BDJ InPractice

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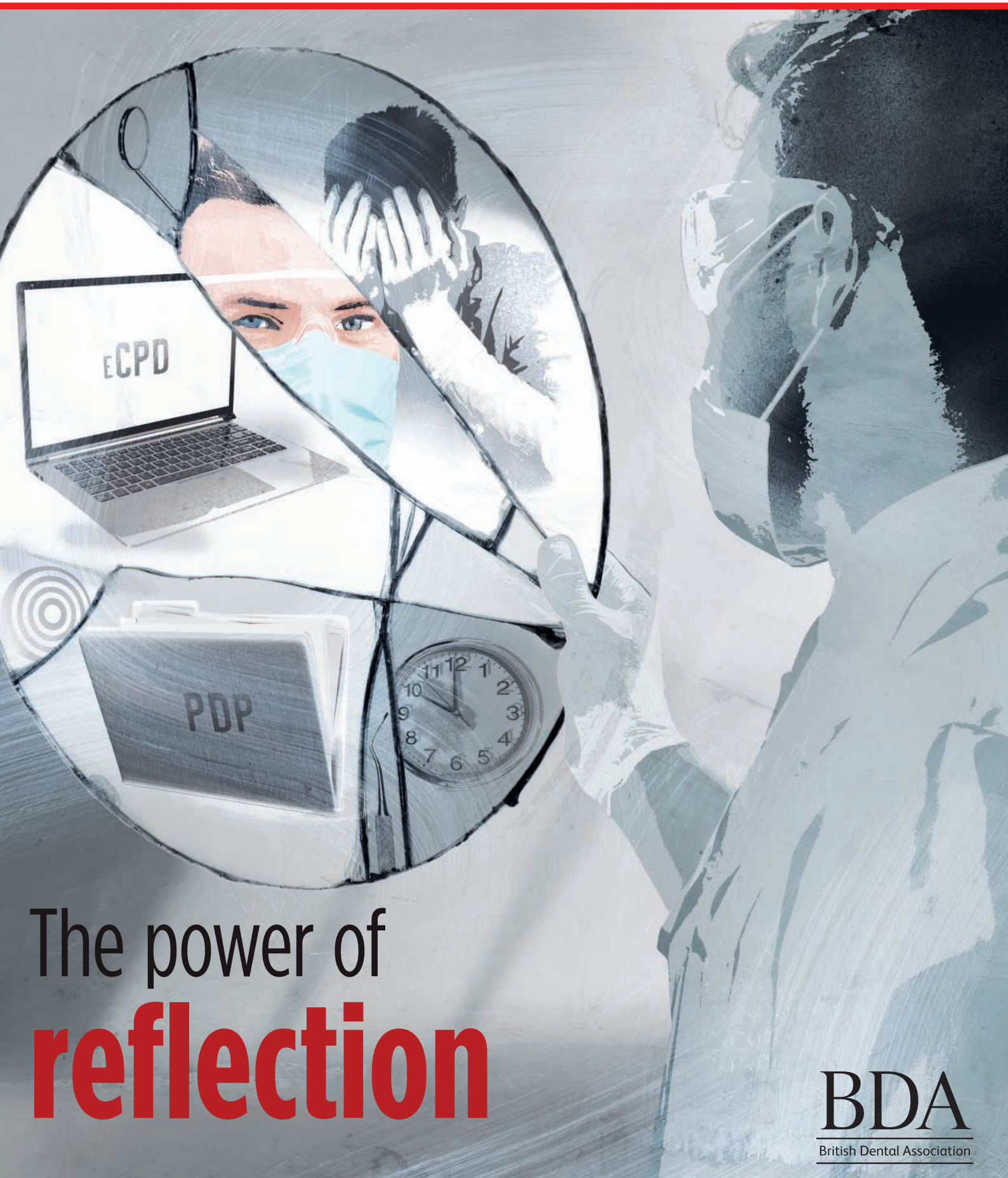

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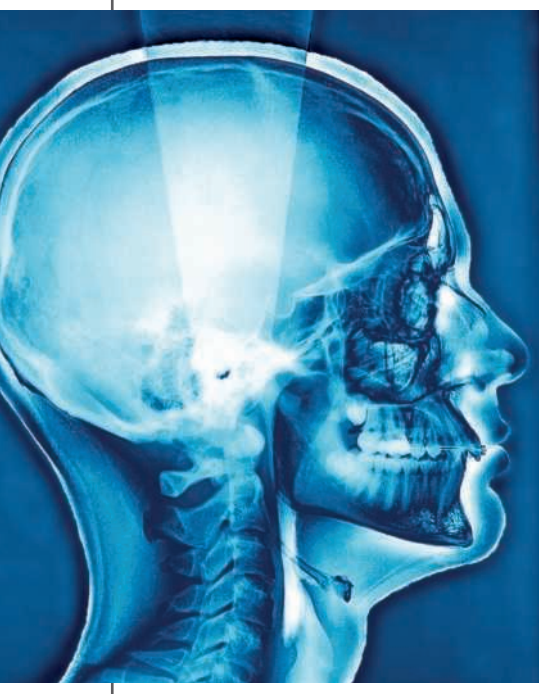
A restrictive issue

Dear sir, I was interested to read the article by Dr Badr-Amin Mihramane on obstructive sleep apnoea. He rightly drew attention to its serious consequences. Fortunately, it is not difficult to diagnose but as he said many dentists and doctors fail to recognise its presence. What concerns me is the apparent confusion about its underlying cause.

Restriction of the airflow may occur in either the nasal or oral part of the pharynx and this alone causes much confusion. Children who breathe through their mouths often have enlarged tonsils and adenoids and these are frequently blamed for the obstruction, but the evidence is contradictory and many people believe that the tonsils and adenoids enlarge because of the mouth breathing. Certainly, recent evidence suggests that the Immune system may be permanently damaged by their removal.

There is also some confusion about the pharyngeal airway which is in fact where most airway obstruction takes place. Some think of it as a supported opening like the trachea which is held open by cartilaginous rings but in fact it is just the space between the back of the tongue and the front of the constrictor muscles of the pharynx which are attached to the cervical spine behind them. As such, the airway requires actively opening by forward movement of the tongue.



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The pharyngeal airway is frequently closed by voluntary movements of the tongue during speech and swallowing, in fact the constrictor muscles together with the Stylohyoid and other muscles deliberately close the airway every time we swallow to prevent inhalation of liquids and food. Many clinicians use X-rays to diagnose the width of the pharyngeal airway but as can be understood this space constantly varies, providing the clinician with little useful information.

Following intermittent colds during their childhood, many children become chronic mouth-breathers and this can have other consequences. It is known that long-term open mouth postures tend to lengthen the face.[1] This can create major changes in the facial structures involving a marked retrusion of the maxilla and mandible. This is often called vertical growth and results in the classic 'adenoidal face' with tired looking eyes and flat cheeks. At the same time the retrusion of the maxilla and mandible, shortens the dental arch lengths, causing the typical crowding associated with such faces.

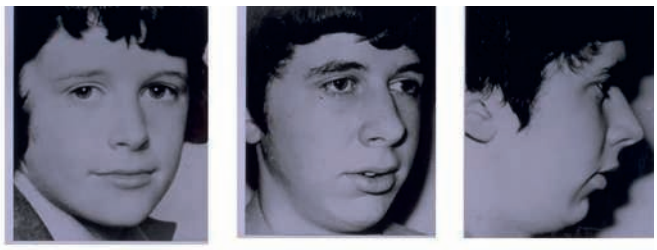

Fig 1. The effect of open mouth posture

Finally, as we know the tongue is supported by the mandible and hyoid bone and if these bones fail to grow forward as they should, the tongue is likely to fall back and occlude the pharynx. This becomes certain if the patient sleeps on their back with their mouth open and Dr Badr-Amin Mihramane described the severe consequences in his article. As he also said, some alternate methods have been developed, which either hold the mandible forward (Mandibular Advancement Devices, MADs) or provide continuous positive airway pressure (CPAPs) so that air is forced down into the lungs.

The MADs are usually held in position by the maxilla and although they do bring the mandible forward, in the long-term they also take the maxilla back. As can be imagined a retruded maxilla is one of the primary causes of sleep apnoea and this must be considered a less than ideal cure. Most patients dislike using CPAPs because they are seen as anti-social and few continue them for long. Sadly it is also accepted by most growth experts and orthodontists that it is not possible to encourage forward growth of the mandible or to reverse the downwards growth of the maxilla, thus there seems to be no satisfactory solution.

From a philosophical point of view this seems surprising, because the cause of vertical growth is so clearly related to open mouth postures (fig.1) and one would assume that this could be prevented or even reversed by keeping the mouth closed. In fact, much research has been conducted on facial growth and it does seem possible that it can be reversed[2], possibly permanently[1]. Illustration 2 shows how the mandible can be brought forward by training children and young adults to close their mouth. If this could be achieved reliably it would seem to be an appropriate option for patients with sleep apnoea.

J. Mew, via email

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Erratum

In the article 'The dirty C word', it stated that half the money spent on dentistry was clawed back. It should have stated that clawback accounted for 3% of the total contract values in England in 2016-17.

We apologise for any confusion caused.

Below inflation pay deal for dentists in Wales 'a cut in all but name'

The British Dental Association Wales has criticised the below-inflation pay rise for dentists, saying austerity pay and the Welsh Government's refusal to let go of a system of rigid targets is leaving the very future of the service in doubt.

NHS dentists in Wales are paid via the widely discredited NHS contract. The system, which has operated in Wales since 2006, funds care for little over half the population, and is based on delivering on activity measures rather than effective prevention or improving health outcomes. The Welsh Government is currently testing a watered-down version of this system, *in lieu* of wholesale reform.

Earnings for dentists in Wales are currently 30% less than their opposite numbers in England. Recent data have shown practitioners in England and Wales have experienced real terms falls in income of up to 35% over the last decade. New figures also show that morale in the profession has fallen to its lowest levels since 2000 and more than half of dentists are considering leaving the profession.

Tom Bysouth, Chair of the BDA's Welsh General Dental Practice Committee, said: 'The Welsh Government's below-inflation pay deal is another pay cut in all but name.

'Morale in the dental profession is at an all-time low, thanks to a failed contract and real terms pay squeeze without parallel in the UK public sector.

'It's bad news for patients that Ministers remain so wedded to a system that actively penalises prevention, and a pay policy that undermines the very sustainability of NHS services.'

Penalties on the way

HMRC have plans to introduce a points-based penalty system for late payments by businesses and individuals for corporation tax, income tax and self-assessment. As with the existing penalty regime, there will be a 'reasonable excuse' get-out, but like the current system, inability to pay and reliance on a third party are not reasonable excuses.

First charge:

Days after due date	Action by taxpayer	Result
0-15	Payment made	No penalty
	OR TTP agreed	Penalty suspended
16-30	Payment made	Penalty calculated at reduced rate
	OR TTP agreed	Penalty calculated at reduced rate then suspended
Day 30	Too late...	Penalty charged based on how much if anything has been paid in the month

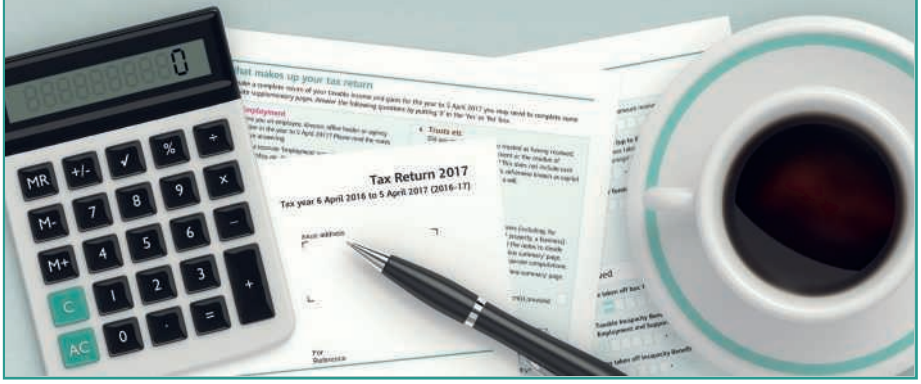
Second charge:

A second charge will also become payable and will be calculated on amounts outstanding from day 31 after the payment due date until the outstanding balance is paid in full. Any TTP (Time to Pay arrangement) agreed during this period will also result in future penalties being suspended from the date the TTP was agreed.

