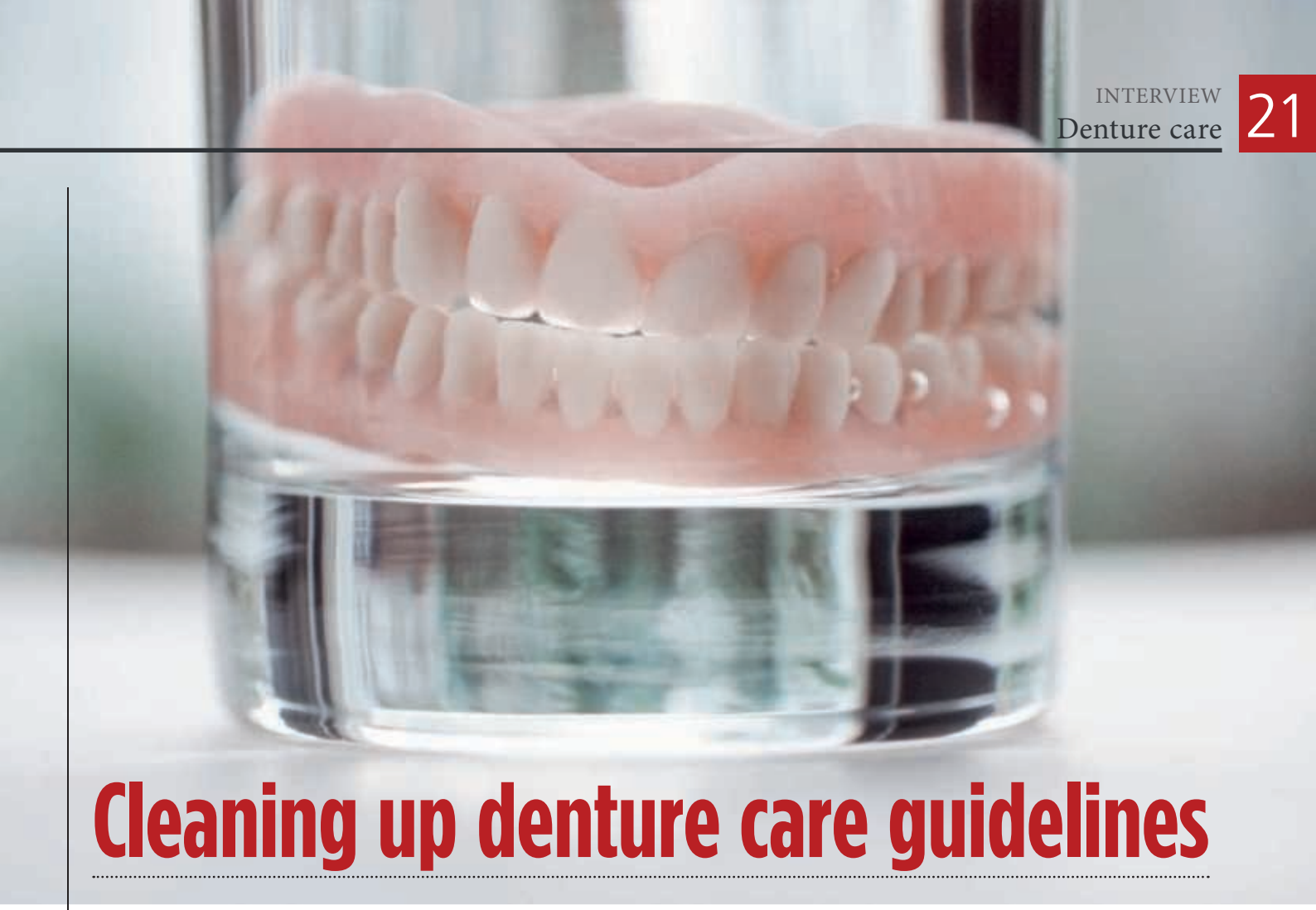

Cleaning up denture care guidelines

Nigel Carter, OBE

At this year's FDI Conference in Buenos Aires, the Oral Health Foundation announced new global denture care guidelines designed to unify the messages professionals give to patients and carers. A tough task indeed, given the varying complexities around the heavy metal generation, increasing co-morbidities and cognitive impairments, to name but a few. **David Westgarth** spoke to **Dr Nigel Carter OBE**, Chief Executive of the Oral Health Foundation, to find out how the taskforce found unity on a topic few have managed to achieve.