In a statement explaining the thinking behind the new system, HMRC said: 'The changes will ensure that people who pay late can avoid a penalty if they take action to make arrangements to pay, and that those that do not will receive a penalty that is proportionate to both the value of the debt and the amount of time it is outstanding for. The measure is designed to encourage those who cannot pay to agree a TTP arrangement as quickly as possible and only penalise those who do not.'

Heidi Marshall, head of the dental team at Dodd & Co and Secretary of NASDAL (National Association of Specialist Dental Accountants and Lawyers) commented: 'These changes illustrate the need for you or your accountant to be in communication with HMRC and to not bury your head in the sand or 'hide' from the debt if there any issues.

As of yet, there is no date for the launch of the points-based system for non-VAT taxes or details of the rates at which the penalties will be charged but watch this space.'



Top dentists call for positive action on school meals

The lunchtime menu in Scottish schools should be improved to reduce excess sugar and ensure children and young people eat more fruit and vegetables, according to the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow. The call comes in the Faculty's submission to the Scottish Government's national consultation on the nutritional requirements for food and drink in schools, which closed last month.

The Faculty, which represents over a thousand dentists and trainees, called for schools to take unhealthy puddings off their lunchtime menus, and instead offer pupils a healthier choice of soup or fruit.

Publishing their submission to the consultation, Faculty Dean Professor Graham Ogden welcomed the overall process, but called for a bolder approach from the Scottish Government. Professor Ogden said: 'We fully support the positive intention of these proposed regulations, but we feel that the Scottish Government should take a bolder approach if it's to ensure that our young people have the healthiest possible start in life.

'For example, we all agree that children should have greater access to more fruit and vegetables as part of their school day, but increasing access does not necessarily increase consumption. The guidance must include an evidence-based plan to ensure any increase in provision also ensures that our young people consume larger amounts of healthier food during school meals.

'In addition, our membership also welcomes the intention to reduce the free sugar content of school meals. However, we totally oppose the inclusion of sugar free drinks on the list of permitted drinks for secondary school as this could see the reintroduction of diet fizzy drinks. This intention is a mistake and we suggest that it must not be permitted. Some will argue sugar free is a harm reduction approach, but it has all of the well-known disadvantages of that tactic. We also know that diet drinks cause dental erosion, in addition to being a gateway to sugar. We should aim to ensure that our children's oral health gets off to the best possible start in life.'

The Faculty's submission also calls for action to ensure that all children and young people have access to facilities in schools to brush their teeth after meals.

Professor Ogden added: 'Although this consultation only covers nutrient and food and drink standards, we would urge the Scottish Government to ensure that other factors involved in school meals that could influence a long-term shift in food culture and improve children's food choices and health are also addressed.

'Childsmile primary schools already provide excellent facilities where pupils can brush their teeth with fluoride toothpaste after eating school meals, and so we feel that this approach should be available more widely. We also need to take tangible steps to empower school children so that they are fully engaged in the process of improving nutritional quality of school meals themselves.'

'Around a third of Scottish children currently suffer from dental decay. That's why we need to take action now. This consultation process is a good start by the Scottish Government, but it doesn't go far enough if we're to effectively tackle this serious problem.' ◆

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More work needed to control legal costs in compensation claims

Some claimant's lawyers are still recovering legal costs that far exceed the compensation their clients receive in clinical negligence cases, the Dental Defence Union (DDU) claimed as it called for further curbs to disproportionate costs.

Responding to a Ministry of Justice review of Part 2 of the Legal Aid, Sentencing and Punishment of Offenders Act 2012 (LASPO), which brought in reforms to civil litigation funding and costs, John Makin, Head of the DDU said: 'There are signs that reforms aimed at reducing disproportionate claimant's legal costs for dental claims are partly working. In some lower value cases costs have halved but this is not a consistent picture.

'We still see cases where the patient's solicitor's legal costs are far greater than the award their client receives. For example, in one case we paid £5,000 to compensate a patient whose solicitor's costs were £35,000.

'It is not right that in some cases lawyers' costs are still higher than the compensation the patient receives. We need further reform to restore balance to the system.

'The harsh dento-legal climate is not our members' fault and we work hard on their behalf.' ◆

Low income patients turn away as ministers say 'don't run the risk'

The British Dental Association has warned that low income patients are turning away from NHS dentistry in droves, thanks to a hostile environment cultivated to keep costs down, as official figures show a fall of two million treatments delivered to patients exempt from NHS charges since 2013/14 – a fall of 23% in 4 years.

8,818,170 free courses of treatment were provided in 2013/14 compared to 6,819,158 in 2017/18.

Dentist leaders have expressed grave concerns that patients are being put off from seeking treatment by the government's aggressive approach to fines for 'misclaiming' free care. Over 400,000 high needs patients a year – many on very low incomes, the elderly, and those with learning difficulties – have received £100 fines simply for ticking the wrong box on forms.

The number of fines issued went up 10-fold in the last 4 years, from 33,887 in 2012/13 to 365,181 in 2016/17, yet 90% of appeals are won.

NHS England has circulated a 'Don't Assume You're Entitled' campaign to NHS practices, and an official NHS Health Costs Twitter feed – meant to provide advice on claiming – is routinely discouraging claims, and using the hashtag #DontRuntheRisk.

Dentists have accused ministers of unwillingness to engage with hard to reach families, while pursuing low impact, unfunded initiatives preaching to regular attenders, as data also reveals over 4.9 million children (41.4%) failed to see an NHS dentist in the last 12 months. The NHS has spent £165 million on child tooth extractions in hospitals since 2012.

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

The British Dental Association's Chair of General Dental Practice Henrik Overgaard-Nielsen said: 'This huge fall in NHS attendance amongst patients exempt from NHS charges is the logical outcome of failed government policy.

'Ministers have created a hostile environment for vulnerable groups and those on low incomes who have a right to free dentistry. These patients, often with complex needs, require early intervention not the ever-present threat of fines.

'Sadly the government has shown no interest in getting hard to reach families to attend, when prevention could save our NHS millions.'

BDA renews partnership with Lloyd & Whyte

The BDA is delighted to announce a renewed partnership with financial service provider Lloyd & Whyte.

The renewal means Lloyd & Whyte will continue to provide bespoke financial advice to BDA members, with preferential rates, features and benefits available.

Matthew Pyke, CEO of Lloyd & Whyte, commented: 'This is a great sign of the support and recognition the BDA have for the partnership. The BDA contract secures the continuation of services for many years to come, which is fantastic news.'

New stats show Northern Ireland dentists are 'at breaking point'

The British Dental Association Northern Ireland has warned that general dental practitioners are 'at breaking point'. The comments were made as the dentists' trade union responded to the publication of NHS Digital Dental Earnings and Expenses, and Dental Working Hours reports that examines morale and motivation levels within the profession.

The reports highlight a number of stark findings among Health Service practitioners:

- There has been a drop in real incomes for practice-owning dentists of 38% since 2008
- Taxable income for practice owners in Northern Ireland has reduced by 15% in the last year alone
- 70% of practice owners, and over half of associates describe their morale as 'low' or 'very low'.

Commenting on the findings, Richard Graham, Chair of the BDA NI's Dental Practice Committee, said: 'This official data paints a particularly bleak picture of what GDPs in Northern Ireland have been warning about for some time. Nine years of successive government imposed pay caps, soaring expenses, increased regulation, the risk of litigation and rising indemnity fees - at the same time as direct cuts on the GDS budget - has created this downward spiral. The full financial impact, and the very real human impact is clearly evidenced by the government's own figures.

'The situation where high street dentists have suffered a real term 38% decline in income levels over the past decade, to the point where the majority question their future in the profession, is as serious as it gets.

'Our message to the Department of Health and the Health and Social Care Board at this time, is they need to act now to ensure the future sustainability of Health Service dentistry. Morale and earnings are at crisis point. Only meaningful investment in dental services, and the professionals who underpin these will safeguard a future for Health Service dentistry'.

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The power of reflection

By David Westgarth,
Editor, *BDJ In Practice*

Job interviews can be a cruel thing. For those who lack confidence and self-assurance, they can feel like a tortuous session. For those at the other end of the confidence scale, they can be a breeze.

Perhaps it's a British thing. We're not very good at talking about ourselves. Give me any questions about my education, my career to date, my achievements and anything else work-related and I can talk to you for hours. Ask me about myself and there's a tendency to quickly deflect a question back to other participants in the conversation.

And perhaps that's why I'm not alone in having the fear of God put into me by two questions interviewers have to ask and interviewees hate answering: what are your biggest strengths, and what are your biggest weaknesses?

Looking in the mirror

Almost everyone who has studied English has been warned about the way Brits love their manners. It is part of our national identity, as much as fish and chips or complaining about the weather. In 2011, the New York Bakery Co sampled 1,000 of their customers and discovered that we Brits say sorry up to eight times a day. It is that politeness that means we're not great at talking about our strengths and weaknesses – something dental practitioners and wider medical professionals need to overcome.

On 1 January 2018, the GDC started its new enhanced CPD scheme – eCPD. Based on a 'plan, do, reflect, record' approach, the GDC is now asking you to approach the CPD you choose in a more considered way and ensure it is relevant to your current or future practice. As Nick Stolls says in his editorial[1], '*presumably the aim is to allow the insight of mistakes made by a colleague through reflection to contribute to avoiding those mistakes in the future*.' It is the black-box thinking approach so successfully implemented in the aviation industry, so why does it work in healthcare?

In his book '*Black Box Thinking*', author Matthew Syed suggests 400,000 people die in America because of 'preventable medical error'. He highlights that mistakes don't need to happen and shouldn't happen, but they do – over and over again. In America, avoidable medical error is the third-biggest killer after cancer and heart disease.

> 'Based on a 'plan, do, reflect, record' approach, the GDC is now asking you to approach the CPD you choose in a more considered way and ensure it is relevant to your current or future practice.'

The numbers are equally shocking in the UK. Why is this suffering happening on such a large scale? Syed stipulates the answer is simple to state but complex to address: it's the inability to learn from mistakes.

The problem isn't confined to avoiding fitness to practise cases. Syed goes on to say evidence suggests indemnity goes down when dentists are open and honest with patients. It is the difficulty that talented, professional people have with admitting their fallibility: the threat to ego, to reputation, to vanity. It is the inability to self-reflect and do it accurately, the very antithesis of the British way, and it stalls progress being made.

Brought to prominence

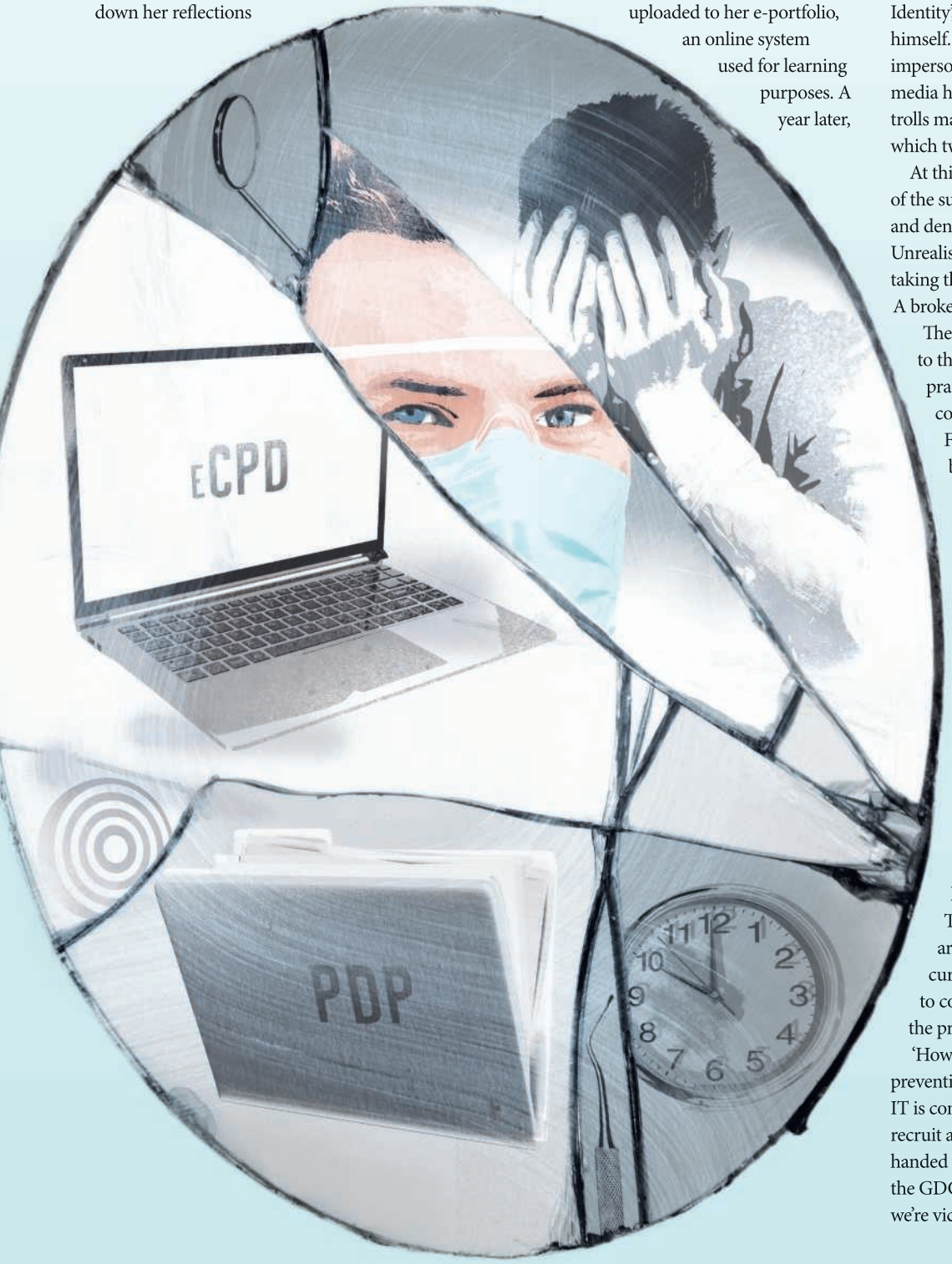
On the morning of 18 February, 2011, Jack Adcock was admitted to Leicester Royal Infirmary's children's assessment unit (CAU). 12 hours later, Jack was dead.

On that morning, trainee doctor Hadiza Bawa-Garba arrived at work expecting to be on the general paediatrics ward – the ward she'd been on all week. However, due to staff shortages, Dr Bawa-Garba volunteered to work on the CAU. This would be the catalyst for a

cascading number of problems that eventually led to Jack's death and a seven-year case that would change the way the medical profession operated.

On 25 February, a week after the passing of Jack, Dr Bawa-Garba met with Dr Stephen O'Riordan – the consultant who was supposed to be in charge that day, but hadn't realised he was on call and had double-booked himself with teaching commitments in Warwick and hadn't arrived at work – to discuss what went wrong. Dr Bawa-Garba was – at Dr O'Riordan's request – asked to write down her reflections about what went wrong, what she could have done differently and how things could be done differently in the future to prevent this from happening again. Dr O'Riordan took notes, which he then transferred to a training encounter form, which contained one section for Dr O'Riordan to write on and one for Dr Bawa-Garba to document her learning points and reflections.

However, as Dr Bawa-Garba didn't agree with all Dr O'Riordan said, she didn't sign the form. Nonetheless, both her reflections and the training encounter form were uploaded to her e-portfolio, an online system used for learning purposes. A year later, Dr Bawa-Garba was arrested on the suspicion of manslaughter.



Throughout the case the reflections of Dr Bawa-Garba were placed in the context of wide, systemic and systematic failings across the entire University Hospitals of Leicester NHS Trust, including a number of IT failures, staff shortages and unrealistic numbers of patients to be seen and treated throughout a shift.

The Spider-Man meme

There is a fantastic Spider-Man meme, derived from a 60s cartoon episode entitled 'Double Identity', where Spider-Man is pointing at himself. In the episode, a villain attempts to impersonate the hero. Only in the age of social media has this been used by pesky internet trolls making jokes describing situations in which two people who are very similar meet.

At this point, you could say the two identities of the superheroes – in this case – are doctors and dentists. IT failures? Staff shortages? Unrealistic numbers of patients? Individuals taking the blame for problems with the system? A broken system?

These are not new concerns being brought to the table. They are stories recounted by practitioners on a daily basis across the country about the state of UK dentistry. Faced with a demand to curb and slash budgets, is it only a matter of time before a Bawa-Garba style case hits dentistry?

I asked two practitioners, who, like the doctors approached by *Panorama* in the documentary about Dr Baw-Garba felt it necessary to remain anonymous as they had previously aired their concerns, whether reflective learning is going to bring about cause for concern.

'The system has been broken since the dental contract in England and Wales was introduced', one practitioner told *BDJ In Practice*. 'In all honesty, I am surprised something like this has not already happened. The day-to-day stress we as a profession are under is enormous. Mistakes in the current climate are inevitable, and talking to colleagues, it's a sad indictment of where the profession finds itself.

'How are we expected to deliver the preventive-led dentistry to patients when our IT is constantly under attack, when we can't recruit anyone to fill positions leaving us short-handed and massively over-stretched, or when the GDC either cannot or will not realise that we're victims of the system?'

Lurking in the background

It is that mis-trust in the GDC that may well make some practitioners think twice about how they approach their PDPs. Indeed, during a presentation at the recent Association of Dental Education in Europe (ADEE) meeting in Oslo, Jeff Lewis and Dr Kirsten Jack suggested students viewed reflective practice as a tick-box exercise that would detail what they thought their tutors wanted to read, rather than how they felt.[2] They went on to assess whether the arts were a more accurate way of reflecting how students felt, and all participants preferred this method to the traditional method of reflection.

If students – numb to the joys of the GDC – view reflective learning as a tick-box exercise and don't truly reflect their shortcomings or strengths, how would a practitioner with 30 years' worth of experience behind them treat it?

If, as reported in the Bawa-Garba case, the details of the conversation with Dr O'Riordan were made available during the resulting disciplinary and subsequent investigation, how likely is it that a professional is going to be entirely forthcoming in their personal development plans to avoid those very mistakes from occurring in the future? As Stolls suggests, '*If we are to genuinely learn from our mistakes then any response has to remain confidential with the colleague remaining confident that it will not be made available at a later date to wider authorities.*'

In light of this case the General Medical Council (GMC) are currently developing guidance on reflective learning to assist both clinicians and those involved in fitness to practise investigations. While the GDC reflects upon its position, the BDA has produced the following advice for members:

'The BDA's CPD hub provides a system of undertaking and recording verifiable CPD; it also includes a Word PDP which is simple to use. We do not provide an interactive PDP system as we believe that it is safer for members to keep in-depth reflective part of their CPD record separate from their PDP and log. The BDA prefers not to keep reflective details of members' personal development planning to ensure we avoid any danger of being asked to provide such information to third parties. We are aware that the chances of this are relatively small, but while ECPD is in its beginning phase, we will monitor how the GDC will exercise its right to view full CPD records (including implications for fitness-to-practise cases) in the future before we consider providing such products and holding such information.'

Following a government review ordered by former Health Secretary Jeremy Hunt, new measures were announced designed to improve patient safety and protect doctors and nurses when mistakes are made, with a clear focus that staff should be able to learn from their mistakes rather than live in fear of them.

One practitioner told me: 'GMC and NMC colleagues work under life-or-death pressures. While the same cannot be said for dentistry, it beggars belief that our regulator should adopt a heavier-handed approach than the aforementioned regulatory bodies.

'With the GDC lurking over our shoulders, why would anyone consider writing down their weaknesses on documents they could access? It boils down to a lack of trust – trust eroded away after years of mismanagement.

'Morale in the profession is at an all-time low for a reason. Increasingly I find myself coming in early, shaving time off my lunch hour and staying late simply to see patients, ensure my notes are done properly and prepare for the next patient. Not everyone is as thorough. Colleagues in community and hospital settings have more time on their hands and aren't under the same target-driven environment as I am in practice.'

> 'Austerity is meant to be over, but across the UK NHS dentistry is running on fumes. We've seen a drop in real incomes without precedent in the public sector. The results are predictable, morale at an all-time low, recruitment and retention problems mounting, as patients wait longer or travel further for care'

Broken system

Only last month The BDA expressed concern about the long-term sustainability of the service, with new data from NHS Digital showing that NHS dentists in England and Wales have experienced a 35% pay squeeze over the last decade.[3]

The unprecedented drop has seen real incomes for practice-owning dentists fall by as much as £47,000, and their associates by over £23,000 over the last decade. Costs facing individual practitioners for regulatory compliance and registration have gone up by 1000% in the same period.

Official data also shows morale and motivation among NHS dentists is now at an all-time low in all UK nations, with lower levels of morale linked to higher NHS commitments. The data shows a continued fall in the NHS workforce in England and Wales, with numbers at their lowest levels since 2010.

Research for the BBC has previously revealed that just 52% of NHS dental practices in England are accepting new adult patients, and just 60% accepting new child NHS patients. The Westminster Government's spend per head on NHS dentistry has fallen £4.95, from £40.95 to £36, in the last five years.

The BDA's Chair of General Dental Practice Henrik Overgaard-Nielsen commented: 'Austerity is meant to be over, but across the UK NHS dentistry is running on fumes. We've seen a drop in real incomes without precedent in the public sector. The results are predictable, morale at an all-time low, recruitment and retention problems mounting, as patients wait longer or travel further for care.

eCPD guidance

To assess whether the training or activities you plan to do are relevant for you consider how they will link to one of the four formal development outcomes. The GDC has stipulated four very broad categories:

A. Effective communication with patients, the dental team, and others across dentistry, including when obtaining consent, dealing with complaints, and raising concerns when patients are at risk

B. Effective management of self, and effective management of others or effective work with others in the dental team, in the interests of patients; providing constructive leadership where appropriate;

C. Maintenance and development of knowledge and skill within your field of practice;

D. Maintenance of skills, behaviours and attitudes which maintain patient confidence in you and the dental profession and put patients' interests first.

The letters A-D need to be indicated on provider certificates and on your log and PDP.

'Underfunding and failure to deliver meaningful reform has left the sustainability of this service in doubt. Matt Hancock pledged to put prevention at the heart of his approach to the health service. In the service's 70th year he must recognise that we can't have NHS dentistry without NHS dentists.'

BDA survey evidence corroborates the problem, with over two thirds (68%) of NHS practices in England who attempted to recruit in the last year struggling to fill vacancies. Half (50%) of the NHS practices who attempted recruitment reported issues in the previous year.

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

> 'There's a feeling that we have to use the bare minimum just to get by. I have reported so many issues with IT, only for them to fall on deaf ears. Any potential compromise in patient data should be treated seriously, and I simply do not believe that is the case, especially when money is factored into the equation.'

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

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

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

IT wise

The 'WannaCry' cyber-attack on the NHS last year caused a whole host of issues, primarily those associated with recovering the data. After the dust had settled, attention turned to how it was able to happen in the first place. Pointing the finger of blame does no favours, but highlighting responsibility and areas the NHS and other organisations has to improve on could not be swept under the carpet.

In fact, one of the trusts affected gave their version of events, and it was not the expected outcome. The Deputy Chief Executive of the Trust said in a video that she learned more about cyber security that weekend than she had ever expected to, and that crucially her and colleagues realised that this was a leadership issue rather than a technical IT issue.

A bold claim indeed, but how wrong was this assessment?

The weaknesses of the system have previously been highlighted by member stories about an increase in Ransomware. In 2016, Anwen Cope recounted how one Monday morning she tried to open up her computer, only to find things weren't as they seem.

'We opened our machines and everything we tried to open requested a password. We had been the victims of a ransom virus and that the criminals wanted $3,000 to give us the password. They had also deleted and encrypted all of our hard drives and memory storage devices that were on the server including the external hard drive back up.

'Our appointment book was booked up about eight weeks in advance. Many of our patients book their recall and hygienist appointments six months in advance too, and all of these appointments have been lost. In a nutshell, this means we don't know who is going to walk in through the door from one day to the next, which is not a good place to be in. We don't know which dentist they are expecting to see, what happened at their last appointment, what they are expecting to have done and on which tooth and so on and so forth.