What's the background behind the development of these guidelines?

It was recognised that on a global basis recommendation for denture care varied both on a national basis and within countries. This situation was confusing for both dental professionals and for the public. Even within a dental practice the advice given by different members of the practice team could vary according to where they had been taught.

Despite there being ranges of specially formulated denture cleansers on the market may clinicians were recommending the use of domestic products such as hand soap and liquid soap or washing up liquid with a variety of brushes from a toothbrush, through denture brushes to a nail brush being suggested. Perhaps the strangest recommendation came from France where the suggestion was that one particular brand of hand soap 'Savon de Marseilles' should be used.

I remember from my own undergraduate and early practice days there was a huge prejudice by prosthodontists against effervescent denture cleaners since it was felt that these bleached the denture base material. In fact, the problem here was largely due to members of the public not following the product directions and using the boiling water from their bedtime drink combined with the effervescent cleanser which clearly lead to bleaching.

Recommendation still occurs for the use of toothpaste whereas in fact these are too abrasive and will scratch the denture surface allowing easier build-up of stains.

Why are there so many variations on guidelines for dentures?

I think the reason for varying recommendations for denture cleaning is down to the lack of a structured review of the scientific evidence prior to the review that our Global Expert Panel undertook. Whilst the evidence is limited, we found sufficient published evidence to allow some standardised recommendations to be made. Much of the advice previously given was therefore based on personal opinion rather than on any real consideration of what denture cleaning was intended to achieve, a plaque free denture.

You recommend that 'all denture wearers should be enrolled into a regular recall and maintenance

programme with their dental professional'. Given the previous comments about the variety in guidance, does this work to fuel that variety rather than streamline it?

We would obviously like to see wide adoption of the guidelines amongst dental professionals worldwide so that consistent recommendations are given. It has been quite remarkable to see the amount of interest that has been generated by the production of these guidelines showing that there was a huge need for them and our thanks go to GSK for funding this important piece of work. Whilst it is early days we are starting to see the guidelines translated into a number of major world languages with Spanish, Portuguese and Polish the first and these will all be hosted on the foreign language versions of the Oral Health Foundation website.

Recall and maintenance programmes obviously have a role in ensuring denture cleanliness but there is of course a more serious reason for these to spot early any problems with the dentures themselves and examine the tissues of the mouth for health. With a regular recall programme, patients should receive the correct recommendations as to when denture replacement might be necessary and also be routinely examined for mouth cancer, an issue very close to the Foundation's heart as organisers of Mouth Cancer Action Month.

Was the taskforce surprised by the absence of definitive guidance from Cochrane on the best way to advise patients to clean their dentures?

The Cochrane group obviously has a huge number of potential areas on which they could issue guidance and in view of limited resource both in terms of finance and reviewers have to prioritise which subjects they will cover and have process for this. With the lack of a great deal of evidence this probably also would influence their decision. We have produced guidelines based on the best published science available we have been careful to say these are not evidence-based guidelines in terms of a Cochrane style review. The Whitepaper has made a number of suggestions on areas where future research would be valuable, an example being on the storage of dentures, dry, damp or in liquid. In the absence of clear evidence our recommendation here is just to leave the dentures out at night.

What impact does this have on UK denture-wearers? If dentists coming from EU and non-EU countries have differing approaches, surely that only adds to the apparent confusion?

We have to start from the basis we have which is one of disparate recommendations as previously described. Hopefully over time, as with any new set of guidelines, these will gradually be adopted universally, and the confused messaging should gradually disappear to be replaced by consistent recommendations of brush, soak and leave out as recommended in the Whitepaper.

In time as the guidelines are more widely adopted we can expect to see improvements in denture hygiene. Particularly for the frail elderly denture wearer this is not just an issue around their oral health but with many cases of aspiration pneumonia claiming lives, cleaner dentures have a role in preventing these unnecessary deaths. To this end we will also be promoting the guidelines among carers.

We have also recognised that recommendations around the use of denture fixatives, more commonly known as adhesives elsewhere in the world are equally diverse and we are currently undertaking a further piece of work with a new panel of experts to come up with guidelines for fixative use.