'Needless to say, our UDA targets are all messed up and we will have lost a lot of UDAs because we don't know who was in on the days that we lost from the last transmission date. It's far more than just data. It's like a domino effect. One thing starts a chain reaction. We're still not fully recovered now.'

Whatever scale of digital engagement, from large NHS Trust to small independent dental practice, failings in IT systems add to the every-day pressures of practice. Surely IT systems are supposed to complement the work practitioners do rather than set parameters for the work they can do?

'Unless you're in private practice, I believe it becomes difficult to keep on top of IT', one practitioner said. 'There's a feeling that we have to use the bare minimum just to get by. I have reported so many issues with IT, only for them to fall on deaf ears. Any potential compromise in patient data should be treated seriously, and I simply do not believe that is the case, especially when money is factored into the equation.'

This very scenario suggests that digital leadership must come from the top. Digital leadership does not simply come by having a dedicated and highly expert digital and IT technical team – it is the management and oversight (and financial decision makers) whilst listening to those experts when they caution or escalate issues of security risk or outdated methods. Again, the similarities between the Dr Bawa-Garba story and the problems reported by the dental profession ring true.

There is a rare opportunity here for the GDC to take the lead. There is no doubt that the Dr Bawa-Garba case has shaken the foundations of trust within the registrants of the GMC. There is also little doubt that reflective learning and subsequent practice is of value to dental practitioners. But for there to be trust and for reflection to be useful, like the interview questions we hate to answer, we have to take a look in the mirror and talk about ourselves. Truthfully. With no apology necessary. ◆

BDA advice

The plan should be revised at regular intervals and updated with new areas as old areas are completed. It needs to reflect what is in the CPD log – don't forget that you will be making a legal declaration of hours to the GDC each year, so make sure you are aware of how much you've done in a year. Also bear in mind that a minimum-hours requirement is now in place – you cannot declare less than 10 hours in any two successive years. The PDP and your log can help you keep an eye on the hours and dates.

You can get a template in the BDA CPD hub online at cpd.bda.org.

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Contract reform – on the way?

By **Penny Whitehead**, Head of Policy and Research, BDA

As you will know, since 2011 the Department for Health and Social Care (DHSC) has been testing elements of a reformed NHS contract in England. It is now clear that, potentially, a reformed GDS/PDS contract could begin to be rolled out from April 2020.

It is very clear that NHS – and specifically general dentistry – is in crisis. A shortage of associates willing to work under a UDA contract, rising clawback as practices fail to meet their UDA targets, high stress and burnout and falling morale and motivation – it's a perfect storm. Research by the BDA has shown repeatedly that the NHS is the major cause of the current situation. We have pressed Government and NHS England again and again on the need for change now to support practices and break the cycle of the current system. It is still not certain that a reformed contract would improve the system, but with the right arrangements in place and a plan for future improvements it might very well help the current dire situation.

In 2018 and early 2019 up to 50 more practices will join the prototype programme and begin using the prevention based clinical pathway. The practices will be either Blend A, where Band 1 care is delivered under capitation, or Blend B where Band 2 and 3 care is delivered in this way. Activity is still measured by UDAs but with a reduced target. The evaluation of the 2016/17 financial year found that those practices joining the programme in 2016 who had not been previous pilots were – in the main – fairly happy with the new way of working. The capitation system being used is based on the number of patients seen by the practice in the previous three years. Managing the contract is based on keeping patients on the correct recall interval and recruiting new patients for those that have lapsed.

> 'We do not know yet what mixture of capitation and activity will be rolled-out or whether there will be two models. Our view is that capitation is better for prevention and we want as much capitation as possible in the mix.'

In order to start a staged roll-out in 2020/21 a lot of work is needed to agree and then negotiate the changes to the current contract. The length of the capitation period, whether or not capitation will be weighted to reflect treatment need, what will be the blend of capitation and activity – these are all questions that remain to be answered.

The DHSC has made it clear that it does not want a 'Big Bang' as occurred in 2006 and that roll-out will be staged. We agree but what might a gradual roll-out mean? One way which seems attractive is for practices to volunteer. This means those that are at a stage where they can see the benefits for themselves and their patients can take part and gradually over time more and more NHS practices will be in the new system. We have asked the DHSC to give all current practices their numbers for the current Blend A and Blend B situations and, if roll-out was on a voluntary basis, this would have to be the case. For some practice owners, the prospect of changing working practices and investing in clinical IT systems may not make sense and we believe they should not be forced to change. For associates, some may prefer to remain in the UDA system, particularly if they have a reasonable UDA value and an achievable target.

We do not know yet what mixture of capitation and activity will be rolled-out or whether there will be two models. Our view is that capitation is better for prevention and we want as much capitation as possible in the mix.

As far as NHS practices are concerned, at this stage it is sensible to look at recall systems to ensure regular patients are returning within their NICE recall periods. There are still some unknowns and as always with general dental practice it is sensible – where possible – to have a mix of NHS and private care. One of the biggest issues for prototypes is associate payment and we have been pressing the BSA to ensure that their systems make it as easy as possible to pay associates and to deal with situations such as sickness and maternity leave where patients will need to be transferred between performers.

As always, if there are any further developments, we will keep you informed across all of our platforms. ◆

Don't cross GDPR off your 'to-do' list

Ian Dalton, Head of Operations and Support for *Software of Excellence*, discusses the immediate impact on the dental profession and warns practitioners not to think the issue has now gone away.

Ian Dalton
Head of Operations and Support, Software of Excellence

Many UK dental practices left it until very late to communicate with their patients in the run-up to GDPR. Speaking personally, Software of Excellence experienced a huge wave of interest from dentists wanting to send consent e-shots to patients. In fact, in the weeks leading up to 25 May, we received over 1,500 unique enquiries about all aspects of GDPR, so it is clear that the profession has taken the new regulations very seriously.

But even for those practices that have embraced the regulations, it's important to understand that GDPR is not a one-off task that can now be forgotten. It is an ongoing commitment, and remaining fully compliant should be part of every practice's patient journey protocol. Processors must keep records of all their processing activities and maintain disclosure readiness of this information in order to demonstrate compliance.

As has been stated by the Information Commissioner's Office (ICO), *'The changes reflect a more dynamic idea of consent: consent as an organic, ongoing and actively managed choice, and not simply a one-off compliance box to tick and file away. There is no set time limit for consent. How long it lasts will depend on the context. You should review and refresh consent as appropriate.'*

To ensure this ongoing process is maintained and followed it's vital that the whole team is fully trained, understands why and what they are doing, which systems they are using and what the desired outcome will be. Again, this is an ongoing commitment and I know that many dental practices are still getting to grips with the changes they have introduced in promoting their services to patients. We are still receiving over 50 GDPR enquiries every month so it's clear that dentists are still concerned about their compliance.

'Legitimate interest' boundaries unclear

Since May there has been a lot of discussion around the topic of 'legitimate interest', with some practices believing that this aspect of GDPR precludes them from the need to gain specific consent from patients for sending marketing materials – I disagree with this interpretation.

A 'legitimate interest' does indeed give dentists the right to communicate with patients in regard to recalls and reminders and Software of Excellence has been very clear about this from the outset. However, when this communication strays into the realms of whether a patient might wish to take up an elective treatment or offers a discount on whitening, then in my opinion this is taking legitimate interest too far.

It's true that the Information Commissioner's Office states that a wide range of interests may be 'legitimate' for processing purposes. They can be your practice's interests or the interests of a third party and represent commercial interests as well as wider societal benefits. If a dentist chooses to rely on legitimate interest, they must take on the extra responsibility for ensuring people's rights and interests are fully considered and protected.

The fact that commercial interest is a legitimate business interest, does not excuse the violation of someone's privacy. GDPR is all about putting people in control of what they do and do not want to receive from you as a business and allowing them the right to give and withdraw consent is a fundamental tenet of the regulations.

Under GDPR, consent refers to 'any freely given, specific, informed and unambiguous indication of the data subject's wishes by which he or she, by a statement or by a clear affirmative action, signifies agreement to the processing of personal data relating to him or her.' This means practices need to demonstrate that positive consent has actually been provided and need an active process by which consent can be given, withdrawn and logged.

Breaching protocols

At the top of dental practitioners' GDPR compliance checklist now must be the capability of meeting breaching protocols. A major change under GDPR is that data breaches must now be reported to the regulator within 72 hours of becoming aware of it, and those affected must be informed, pending conditions. So, practices must now have in place clear, practical and effective procedures that can be immediately acted upon.

We have deconstructed the breach definition and created a 3-tiered framework that helps practices classify the type of breach and helps them to determine whether it is reportable or not (Fig 1).

The severity of the breach determines whether it is reportable or whether it only requires an internal change of process or re-training. Of course even a minor breach should be documented, as should the action which is subsequently taken (Fig 2).

What now?

Amidst the flurry of activity leading up to 25 May, many practices lost sight of the fact that much of the work required to comply with GDPR was in fact already being covered under their day-to-day data protection processes and simply required clearer documentation and updates to fair processing notices.

Complying with GDPR needn't be an onerous task but practices should be vigilant in terms of maintaining their focus on consent and documentation. It should also be remembered that there are two aspects to compliance – for patients and for employees. However both areas must be regarded as ongoing tasks and in this way you can ensure compliance with minimal disruption to the day-to-day workings of the practice and reduce the administrative burden on the front-desk and management teams.

Additional information is available at ico.org.uk/for-organisations/guide-to-the-general-data-protection-regulation-gdpr/ ◆

For more information on how to gain and document patient consent, visit www.softwareofexcellence.com or call 0845 345 5767.

Members can find out more about the BDA's GDPR policy at www.bda.org/gdpr

Fig 1 Reportable or not?

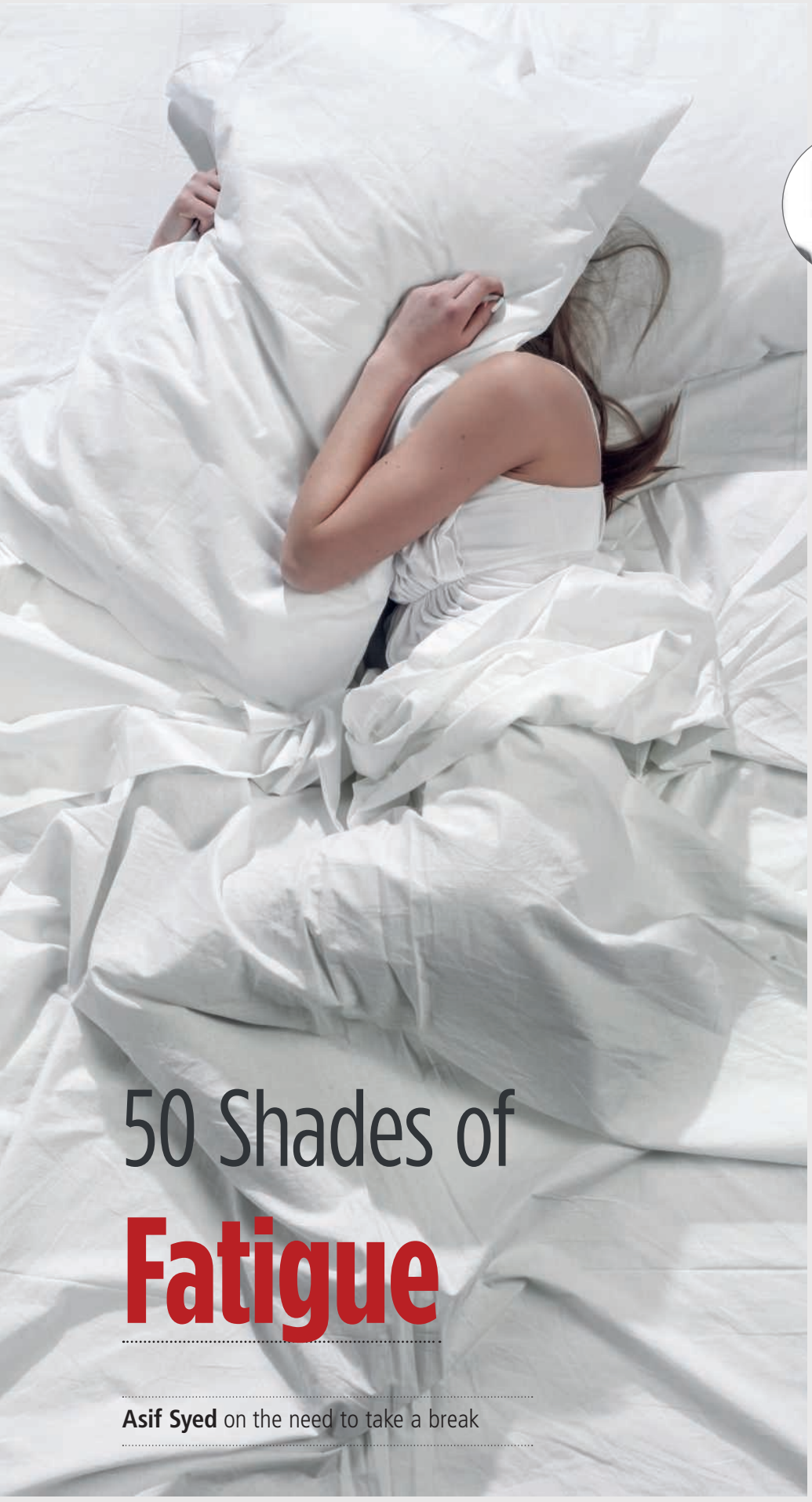
A4.12 – 'personal data breach' means a breach of security leading to the accidental or unlawful destruction, loss, alteration, unauthorised disclosure of, or access to, personal data transmitted, stored or otherwise processed.

Context				
accidental		unlawful		unauthorised
Type				
destruction	loss	alteration	disclosure	access
State				
transmitted		stored		otherwise processed

Fig 2 Breach and action

			Risk Rating = Likelihood x Severity				
Severity of impact on rights and freedoms of a natural person	Catastrophic	5	5	10	15	20	25
	Significant	4	4	8	12	16	20
	Moderate	3	3	6	9	12	15
	Low	2	2	4	6	8	10
	Negligible	1	1	2	3	4	5
			1	2	3	4	5
			Improbable	Remote	Occasional	Probable	Frequent
			Likelihood of risk to rights and freedoms of a natural person				

Risk Category	Risk Level	Action
Extremely High		Emergency action required to control the present and future
High		Urgent action required to mitigate the present and future threat
Moderate		Some mitigation and risk avoidance likely to prevent reoccurrence
Low		Monitor and consider mitigation
Very Low		No further action likely



50 Shades of Fatigue

Asif Syed on the need to take a break

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.

I remember my first day as an associate. I turned up in a crisply-ironed shirt, freshly polished shoes, and a brand new briefcase with nothing inside – I was ready for the world of work. After 8 hours, 25 patients and no lunch break, I returned home defeated with alginate on my trousers. By dinner time, I was fast asleep on the sofa, and by 9:30pm I was already in bed.

I doubt my experience is unique, but I do recall it was a rite of passage – something to look back and smile about. But the smiling seems to have stopped as a phenomenon is engulfing the profession that you may have noticed too: dentists up and down the country are exhausted.

In the last month alone, no less than a dozen GDPs have confessed to me their working pattern is unsustainable, their motivation evaporated, and they regularly fantasise about winning the lottery.

Even accepting that the delivery of dentistry has intrinsic demands, such as the intense bursts of absolute focus and the emotional management of the patient. This testimony is at odds with the bright individuals who toiled for the best part of a decade to register themselves as dental surgeons.

Deeper conversations with dentists have cited the addition of recent pressures as the catalyst for this sense of depletion, so I have categorised these into ten broad categories:

1. **Threat of litigation**: UK Litigation has doubled in the last decade with many DFT course organisers expecting their younglings to receive a formal complaint within the first three months of general practice.
2. **Patient demands:** Both NHS and private patients now have increasing access to information turning them into the most

discerning dental purchasers in history.

3. **Narrowing finances:** Enthusiastic dentists face a financial landscape of immense university debt, falling associate percentages and shrinking dental practice margins, as the BDA reports that real dental income has not risen in a decade.
4. **Target driven work:** The NHS contract has ensured that 'targets' have fallen seamlessly into NHS dental practice lexicon, and are now being adopted by private practices as they increasingly place their workforce under metrics to make ends meet.
5. **Patient numbers:** NHS practices believe seeing more patients is the surest way to fulfil their contracts, and private practices believe that finding more patients is the surest way to long term success. However, speeding up is also the surest route to fatigue.
6. **Team toxicity:** The weight of increasing demands on general practice often falls directly on auxiliary team members who may not be equipped to deal with the burden. This can result in broken bonds and caustic relationships.
7. **Ruthless regulations:** In his excellent 2015 paper *'Quis custodiet ipsos custodes'* (who will guard the guards?) Martin Kelleher, consultant in restorative dentistry, detailed the 'labyrinthine' conflicting doctrines of overbearing regulators. The sum result is a maze of bureaucracy which is too difficult to understand but too easy to fall foul of.
8. **Increased competition:** A profession once built on collaboration is acceding to one built on competition as dentists elbow each other for DFY1 posts, associate jobs, practices, patients and even courses.
9. **Deferential differentiation:** Modern dentists are now required to manage their entire career journey with a new skill set not passed down by their predecessors. For example, 'Do I specialise?' is now a serious consideration for the majority of new graduates.

'NHS practices believe seeing more patients is the surest way to fulfil their contracts, and private practices believe that finding more patients is the surest way to long term success. However, speeding up is also the surest route to fatigue.'

10. **Social media:** In a 21st century issue, the vocal few may accidentally antagonise the silent many with glimpses into a carefully crafted, yet impossibly glamorous lifestyle, with all the clinical cases to match. Negative comparisons can form an echo chamber of pessimism from which it is difficult to escape.

Delivering dental care whilst contending with the above is draining practitioners' finite energy resources. Although these evolving challenges are well documented, the dental profession continues to offer its traditional response: work harder for longer.

This continued stoicism in the face of adversity is admirable, but a fault line is appearing across the profession as even the most talented find themselves running on empty. Put simply, even when the hours are worked, there is decreasing amounts of energy left to make them count.

Fatigue may be hard to read but one of the leading indicators is a sharp increase in negativity which only hints at deeper dangers. It would be prudent for responsible dentists to be wary of the following potential sequela of fatigue:

→ **Persistent negative emotions:** It is healthy to experience a wide range of emotions but when negativity such as anger, frustration, and disappointment persist for long periods of time it can make those affected act out of character, displaying insensitivity, impatience and paranoia. This is destructive not only to the dentist, and their own quality of life, but to the very support staff they count on for assistance

→ **Impaired decision making:** There is a finite number of good decisions any one person can make per day. Once this is exhausted the individual makes decisions of deteriorating quality, which has aptly been recorded as 'decision fatigue'. When dentists work in increasingly complex environments they can use up their decision-making capability early in the day/week, resulting in increasingly erratic instructions

→ **Susceptibility to unethical behaviour:** In perhaps the most worrying casualty of fatigue, research by many, including associate professor CM Barnes of Washington's Foster School of Business, has concluded that fatigue leads to increasingly unethical behaviour. It appears that victims lack the reserves of mental energy required to resist the temptation of shortcuts.

Table 1 How many shades of fatigue?

Emotion	Score	
BALANCED	0	I am done for today but I'll be ok tomorrow
TIRED	10	Irritable & short tempered
DRAINED	20	Seeing problems not solutions
EXHAUSTED	30	Continuous moaning
FIREFIGHTING	40	Reactive and feelings of isolation
DESPAIR	50	Gloom & impending doom

Further along from fatigue, the individual may fall into the clinically defined pathologies of burnout, depression, mental breakdown and suicide. These are serious threats facing modern dentists so the battle lines should be drawn at fatigue. The frontline in the fightback against fatigue is to assess your own energy levels using the framework in Table 1.

As you have no doubt noted, you can score yourself anywhere between 0 and 50, resulting in up to 50 Shades of Fatigue. As a guideline, those dentists new to the framework typically have an initial score of: young dentists 28, associate 33, principals 40.

Having used this framework to help dentists beat fatigue, I would like to suggest five actions which can help to protect energy, improve focus during clinical hours and increase empathy, which in turn brings better team relationships, happier patients and ultimately enhanced revenue.

- **Experiment** Energy levels are entirely subjective so it would be wise to discover your own rhythm. This can be achieved by recording a simple daily energy score out of 10 on the daysheet. It is not uncommon for GDPs to find their initial scores are between 2-5. If this is the case, it is worth noting that this score is unsustainable without cost. Next would be to experiment by introducing simple single changes such as: caffeine intake, hours slept, hours of *Netflix* watched, foods eaten, social engagements a week, gym training sessions, ensuring all team members are greeted positively each morning or increasing the number of 'thank you's a day. These are all real-life examples which have made a profound difference. It is likely that you will discover your own energy influences through experimentation, rather than logic. During this process resist being blinded by one major factor such as 'my nurse', 'my surgery', 'my principal' or 'my patients'.
- **Approach** As pressures increase, decide to put some time aside to meet those pressures. I suggest GDPs should allocate two hours a week of non-clinical time to use their proven intelligence and creativity to identify solutions. In its simplest form these two hours can be used to review your collected daysheets to apply the 80/20 rule: 80% of your energy drain will come from 20% of your issues. Oftentimes, the identified issue looks unsurmountable at first glance.

> 'Holidays should be an opportunity to recharge energy and return as a better dentist, not a temporary escape where energy is exhausted within days of return.'

However, if you spend 2 hours a week at 46 weeks, that's 92 hours p.a. on this one main issue, it is unlikely that you will not have made significant progress. Instead of learning to complain, learn a solution-seeking capability. Not only would this be a shrewd career investment, the emerging sense of control will prove a striking energy boost.

- **Vacation** Holidays should be an opportunity to recharge energy and return as a better dentist, not a temporary escape where energy is exhausted within days of return. If this is the case, continue to work on the above, but also check your holidays are allocated correctly. Holidays should not be planned once you are already exhausted; this will ensure you stay in exhaustion for another six weeks until the flight leaves. This extra six weeks of exhaustion means your upcoming one week holiday is no longer sufficient and triggers another cycle of fatigue. Instead, roughly plot your allocated holiday allowance on an annual basis using coloured Post-its. Ensure there is some break planned every three months, using both your big break and bank holidays wisely.
- **Peer group** Jim Rohn said '*you are the average of your 5 closest friends*'. If your friends are caught in a cycle of negativity, it is unlikely that you will escape. Help your friends out by forming an accountability group to get issues – such as energy – handled. Failing this, find a teacher on a course, locate a mentor who can advise, and be brave enough to step outside your friendship group to bring in new influences. It has never been easier to connect with the right people for you.
- **Schedule** Energy is not equal. Humans respond to their daily cycle of energy involving two peaks and two slumps – called their circadian rhythm. The timings of this can vary considerably between individuals and can vary again over the week. This means not every dentist is suited to working 9-5 from Monday to Friday. Some work better on four longer days, others prefer working evenings, and a few love Saturdays. Long term, the biggest energy boost for dentists is finding a schedule that allows them to perform at their best.

Adding these five actions into your clinical practice will add energy over time, which you may reassess by returning to the '50 Shades of Fatigue' framework.

However, there is a final fallacy that I wish to uncover. I see many GDPs casually trading energy in the pursuit of revenue. This forms a trap where more fatigue is required for more revenue. This distracts dentists into a dangerous downward cycle, resulting in an inevitable system crash before the same unsustainable system is rebooted.

So, this is the final fallacy; increased revenue does not bring increased energy. It is enhanced energy which brings enhanced revenue. Of course, testing the preservation of energy is the only way to be sure. In short, don't go to work with an empty briefcase. ◆

Reap the rewards of Goodman Grant's combined legal and brokerage services

Owning a dental practice nowadays can be fraught with challenges, with day-to-day issues arising from staff and employment issues, regulatory compliance, and the achievement of NHS contract targets – all whilst you strive to continue to delivering exceptional patient care.

However, when faced with situations that require more than your clinical expertise, who do you entrust to give you the best possible advice, support and, more importantly, resolutions? There are many self-professed 'experts' in the field of dentistry, but just how do you identify the truly competent?