EU versus non-EU is not really a specific issue since the recommendations within the UK itself from various dental schools and authorities can be equally varied.

Is the current workforce equipped to deal with the complex needs of the patient?

With the decline in the number of full denture wearers dental students and practitioners alike are seeing fewer full denture cases than would have been the case thirty or forty years ago. The skills needed for full denture construction are therefore becoming much more of a specialist art and the advent of clinical dental technicians is increasingly fulfilling a role in this area.

More importantly, is the future workforce going to be able to cope with the demand?

Demand for full dentures is of course in decline and is predicted to continue to be so. We are likely to see more implant retained dentures and more partial dentures as time progresses. With an increased emphasis on prevention and a much-reduced experience of decay, specialist dental workforce time can better be allocated to these more complex cases.

Care homes and hospitals are renowned for not prioritising oral health. How can they possibly know which set of guidelines to follow?

There have been no previous sets of guidelines in the UK on denture care just varying recommendation from different bodies. It must be hoped that the care community will adopt these guidelines as the best available care for their patients. We will be undertaking a workstream to promote the guidelines to the care community as part of the project and this was always seen as essential from the early stages of the work. There are many examples of good practice in oral care for the institutionalised elderly, notably Gerodent in Belgium and a number of programmes in the US.

We can learn from these and the introduction of oral health champions within the care home seems to be a great way forward. There are huge challenges within a largely privatised system and resource will need to be allocated if these programmes are to be successful. *Delivering Better Oral Health* currently has no advice on denture care and I would hope that this can be rectified with the fourth edition, currently under consideration.

For so long we've all been singing from different hymn sheets when it comes to denture care advice. Now many of us, not just at the Oral Health Foundation but organisations across the world, are committed to finding a common solution. This can really make a difference to the health of denture wearers. We know exactly how mammoth the task is, but it is essential when we see the consequences of poor denture cleanliness. ◆

Dr Nigel Carter OBE BDS LDS (RCS) has been CEO of the Oral Health Foundation since 1997.

Previously, he was Chairman and long-term trustee of the Oral Health Foundation. Under his leadership, the charity is increasingly influential internationally, with the website recently being translated into nine major world languages. This is in addition to its established programmes of National Smile Month and Mouth Cancer Action Month, wide range of educational resources and extensive oral heath product accreditation scheme.

He is also chair of the Platform for Better Oral Health In Europe, a lobby group based in Brussels aiming to raise the profile of oral health with the European Parliament and European Commission, in order to reduce inequalities in oral health across Europe.

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A partnership or two sole traders?

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

Many dental businesses are run by partnerships. Occasionally several dental businesses operate under one roof and work as expense sharers. These arrangements can be formal or informal but where it is informal this lacks clarity and legal certainty for the parties involved. Therefore, the BDA always recommends seeking advice so the parties understand the legal relationship they are in and understand their rights and responsibilities. Where legally binding agreements are absent, legislation may take over and this may not be what the parties intended or what they would like.

What are partnerships?

Partnerships are an agreement between two or more legal persons (individuals or companies) to carry on business together, such as running a dental practice, with a view to making a profit. The motivation is key. Partnerships require parties to want to make money together. In dental practices it is common for principles to be partners and running the business together. Although they may delegate responsibility between themselves as to who performs what role- one may be in charge of accounts whilst another in charge of personnel for example- they may also do everything together. However ultimately, they will be both be responsible legally for everything. A key aspect of a partnership is that partners are jointly liable for losses of a business. Within a well drafted agreement they may indemnify each other for certain losses, to the outside world they are all liable for each other. This may not be what each party intended.

What are expense sharing relationships?

Expense sharing businesses are just that – parties that only share expenses. They are different to partnerships because they do not share profits. They run as two separate businesses. They will have separate bank accounts, the money from each going into its own bank account. They may share an expense, such as a receptionist or computer system but will have separate agreements in place as to how these expenses are shared.

It is not uncommon for expense sharers to in fact be a partnership. For example, where they see and treat each other's patients regularly, their funds go into the same bank account or they use joint bank accounts to pay staff but those bank accounts run in surplus. This is because the surplus in the account would evidence a shared profit being held together. Therefore, if the parties wish to run as expense sharers and avoid being a partnership they should make sure their businesses are run as separate businesses and that patients visiting the practice would understand them to be separate businesses. Parties should take specialist advice regarding their business set up to avoid any unwanted surprises.