Richard and Anne Stevenson faced such a dilemma recently. Having owned a practice for many years – which was located in a 'character' building that presented its own challenges – the impending changes in healthcare regulation and registration criteria meant that the practice premises would now prove unsuitable to continue as a working dental practice. Richard and Anne, therefore, found themselves in the unfortunate position where they would be forced to consider a costly relocation of the business less than a year before their planned retirement date, or indeed to consider the option of just 'closing the doors'. At that point, they had six months to find and implement a solution.

Anne recalls: "For the first few months, we attempted to sort this out ourselves and had been put in touch with a dentist locally who had indicated that he might be interested in purchasing the patient list alone. However, matters were slow to progress and his practice was a few miles away in a different town."

With a very loose agreement for the deal verbally agreed, and concluding that the perhaps less than favourable terms offered were going to be the only option available to them, Anne and Richard decided to contact Kate Beech at Goodman Grant for specific legal advice on their proposed transaction, including the handling of their existing lease and to establish their employer obligations to their loyal staff of many years.

That initial phone call, according to Anne, was "the best thing we had done". With only three months before the practice would be forced to close its doors, Kate and the legal team at Goodman Grant jumped into action to assess the lease position and to advise on the regulatory requirements for handling the potential closure of the practice – including specific employment advice in relation to each employee.

Crucially, the legal team also recommended that Anne and Richard speak with Goodman Grant's in-house Business Services team to ascertain if their privately negotiated sale terms were, indeed, commercially viable, and to see if there were any alternative possibilities.

After a quickly arranged consultation with Heather Meakin, Anne explains: "We were very relieved to hear that she thought that it was still possible to affect an alternative sale option during such a tight timescale. Heather worked tirelessly on our behalf and was able to find another buyer for us."

As an added benefit, the sale negotiations with the new buyer also included an agreement where Richard was able to merge with the new buyer's practice to assist with the transition of patients, thus allowing him to continue his earning potential as an Associate for at least a year post-completion. This would take him to his planned retirement date, but with the option of extending those timescales at the appropriate time if he wished.

Richard comments: "There were some problems along the way as the original deal brokered fell through with only seven weeks to go. However, Heather's perseverance and optimism helped us all the way through and a replacement deal was quickly made with yet another buyer that Heather had found using her highly confidential buyer sourcing techniques."

With the new deal offering an immediately available surgery in an unbelievably close location, with excellent clinical facilities from which to operate, Richard was delighted that the disruption to his patients would be absolutely minimal. Timescales were an obvious concern due to the looming deadline and the deal needed to progress quickly.

Anne continues: "There was so much legal work to be done and Kate, Ben, Caroline and the team were all professional, helpful and friendly – always available by phone or email and very often outside of working hours. We really appreciated everyone's expertise and efforts on our behalf to ensure exchange and completion happened in time."

The benefit of having a commercially focused in-house broker team working alongside the legal team was never more evident. With an ethical obligation as a law firm to act in the best interests of its clients at all times, Goodman Grant are always determined to provide the best solutions and outcomes.

The seamless co-operation and transition of work between the two expert areas within just one firm meant that Richard and Anne witnessed the benefits of all elements of their transaction being skilfully managed on a commercial and legal basis. As a result, they experienced an exceptional level of client care. On completion, Richard and Anne reflected that the successful sale which was negotiated and legally executed on their behalf by Goodman Grant was indeed the perfect solution for them.

They say: "We have no hesitation in recommending the services of Heather and the legal team at Goodman Grant – we literally could not have done it without them! For anyone thinking of selling a practice, our advice would be to give yourself a lot more time to accomplish this than we did – and to use the experts at Goodman Grant."

Anne and Richard Stevenson

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Changing with the times

Mark Topley on the need for dental practices not to rest on their CSR laurels

The times they are a changing. And no more so than in dentistry, particularly when it comes to the place of the dental practice in local communities.

In many towns across the UK, the traditional 'family' dentist is already a thing of the past. In fact, it's not just dentistry that has felt the sting of corporatisation and the growth of chain stores over the local independent – cafes, restaurants, clothing stores and grocers have all but disappeared or are doing battle to stay alive.

A few weeks ago, a flyer was dropped through my door and also appeared on my social media feeds. It advertises a new campaign from a local independent estate agent offering to profile local businesses and groups on its website. The idea is to give potential new residents a view of the area they are considering moving to, including a better idea of the independent, local businesses they could frequent.

In my view, it's a good move. This particular agent has always struck me as a genuine, authentic local business, with roots in the community and a love of where they live.

As Howard Schultz says, '*Authentic brands aren't created in marketing cubicles or advertising agencies, but in everything that a company does...*' The key, now, is for this estate agent to follow through. They've created a way to connect to the community, but they need to maintain that connection through this, and other ventures.

In reality, this is what a Corporate Social Responsibility (CSR) strategy is all about – not just the initial goodwill gesture, but the follow through that connects the business to the community they serve.

What this estate agent does next will determine whether this genuinely helps local businesses (including their own), or whether

it peters out and becomes just another fake attempt to use CSR to get an edge. Personally, I'm hopeful the campaign will do well and add genuine value to the local area, in however small a way it might be.

I expect to see more of this kind of initiative in the coming months, on both local and national levels in all industries. It's no secret that consumers are demanding that the businesses they deal with have a view to improve society, and those who want to stay in business are looking for ways to meet this demand.

Consumer demands

Though many of us have witnessed the changing perceptions in the way the public expects businesses to give back and be good world stewards, it hasn't been obvious to everyone until recently.

Earlier this year, a letter from Laurence Fink, Founder and Chairman of BlackRock, to the CEOs of some of the world's largest companies was published. If business owners didn't believe in the necessity of CSR before, this letter should change their minds.

BlackRock, as you may already know, is one of the largest investment firms on the planet managing around $6 trillion of capital. Their sole focus has always appeared to be to generate a return for investors. This letter changed that.

In the letter, Fink sets out a very clear message to global business – our clients demand that you demonstrate social good. If you don't, we can't continue to support you.

So, what about dentistry?

Well, for independent dentists looking to differentiate from other practices in the eyes of the consumer, this shift in consumer expectations creates an opportunity to stand out strongly from the competition. They can use their personal ties to the community to create opportunities to engage, and support organisations that matter to their clientele and prove that they go above and beyond for staff and the environment. Without corporate guidelines in place, they have the flexibility to create a CSR strategy that fits both their business values and vision, and the community.

Corporate dental practices will have the challenge of following corporate guidelines while still finding ways to connect to the causes that matter to the community. They must prove that they are more than just the national brand, more than just a corporate giant who cares only for profit. A strong CSR strategy can bring about real change for your business way beyond just a little 'feel good' moment.

Positive PR and a boost to reputation

A dental practice won't grow if it doesn't have a good reputation. CSR provides opportunities for good PR to positively affect what the community thinks of your practice.

Chipping Manor Dental Practice in Gloucestershire started out doing small fundraisers, but quickly developed a strategy to support local schools, provide grants, and assist staff to volunteer overseas with Bridge2Aid. Holding large and small fundraising events, they contributed huge amounts of money to causes that aligned with the values of the practice. They then promoted their events and the outcomes through press releases and word of mouth.

The results were impressive. The practice grew to have four times the number of patients expected for the town in which they were located. They had a lower attrition rate compared to the dental average, too. Shaenna Loughnane, who was owner and practice manager, said to me: 'I truly believe that without CSR being at the heart of all that we did, the business wouldn't have grown as quickly, and as positively as it did. The shared sense of purpose, vision, and care for their fellow human beings brought the team together in ways we couldn't have imagined, and brought the practice right into the heart of our community.'

Strengthening patient and staff relationships

CSR activity builds rapport and engagement within your team, and between staff and patients. It also gives patients a chance to make a contribution and educates them about the causes.

Zaki Kanaan and I climbed Mount Kilimanjaro in 2011 in support of Bridge2Aid. I asked him how it made an impact on his practice. He said: 'In the run up to doing Kili it was a constant talking point between, not just myself, but also the rest of the team, even those that weren't doing it. In fact, it was much easier building a rapport with patients during this period.

And on top of the patient relationships, having staff take part in events together will bring your team together in ways that a night out after work or a lunch treat just can't.

Doing it well creates bigger impact

Simply put, well organised events, clearly communicated, raise more. Being intentional about causes and making a longer commitment means you get more value, and the charities will thank you for helping them plan for the work they can accomplish. Your team will also get a boost from seeing the difference that their involvement is making to the organisations you support.

How one practice is incorporating CSR

The Campbell Clinic (TCC), in Nottingham, has been including CSR as part of its core business for a number of years, and has partnered strategically with good causes, notably The Friary – a homeless project in Nottingham – and Bridge2Aid. Since 2008, TCC has donated 1% of turnover to a charity fund, and run an annual fundraising ball, the Campbell Giving Ball.

However, they realised that they were missing some areas of CSR but weren't sure how to get to where they envisioned themselves. Together, we worked to create their vision and narrow down their three-year aims with the goal of putting a 'Gold Standard' CSR strategy in place that would address good causes, the community, TCC people and the environment. To avoid the previous disconnect between policy, practice and staff engagement, we created a Community and Charity Team to execute the strategy and engaged staff in a year-round plan.

It's exciting to see teams draw together when the leaders of a practice bring CSR to the table. We're looking forward to seeing the impact that their new CSR strategy has on their team, the community and their practice.

So, what now?

It's not hard to make a difference in your business – get clear on our values and vision, make a commitment, bring your team with you, and plan and execute systematically.

What this is actually about, then, is leadership, environmental responsibility, integrity, and smart, authentic marketing for the 21st century – if that's what you want, then CSR can help you achieve it. ◆

Mark Topley is a CSR Coach, helping dental practices and businesses to maximise impact from their CSR. He writes at marktopley.co.uk, and provides free articles and advice on his Facebook page – facebook.com/toppernator, Twitter @Mark_Topley

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A stressful profession

Trevor Collins,
Clinical hypnotherapist

As dental professionals you are fully aware that pressure is part of the job. And that feeling of pressure may be there from the start to the end of your career. Given this, it's obvious that prevention is key, as is knowing how to manage the repercussions of stress and acquiring the tools that will help when new issues arise.

Fortunately, society has developed to such an extent that we are now in a position where discussing mental health issues is acceptable. This is unequivocally good news for the millions who suffer, especially those who in the past would have done so in silence. In fact, one in four people in the UK experience mental health problems each year, and one in six in England report a common problem such as anxiety or depression in any given week.[1] According to MIND, the UK's leading mental health charity, mental health issues include anger, anxiety, loneliness, stress, seasonal affective disorder (SAD) and self-esteem concerns.[1] With so many commonly-encountered issues impacting on our mental health, it's essential that we recognise and deal with these issues as early as possible.

Highlighting the extent of the problem even further, the independent Mental Health Taskforce, formed in 2015, brought together healthcare leaders to produce a five year forward plan for mental health care in the NHS in England. They reported in their first year that £105 billion was being lost by the UK economy annually as a result of mental health; is a sum similar to the total annual cost of the entire NHS.[2]

Mental health issues in the medical professional, and specifically with dental professionals, are well documented; many of the top 10 lists of the UK's most stressful jobs include dentistry and the Office of National Statistics (ONS) last year stated that dentists, amongst a small number of other professions, had an increased risk of suicide.[3]

Mental health issues can present themselves from a young age and there are numerous studies that have documented the pressure dental students are under. One recent study noted the high occurrence of depression, anxiety and stress. This highlights the importance of providing support programmes and implementing preventive measures at an early stage.[4] If not recognised and dealt with, once in practice, regulation, patient expectations and the fear of being sued could cause a perfect storm for stress to occur. Following this path, dentists could find themselves in a position where they have to retire early due to ill health. And the link between one's professional status and sense of 'self' is already well established.

Last year nearly 15% of all claims paid by Dentists' Provident were for psychiatric disorders which cover a range of conditions such as work-related stress, fatigue, neurosis, depression, and anxiety with over £650,000 paid out in claims for these issues that dentists have had to take time off work for.[5] Examples of recent claims include a young dentist in their early 30s who experienced work-related stress and an older member who began suffering from depression as a result of selling their practice. Dentists' Provident supported both of them for nearly three months before they could return to work.

Prevention and solutions

How you deal with feeling overwhelmed or stressed with life and work can be very personal; from taking the dog for a walk, going for a run, having a relaxing bath, reading a book, listening to music or trying to get more sleep. Some people try more pro-active techniques that can offer stress prevention, such as yoga, the Alexander Technique, meditation and mindfulness.

But when things aren't working so well on a preventive front, you know only too well in your profession that you have to start intervening. If you visit a GP they may suggest a more active approach, some prescribing anti-depressive drugs, while others may recommend the NHS approved Cognitive Behavioural Therapy (CBT).

The NHS describes CBT as 'a talking therapy that can help you manage your problems by changing the way you think and behave. It's most commonly used to treat anxiety and depression, but can be useful for other mental and physical health problems.' CBT is highly structured and needs the complete commitment of the participant to effectively deal with the issue at hand.

Sarah Bradbury from Dentists' Provident, keen to explore potential ways to support dental professionals, spoke to **Trevor Collins**, a clinical hypnotherapist, about the various approaches and what he recommends for dental professionals.

Trevor said: 'What you choose to do and what works for you can be very personal, and talk therapies such as CBT are very useful, as talking about an issue, whether it is to a friend, family member or therapist, in itself, can be very therapeutic.

'The advantage of talking to a professional and stranger is the chance for objectivity, without opinion, within a more structured framework for your thought processes. It can be very valuable for you to be assisted in seeing things from a different point of view and putting it into perspective. However, its true value can be limited when you are addressing issues of the subconscious that are deeper and more embedded and you may not be aware of the cause.'

Hypnosis, is a practise that is becoming more popular and being offered in some dental practices with many practitioners undertaking courses to provide the service for patients suffering conditions such as fears and phobias, gagging and bruxism.[6] Hypnosis has been around for centuries with its scientific history beginning in the late 18th century with Franz Mesmer, a German physician who used hypnosis in the treatment of his patients. His methods, called 'mesmerism' continued to interest medical practitioners. Then in the middle of the 19th century, the English physician James Braid studied the phenomenon and coined the term hypnosis, after the Greek god of sleep, Hypnos.

Trevor explained its working in more depth.

'Hypnosis is essentially focussed relaxation, where the therapist can employ hypnosis 'suggestion' or 'analysis' to the client in a subconscious state, in order to assist themselves to resolve their presenting problems or unwanted habits', he said. 'Habits such as nail biting and smoking have an estimated 70% success rate. More complex issues such as extreme anxiety or panic attacks respond very well with hypno-analysis.

'Its downside is that it can be a very lengthy process that is then costly to the client and it also can be a bit hit and miss. When a client is in their relaxed state the therapist has no true control over what they are thinking. It could be what to have for dinner or about a difficult patient tomorrow which means they could lose focus and therefore the benefit of the hypnotherapy.'

Trevor then moved on to explain a newer therapy, Brain Working Recursive Therapy (BWRT) and how it was discovered.

'It was pioneered by Terence Watts, a UK-based hypnotherapist with his research partner psychologist, Rafiq Lockhat. Terence was aware that the brain has an ability to identify stimulus in the form of 'brain patterns', that if we recognise a situation our subconscious triggers an automatic response, a third to a half a second before you actually become consciously aware of it; that's assuming your brain was going to make you consciously aware of it. If this automatic response is an erroneous or out of date response to a 'perceived threat' from a much earlier time in your life, then again before you have a chance to make a conscious decision about how to respond, your brain has already triggered the 'fight, flight or freeze response', commonly experienced as stress, anxiety, fear, anger, frustration self-doubt, panic attacks, sweating, shaking, generally unwanted functioning, thinking and or behaviour.

'Most of us tend to have picked up some reaction or behaviours that we aren't quite happy with by middle age, especially if we are put in a stressful situation in our lives or careers, and if left unresolved could have potential repercussions. Terence found a way of 'interrupting' this automated response and exchanging it with a more rational and desired response.'

Trevor quoted one case of a young woman who developed a phobia of needles and this caused a great deal of concern as she was diabetic and had to inject daily, after one session she was able to do so with no fuss whilst also attending her doctors for regular blood tests.

Trevor finished by saying: 'In my professional opinion, this is the most important and impressive psychological therapy for generations, and it is staggering how effective it has shown to be in the seven years it has been practised.

'Results are shown time and time again after only one to three sessions. It is commonly used in South Africa but as yet the NHS still only supports CBT. The good news is that there are currently two PhD papers being undertaken along with an NHS Health Research Authority controlled study which should assist with hopefully a wider national study in due course. Proof is in the pudding at the moment in the extensive results being achieved in therapy sessions worldwide now. BWRT doesn't rely on a specific state of mind. All you need to do is answer a number of questions, follow simple instructions and see the results yourself!' ◆

1. https://www.mind.org.uk/information-support/types-of-mental-health-problems/statistics-and-facts-about-mental-health/how-common-are-mental-health-problems/#.W1Hgl9VKjcs
2. https://www.england.nhs.uk/wp-content/uploads/2016/02/Mental-Health-Taskforce-FYFV-final.pdf
3. https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/deaths/articles/suicidebyoccupation/england2011to2015
4. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5457790/
5. DPS claims stats 2017/2016
6. https://publishing.rcseng.ac.uk/doi/full/10.1308/rcsfdj.2015.172

First aid in the dental setting

By Harriet Purdie

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

People at work can suffer injuries or be taken ill. It doesn't matter whether the injury or illness is caused by the work they do or not, it is important to give them immediate attention. Providing first aid can reduce the effects of injury or illness suffered. Within the dental practice, accidents, such as sharps injuries, burns, trips and slips can happen to even the most diligent team members or patients.

The minimum provision for first aid at work is:

- A suitably stocked first aid kit
- An appointed person to take charge of first-aid arrangements
- Information for employees about first-aid arrangements (notices telling staff who and where the first-aiders or appointed persons are, and where the first-aid box is).

Carrying out your first aid risk assessment

The Health and Safety (First-Aid) Regulations 1981 require you to assess the first aid requirements of the practice.

Areas to consider include:

- Hazards and risks associated with the work
- Number of people at the practice and where they work
- Previous accidents (recorded in the accident book)
- Access to emergency facilities and services
- Arrangements for covering planned and unplanned absences.

Your first aid arrangements should be based on the assessment of risks in the practice

Do I need a trained first aider?

Although there are no hard and fast rules on exact numbers, the following should be considered:

- Fewer than five workers you should have an appointed person to look after first aid
- Five or more workers may want to consider having at least one person trained in basic 'emergency first aid at work' (EFAW) (one-day course)
- Larger practices with more than 50 workers must have at least one first-aider who has completed the first aid at work (FAW) (three day course).

It is recommended that first aiders undertake annual refresher training.

What is the role of the appointed person?

If you identify that a qualified first aider is not required, then you should appoint a member of staff to:

- Call the emergency services if required
- Look after the equipment and facilities
- Re stock the first aid kit and check its contents are in date.

They do not need first aid training, but you may wish to consider it.

First aid kit

All practices must have at least one first aid box which should be clearly marked with a white cross on a green background. It should be kept in a central location and all team members should know where it is. It is helpful to have a sign to indicate this.

You should ensure there is adequate first aid provision at all times when people are at work.

Minimum quantities for a low risk workplace may be considered as:

- A general guidance leaflet on first aid
- 20 individually wrapped sterile adhesive dressings (assorted sizes) appropriate for the work environment
- 2 sterile eye pads
- 4 individually wrapped triangular bandages (preferably sterile)
- 6 safety pins
- 6 medium-sized individually wrapped sterile unmedicated wound dressings (approx 12cm x 12cm)
- 2 large sterile individually wrapped unmedicated wound dressings (approx 18cm x 18cm)
- 1 pair of disposable gloves
- Where mains tap water is not readily available for eye irrigation, sterile water or sterile normal saline solution (0.9%) in sealed disposable containers should be provided. Once opened they should not be re-used.

First aid kits should be checked regularly (ideally monthly) to ensure that the contents remain in date.

COSHH

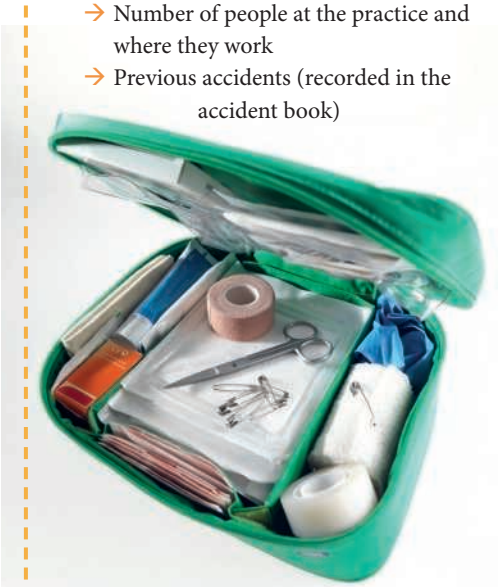
Dental products and materials come with safety data sheets explaining the first aid measures that should be taken if an accident were to occur. Practices should ensure this first aid information is readily available.

It is good practice that the information on products you have in the practice is:

- Kept in a central location, accessible to all team members
- In alphabetical order to ensure quick access
- Kept up to date by a responsible person. ◆

A First Aid in the Dental Practice poster has been designed as an aide memoir for dental staff to provide basic first aid in the dental practice. It can be found at www.thewhea.co.uk/WebRoot/Store25/Shops/a6d2e554-571a-4555-9f21-5ba389a1239b/MediaGallery/Fist_Aid_in_the_Workplace.pdf

The Health and Safety (First-Aid) Regulations 1981 can be found at: www.hse.gov.uk/pubns/indg214.pdf



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A general approach to risk assessments

By Harriet Purdie

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

What is a risk assessment?

Managing health and safety in your practice does not have to be complicated, costly or time-consuming.

A risk assessment is basically a look at what could go wrong and cause harm (a hazard) and whether there are adequate controls in place. You must record the findings if you have more than 5 employees, however it is good practice to still record if you have fewer.

It is never possible to eliminate risks altogether, but we should try to reduce them as far as possible.

Some individuals are especially at risk. This includes:

- Lone workers
- Pregnant and nursing mothers
- Children, young people and vulnerable adults
- Disabled team members and customers.

In order to carry out a risk assessment for each significant hazard, decide if the risk is high, medium or low. For example, the risk of infection from a blood-borne virus is high in dentistry but, providing current infection control procedures are followed (including recommended immunisations), the risk should be low. Draw up an 'action list' and give priority to hazards where the risks are high and/or those which could affect most people.

Risk assessments should be dated, done yearly and brought to the attention of all team members. In addition, they should be revised when any equipment, machinery, substances or procedures that could create hazards are introduced or changed.

Who is responsible?

Health and safety laws apply to all businesses. As an employer, or a self-employed person, you are responsible for health and safety in your business. Health and safety laws are there to protect you, your employees and the public from workplace dangers. It is a good idea to involve the whole team in assessing the practice for hazards. Research has shown that we can become blind to our environment and selective in what we see and do not see. Newer team members are invaluable in assessing the practice environment as they will have had less time to get used to it and may spot hazards that long term members of staff no longer notice. Begin at the entrance and move through the building.

Potential hazards in a dental practice that can cause some confusion

A chemical products (COSHH) assessment concentrates on the hazards and risks from substances in your workplace. Most materials come with a Safety Data Sheet (SDS) which should help you to produce individual risk assessments. The SDS will provide information on the hazardous properties of the substances you are using, any health effects associated with its use, how likely it is to get into the air or onto the skin, and what risk reduction measures you should use to control exposure to an acceptable level. Bear in mind that it will not be specific to your workplace and cannot take into account the particular environment you work in. You will need to assess, for each product, who might be harmed and the first aid measures, should an incident occur. Store the assessments in a folder which is easily accessible for all. Any significant risks should be brought to the attention of all team members.

Your COSSH folder should be a 'living' document, which you revisit if circumstances change. It should definitely be reviewed when:

- There is reason to suspect the assessment is no longer valid
- There has been a significant change in the work
- The results of monitoring employees' exposure show it to be necessary.