Why is it important to know the difference?

The importance of knowing the difference is liability. If a party unwittingly finds themselves in a partnership rather than an expense sharing relationship they will most likely be liable for their partner's actions, even where they did not have knowledge of the actions or consent to the actions in question.

Partnership agreements

The best way to avoid unwanted surprises is for the parties to speak to a specialist legal adviser and to get an agreement drafted to reflect their situation and shared goals. With a properly drafted agreement most accidents can be avoided and unexpected surprises negated. Talk to the other party or parties before seeing a specialist. This allows the parties to have a frank discussion and ensure they are on the same page. Think about the following points:

- How do the parties share the business – is it in equal or unequal shares?
- Do the parties make all decisions jointly or can some be taken without discussion?
- How will the parties manage staff on a day to day basis and on a disciplinary and hiring basis? Are staff shared or separate?
- How will the parties manage finances? Do the parties need joint consent to make payments or make payments above a certain value?
- How will the parties manage annual leave between them? What will their allowances be and can they take leave at the same time?
- How will the parties manage parental or sickness leave or other absences?
- How will the parties compensate each other for administrative work as well as clinical work?
- Will the parties allow sabbaticals?
- What happens when someone wants to join or leave? Buy-ins and buy-outs?

A good specialist legal adviser will take the parties through these and many other considerations so that they end up with a workable business arrangement which is clear and easy to manage. ◆

Contracts with suppliers

By Shabana Ishaq

Shabana is a practice management consultant in the BDA Practice Support Team. Shabana is a qualified solicitor and advises general dental practitioners on associate contracts and a wide range of employment and other law.

As a dental practice owner, you will find yourself entering into contracts with a variety of external suppliers such as clinical waste management companies, software providers or suppliers of dental equipment to name a few. You will need to be careful when negotiating and agreeing to any supply contract to ensure that you and your business are protected. Most supply contracts have minimum terms and it can sometimes be very difficult to end the contract. It's not a case of simply 'walking away'.

It's important that you do your background checks on any company you are going into business with. Reviews on websites are a good starting point and word of mouth recommendations. You may find that you are told which suppliers to avoid once you start your research – a useful exercise to undertake. It may be that you can arrange to meet with a representative of the supplier, so you can discuss how you see the relationship working and ask any questions face to face. It's crucial that any provider understands what you're trying to achieve and what your business needs are before you begin discussions and establish the working relationship. Sometimes it's better to meet with a few suppliers. Cheapest is not always the best.

When it comes to reviewing and signing a contract with a supplier you must ensure you receive the written terms in advance and take time out to read the contract in full. If there is a definitions section check this carefully as this will form part of the contract. If anything is unclear make sure you ask for clarification and don't be afraid to ask for amendments to any contract you are provided with. Many suppliers have their terms and conditions on the back of standard forms which you may not be aware of. As a busy dentist, it's easy to think that a supplier is providing you with fair terms and to sign any paperwork without hesitation. This could cost you and your business a lot of money if you are not happy with the service subsequently provided.

Any contract you do enter into with a supplier will be a legally binding document and it will not be easy to argue that you didn't read the contract fully, so you are not bound by the terms. These days, more often, you will be entering into agreements with suppliers online. With a busy schedule and lengthy terms and conditions it is tempting to click on the button saying you have read and agree to the terms without fully reading them. Try and avoid this temptation.

If you have agreed any terms verbally ensure they are included in the final written contract. Do not presume any verbal discussions will be reflected in the contract no matter how friendly and sincere the sales representative appears. Many written contracts will have an 'entire agreement' clause meaning what is in writing is what counts – any previous pre-contract discussions are not relevant. As a practice owner, tell your staff that only you can sign contracts on behalf of the practice. Sometimes, representatives of supply companies may put pressure on practice managers to enter into agreements there and then which can tie in the practice for a lengthy period.

The payment terms of the contract such as costs of the good and services and how many days you need to make payment within are inevitably key terms you will need to look out for. However, it's important that other terms are also considered. Request a full description of the goods and services to be provided, any time frames for deliveries of the goods and services, whether VAT is included in the price, the cost of any insurance and delivery. Ensure you read any small print. Do you have to pay extra under the contract terms such as late payment interest? If so, how will this be calculated? Can the supplier increase their prices at any time or vary the goods and services provided? Where possible include a term in the contract clearly stating that the supplier cannot increase the charges without your express written consent. Usually there will be a term in the contract allowing the supplier discretion to increase its charges with limited notification.

Many practices have fallen short when it comes to the minimum term you are agreeing to. If you have signed up for 3 years you may find your business tied in for that whole period. If you aren't fully happy with the service and in the absence of a serious failure on the part of the supplier, it may be difficult to extricate yourself from the contract. If you do want to part ways you may find yourself having to pay a penalty or the remainder of the cost of the whole contract.

Automatic renewal on the anniversary date of the contract unless it is cancelled by a certain date catches many dentists out. You may find yourself tied in for another 3 years for example. A very expensive mistake. If you are entering into a new supply contract note down any notice periods and at what date you can serve notice to leave, should you wish to do so.

In most cases dentists will enter into contract with suppliers and the working relationship is without incident. However, when entering into a contract it is worth concentrating on what could go wrong so you can try and safeguard against these events occurring.

Record keeping: what do you need to record and why?

By Claire Bennett

Claire is a practice management consultant in the BDA Practice Support Team, she qualified as a solicitor in 2008 and advises general dental practitioners on associate contracts and a wide range of employment and other law.

All dental practices collect, hold and maintain information relating to the business, including information about commercial suppliers, employees and patients. There is a substantial amount of UK legislation that effects the retention of practice records, as well as established good practice. In order to comply with relevant legislation, including the Data Protection Act 2018 (DPA), which incorporates the EU General Data Protection Regulation (GDPR) into domestic law, it is important for dental practices to identify at the outset what information must be kept. Practices must then have effective and well-organised systems in place to ensure that data is stored lawfully and appropriately, can be easily and reliably retrieved and, when the time comes, disposed of securely.

Retaining information

Practice records may be stored in hard-copy or electronically. Either way the DPA and GDPR require that information is retained for a legitimate purpose and for no longer than necessary.

Practice records typically comprise: patient records; HR records and financial and other business records. Whilst the DPA and GDPR do not set out specific retention periods, there will be information within these records that is subject to a statutory retention period. Where that is not the case, there will almost certainly be a recommended retention period.

Patient records

Patient records usually include clinical information and financial data. Whilst a patient actively attends the practice, records relating to their clinical care should be stored securely and kept up to data. When the patient ceases to be a patient of the practice, their records should be stored for 10 years following their last visit, or up to the age of 25, whichever is longer.

For NHS practices, the PR form, relating to a patient's financial eligibility, can be destroyed securely after 2 years.

HR records

HR records can be extensive and relate to employees and self-employed associates. Records will typically capture information concerning an individual's pay, pension, absence levels, disciplinary matters and health information.

Some HR information will be subject to a statutory retention period. For example, accident books and records should be stored for 3 years from the date of the last entry (or, if the accident involves a child/ young adult, then until that person reaches the age of 21); income tax and NI returns, income tax records and any correspondence with HMRC should be retained for not less than 3 years after the end of the financial year to which they relate; national minimum wage records should be retained for 3 years after the end of the pay reference period following the one that the records cover; payroll wage/salary records should be kept for 6 years from the end of the tax year to which they relate; statutory maternity pay records should be kept for 3 years after the end of the tax year in which the maternity period ends; and working time records should be kept for 2 years from the date on which they were made.

For HR records where there is no statutory retention period, it is up to the employer to decide how long keep the record. As most employment tribunal claims have to be brought within 3 months of the matter complained of and the Limitation Act 1980 provides for a 6-year time limit for starting contractual claims, it is recommended that information relevant to such claims is retained for 3 months and 6 years respectively. By way of example, personnel files and training records (including formal disciplinary records and working time records) should be kept for 6 years after employment ceases; recruitment application forms and interview notes (for unsuccessful candidates should be kept for 6 months to a year (because of the time limits in the Equality Act 2010)); and minimum retention periods for records relating to advertising of vacancies and job applications should be at least 6 months, although a year may be more advisable as the time limits for bringing claims can be extended.

Financial and other business files

Most modern dental practices will have a number of contracts with suppliers. These contracts should be reviewed regularly and managed to ensure that they continue to deliver what the practice requires and provide value for money. Documents relating to commercial supply contracts should be retained for a period of 6 years after cessation, just in case they need to be referred to as part of a contractual claim.

Accounting records have a statutory retention period of 3 years for private companies.

Secure storage and archiving

To comply with data protection legislation, practices must have appropriate security in place to protect personal information against unlawful or unauthorised processing and accidental disclosure or loss.

Personal information should never be left unattended. Personal health information calls for a high level of security because of the potential damage that could result by unauthorised disclosure:

Manual records should be stored in lockable, fireproof cabinets and the premises should be protected to prevent entry by intruders. Computerised records should be protected by passwords known only to essential staff. CCTV recordings must be stored securely and in a way that maintains the integrity of the image. You should restrict access to the images and delete those that are no longer needed. ◆

References: to give or not to give

By Nashima Morgan

Nashima Morgan is a practice management consultant in the BDA Practice Support Team. Nashima advises general dental practitioners on associate contracts and a wide range of employment and other law.

If you have been approached for a reference for a current employee by their potential new employer, think carefully as to whether you are going to write one.

It is worth bearing in mind that there is no legal expectation for you to provide a reference. However, you do have a moral obligation to consider providing a reference, as adverse inferences can be drawn about the employee by the potential new employer, therefore increasing the chance of their job offer being withdrawn.

There may be legitimate reasons why you don't want to provide a reference. For example, the employee might have left on bad terms and you just want to put the experience behind you for the benefit of both parties. Preparing and writing a reference is another thing to do in a busy practice when we know time is precious, but the employee will be counting on this. If this sounds like you, remember the practice manager may have had just as much contact with the employee – ask them to prepare the reference for you to approve.

When writing a reference aim to be as objective as you can. This can be difficult at times, especially in the situation where an employee's contract was terminated due to dishonesty. You do have a responsibility to ensure that the information provided in the reference is true, accurate and fair. Look at the employee's performance whilst at the practice – were they enthusiastic, always on time, efficient and a good team player?

If, in the above scenario, the contract was terminated due to dishonesty, you have a duty towards the potential new employer to give this information. The key issue to bear in mind is that employers have a duty of care towards both the employee (referee) and the new potential employer when providing a reference.

A reference that contains the bare minimum is of limited use. A further downside to providing the bare minimum is that you could expose yourself to a negligent claim from a subsequent employer if you fail to reveal something which ultimately causes them loss of any sorts. If an employee leaves with serious questions hanging over their performance or conduct, or if these concerns arise after the employee has left, you should disclose the issues to any prospective new employer and must make absolutely clear if the allegations have or have not been investigated and the current status – where appropriate – of the investigation.

When writing the reference, remember the employee might be shown the phrases which possibly may have caused the withdrawal of an offer. As a result, you are more likely to be challenged on the accuracy of the statements made. Some practice owners take the view that the safe option is to confirm the employee's dates of employment and job title, because they fear that they may be sued if they give a negative comment that could be challenged or incorrect. Whilst this is perhaps a safe approach, think about whether you would consider hiring an employee on the reference you are providing.

There are some circumstances where refusal to supply a reference could be seen to be discriminatory. If the employee complained about discrimination and before you had the opportunity to investigate the matter the employee resigned, we would advise you to provide a full and comprehensive reference. ◆

Bear in mind the basic rules:

- The reference you write must be true, accurate and fair.
- State facts and not opinions
- Must state negative issues such as gross misconduct or events giving rise to a disciplinary process in a way which is overall accurate and correct.

Further written guidance on references can be found at www.bda.org/dentists/advice/Pages/employing-staff.aspx

No screw, no glue – a dream come true!

When it comes to the restoration of implants, traditionally there have been two ways for successful retention between the crown and abutment – screw-retained or cement-retained. Both are tried and trusted solutions and have many advantages, and occasionally, some limitations.

But now, based on an innovation by Dr Marco Degidi working in close collaboration with Dentsply Sirona, there is a third way, and it's a game-changer. Instead of cement or screws, the Acuris conometric concept uses friction retention to secure the crown and cap onto the abutment, and thanks to the unique Fixation Tool, it takes just seconds.

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Acuris will be available for all major Dentsply Sirona implant systems: Ankylos, Astra Tech Implant System and Xive. All abutments, caps and the final crown are designed to make the conometric concept easy and efficient, with guaranteed excellent long-term results.

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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.

Thinking of buying or selling a practice?

The complex legal processes and regulations involved with the sale or transfer of a dental practice can be confusing, to say the least. Getting even the smallest details wrong can be detrimental to your future, so it's natural for you to want to make sure all the paperwork is in order.

With Goodman Grant, you can be confident that you have a specialist firm of dentolegal solicitors supporting you when you need it most. Decades of combined experience and knowledge means that the team can guide you efficiently through the minefield of dental law, helping you progress through the sale or purchase of a dental practice.

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For more information visit www.goodmangrant.co.uk

A better future

Dental professionals cannot see into the future but the CALCIVIS imaging system enables them to gain valuable insight into what may lie ahead. The CALCIVIS imaging system is a revolutionary device that uses bioluminescence to provide a visual map of active demineralisation at the chair side. Patients can now see potential 'hot spots' and with the advice and expertise of dental practitioners, effective preventive measures can be implemented to avoid invasive or complex intervention in the future.

Although it is impossible to see precisely what is on the horizon, CALCIVIS offers unique vision and supports the preventive dentistry approach. To fast forward into the future, visit www.CALCIVIS.com or call 0131 658 5152.

A Christmas cracker!

To make a difference to your patients' oral health this Christmas, consider products that you could offer within your practice that would make a great gift or stocking filler.

Curaprox offers a range of adjuncts that are worth recommending; including the brand new Hydrosonic Ortho toothbrush designed to help brace wearers maintain a healthy and attractive smile. Using the Hydrosonic Ortho it is possible to clean effectively between the teeth, braces, brackets and retainers thanks to the CURACURVE bend, CUREN bristles and powerful motor.

To find out more about the innovative Hydrosonic Ortho and other products available, contact Curaprox on 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.

Two major breakthroughs in composite technology!

Made with the dentist and the patient in mind, Tokuyama grow 'aesthetic pearl fillers'. Supra-nano Spherical Filler is produced using the Sol-Gel method. This allows Tokuyama to grow spheres of specific translucency, colour, size and refractive index for optimal optical and physical performance.

Other composites are made from blocks of filler that are randomly ground thereby compromising the product.

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Dr. Malihe Moeinian
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Dr Prabhleen S Anand
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IQE, BDS, MMedSc, FDSRCS(Eng) MPaedDent, FDS (Paed. Dent)
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Interests: Children

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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

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

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

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Interests: Dental Implants, Fixed and Removable Prosthodontics, Bone Grafts, Sinus Lifts, Full Mouth Reconstructions, Periodontics, Occlusion, Restorative and Cosmetic Dentistry, Implant Mentoring
Mr Rehan Ullah BDS, MFDS (RCPSG), MPhil, MOrth (RCPSG), FDSOrth (RCPSG)
Interests: Specialist Orthodontics, Temporary Anchorage Devices (TADs), Lingual Braces
On Specialist List: Yes
Dr Lukas Javorskis MSc Endodontology (Kaunas, Lithuania)
Interests: Endodontics (including Instrument Removal), Use of on-site Microscope
CT Scanner and dedicated implant suite on-site.

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In Practice CPD

Q1: What are expense sharing relationships?

A A contract where profits are shared

B A contract where expenses are not shared

C A contract where expenses only are shared

D None of the above

Q1: Why are online contracts with suppliers potentially dangerous?

A They may not understand the needs of the business

B You won't read the lengthy terms and conditions

C Verbal agreements will not be in there

D All of the above

Q3: When a patient ceases to be a patient of the practice, how long should their records be stored?

A 10 years following their last visit or up to the age of 25 – whichever is longer

B 10 years following their last visit or up to the age of 20 – whichever is longer

C 5 years following their last visit or up to the age of 25 – whichever is longer

D 5 years following their last visit or up to the age of 20 – whichever is longer

Q4: Are you legally obliged to write a reference?

A Yes

B Yes, but only if it is positive

C No

D It is discretionary

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