Fire risk assessment

As an employer (and/or building owner or occupier) you are required to carry out and maintain a fire safety risk assessment. This is under the Regulatory Reform (Fire Safety) Order 2005, which applies in England and Wales, and under Part 3 of the Fire (Scotland) Act. The fire safety assessment can be carried out either as a separate exercise or as part of a single risk assessment covering other health and safety risks. You need to make sure that, based on the findings of the assessment, you take adequate and appropriate fire safety measures to minimise the risk of injury or loss of life in the event of a fire.

When assessing fire hazards, you should ask how a fire could start, eg electrical equipment, naked flames, and what could burn, e.g. packaging and varnish. You may wish to consider having the first one carried out by a fire expert. They will be able to advise you on the risks and control measures that need to be put in place. They should also be able to find the best escape routes within the practice.

You'll need to consider:

- Emergency routes and exits
- Fire detection and warning systems
- Firefighting equipment
- The removal or safe storage of dangerous substances
- An emergency fire evacuation plan
- The needs of vulnerable people, for example the elderly, young children or those with disabilities
- Providing information to employees and other people on the premises
- Staff fire safety training.

You can do the fire risk assessment yourself with the help of standard fire safety risk assessment guides.

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Decontamination of treatment areas

By Lynn Woods

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

Decontamination is a very important part of dental care and treatment, and one where we continue to take queries from members and their staff on a regular basis. Patients rightfully expect to be cared for and treated in a clean and safe environment each time they visit the practice, and a clean and organised treatment area may help inspire confidence in otherwise anxious patients.

In this issue we will look at the decontamination of treatment areas in a practical way, from the beginning to the end of the working day and beyond! We will assume that practices have a separate decontamination area for instrument processing but this feature should also be of help to those who still decontaminate their instruments in the treatment area.

Firstly, it is worth mentioning that all practices should have a nominated lead member of staff responsible for infection control and decontamination, this could be a competent and experienced dental nurse or decontamination assistant.

Cleaning with detergents and/or disinfectants – always read the label!

Surfaces

Surfaces in treatment areas should be impervious and easily cleanable – manufacturers' advice should be sought with regard to detergent/disinfectant compatibility. Where surfaces have joints, these should be welded or sealed. Surfaces can be effectively cleaned using disposable cloths wetted with clean water and detergent – provided the surface is then dried – or by using commercial cleaning agents and wipes. Whatever chemical cleaning product is used, it is very important to have read the label and product information before use to ensure it is used safely and to comply with COSHH.

All new chemical cleaning products should be assessed prior to their first use, this should not take too long to do as the relevant information should be provided on the labelling or in the safety data sheet in the form of either:

- The newer hazard pictogram(s) and hazard and precautionary statements; or
- The older danger symbol(s) and risk and safety phrases.

Spray bottles

Because of concern that bacteria can adapt and grow in the spray mechanisms it is advised these bottles are single use and not refilled. Again, always read the label and use the product according to the instructions for

use. Some products can cause respiratory irritation if over-sprayed or used without adequate ventilation.

Flooring

Flooring in treatment areas should also be impervious and easily cleanable. Carpets, even if washable, should not be used.

In practices where the decontamination of instruments still takes place in the treatment area, procedures that generate the risk of exposure to aerosol dispersion or splashes (such as manual washing, the use of an ultrasonic cleaner without a sealed chamber (or lid) or the opening of decontamination equipment) should NOT take place while the patient is present.

Hand hygiene is a must

Hand hygiene is very important in the decontamination process. Hand-washing (using a mild liquid soap) should take place at least at the beginning and end of every session, and if hands are visibly soiled. Outside of the beginning and end of sessions, hand hygiene in the form of antimicrobial handrubs (conforming to BS EN 1500) can be used on visibly clean hands as an alternative to washing.

Hand hygiene should take place:

- Before and after each treatment session
- Before and after the removal of PPE
- Following the washing of dental instruments
- Before contact with instruments that have been steam-sterilised (whether or not these instruments are wrapped)
- After cleaning or maintaining decontamination devices used on dental instruments
- At the completion of decontamination work.

Transport containers for instruments

Suitable containers for transporting instruments to and from the decontamination area should be marked as such (e.g. dirty and clean) and should not be used interchangeably.

The BDA's advice on infection control can be found at www.bda.org/healthandsafety ◆

If you would like to speak to a member of the compliance team about an aspect of infection control or decontamination please contact us on 0207 563 4572 or email us advice.enquiries@bda.org.

Decontamination of treatment areas

Dental Unit Water Lines (flushing of)

- ☐ Flush for two minutes at the beginning of the day
- ☐ Flush for 20-30 seconds between patients
- ☐ Flush for two minutes after lunch break
- ☐ Flush for two minutes at the end of the day

Clean between each patient

- ☐ Local work surfaces
- ☐ Dental chairs
- ☐ Curing lamps
- ☐ Inspection lights and handles
- ☐ Hand controls including replacement covers
- ☐ Trolleys and delivery units
- ☐ Spittoons
- ☐ Aspirators
- ☐ X-ray units

Clean at the end of each session

- ☐ Taps
- ☐ Drainage points
- ☐ Splashbacks
- ☐ Sinks
- ☐ Spittoons and aspirators – wash through according to manufacturers' instructions

NB After some clinical procedures, it is necessary to start cleaning as soon as care of the individual patient is complete. In these cases, staff should not wait until the end of the session to start cleaning the area.

Additional clean at the end of the day

- ☐ Drain and clean steriliser reservoir
- ☐ Cupboard doors, other exposed surfaces (such as dental inspection light fittings)
- ☐ Floor surfaces, including those distant from the dental chair
- ☐ DUWLs – decontaminate in line with practice protocol

Clean weekly

- ☐ Window blinds
- ☐ Accessible ventilation fittings
- ☐ Other accessible surfaces such as shelving, radiators and shelves in cupboards

Medical emergencies... are you prepared?

By Harriet Purdie

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

Medical emergencies in the dental setting are uncommon but they do happen. The stress felt by many patients when attending the dentist, and the nature of the treatment, means the risk is higher than in most other settings. When it does happen, dental team members need to be able to perform lifesaving treatment as if it were an everyday occurrence.

GDC Standards state that registrants must follow the guidance on medical emergencies and training updates issued by the Resuscitation Council (UK). This includes ensuring specific resuscitation equipment is available, including access to an automated external defibrillator.

How much oxygen do I need?

It is worth noting how far the practice is from the nearest accident and emergency department, as this will determine how much oxygen you need to have available. Oxygen cylinders should be of such a size to be easily portable but must also allow for an adequate flow rate until the arrival of an ambulance. A full 'CD' size integral valve cylinder contains 460 litres of oxygen and can deliver a flow rate of 15 litres per minute for approximately 30 minutes. This should be adequate for most practices, but local policy should dictate whether a second cylinder is required in case the first one is at risk of running out. This may be applicable in remote areas or where traffic can be especially busy.

Prefilled adrenaline syringes

The UK incidence of anaphylactic reactions is increasing and early treatment with intramuscular adrenaline is the treatment of choice. The first dose should be given without delay and prefilled syringes provide a quick and easy method of doing this. Practices should, however, ensure there are ampoules available in addition as top ups may be required. Your emergency kit should hold 1ml syringes as the markings will enable greater accuracy when drawing-up 0.5ml, 0.3ml or 0.15ml.

How to store emergency drugs

There has been some confusion regarding the storage and availability of emergency drugs. Some regulatory inspectors had issued advice that such equipment must be locked or secured in some way to prevent public access to the drugs they contain. The risk of theft or tampering is rare, and this small risk must be balanced against the risk of locking emergency drugs and equipment away, which will cause inevitable and unacceptable delays in emergency situations. Practices should, however, ensure that they are stored in a safe place, in areas where it is unlikely that a member of the public could have access and stored securely when the practice is closed. Midazolam, when used as part of emergency drug kit, does not need to be kept in a controlled drugs cabinet, however documentation stating the Standing Operating Procedures (SOP) should be in place.

All medicines should be stored at the appropriate temperatures. Attention should be given to the storage of these drugs on particularly hot days.

Training and practice sessions

The resuscitation council states that:

'Dental practitioners and other dental care professionals must be trained in cardiopulmonary resuscitation (CPR) so that they are able to respond appropriately in the event of cardiorespiratory arrest occurring. It is also recommended that dental practitioners and other dental care team members who work with children should learn CPR for use in children and practise these on paediatric manikins.'

For all staff, various methods to acquire, maintain and assess resuscitation skills and knowledge can be used for updates (e.g. life support courses, simulation training, e-learning, video-based training/self-instruction). However clinical staff should carry out 'hands-on' simulation training and assessment.

Despite the changes to a new enhanced scheme, the GDC give medical emergencies and CPR as an example of CPD content for development outcome C: 'Maintenance and development of knowledge and skill within your field of practice'. It is recommended that team members stick to the previous recommended; at least 10 hours in every CPD cycle, and at least two hours of CPD in this every year.

A year between this training is a long time, therefore practice sessions, at least quarterly are recommended. There are various methods for carrying these out. Mock sessions are ideal, especially if other members of the team don't know it's happening. An alternative would be to have a selection of flash cards, containing the emergency, the symptoms and the recommended treatment. Team members should match the cards appropriately. It is also a good idea to keep these flash cards with the relevant emergency drugs as a quick prompt in the case of an emergency. Practice sessions should be documented, and areas of learning addressed.

Glucagon – to fridge or not to fridge

Practices should have Glucagon available as part of their emergency drugs. Glucagon can be kept in the fridge, which does increase its lifespan, if kept between 2 and 8 degrees Celsius. If kept at room temperature then it will only keep for 18 months, so the expiry date on the box should be adjusted. If you decide to keep your glucagon in the fridge, you must monitor the fridge temperature regularly (ideally daily) to ensure it is being kept within the ideal parameters. ◆

For further information, have a look at the BDA's advice page on medical emergencies at www.bda.org/healthandsafety.

If you are a BDA Extra or Expert member, you can contact the Compliance Team at advice.enquiries@bda.org. or telephone 020 7563 4572.

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Advanced lighting

Good lighting is necessary to practice good dentistry. Belmont have a range of options including both traditional halogen lights as well as LED options. New to the LED range is their 300 Series light. These have five LEDs with a touchless sensor for light activation, thus avoiding unnecessary cross contamination. The white natural light beams give the clinician fantastic visibility.

They also feature easily adjustable controls (from 3,100 lux to 28,000 lux) so that you can change the intensity when working with composites. The rectangular light pattern emitted is designed to prevent eye fatigue, whilst the compact head design, with forward-facing handles, makes the unit easy to maneuver.

Alternatively, there's the top-of-the-range 900 LED light. Once positioned correctly it will provide a flooded area of illumination, with minimum heat transfer and white light, the closest match to daylight. It also encourages good posture, as the light output is so good that the clinician should not need to lean into the patient. The 900 LED also has a third axis of rotation, unlike most lights, which have to sit directly at 12 o'clock. Changing position does not therefore interfere with visibility; full illumination is maintained and space is available both above and to the front of the patient.

Both the new 300 and the 900 LED Series lights can be fitted retrospectively. To find out how they might brighten up your day call 020 7515 0333.

New distributor appointed

DenMat Holdings, LLC has entered into an exclusive distribution agreement with Henry Schein UK Holdings Ltd.

The agreement, effective from September 1, 2018, states that Henry Schein will assume sales, customer service, and fulfillment activities for all of DenMat's professional products in the United Kingdom. This new distribution agreement will complement DenMat's existing field sales resources in the UK, who will continue to support the existing customer base while introducing new dentists to the company's wide range of restorative and preventive solutions.

You can continue to call your existing DenMat area representative, or call Henry Schein directly at 0800 023 2558.

24-hour oral health protection

Normal fluoride toothpastes do not provide the best protection against plaque. Patients may think they're looking after their teeth, but 90% of toothpastes do not provide complete oral protection beyond regular fluoride technology, which was invented 60 years ago and is not designed to resist the high amounts of acids in our modern diet. But that can all change with Oral-B!

Powered by the innovative stabilised stannous fluoride formula, Oral-B Pro-Expert toothpaste provides 24-hour protection for the eight areas of your patients' mouth that you check the most including: cavities, dental plaque, gum problems, tooth sensitivity, stains, bad breath and enamel erosion – giving patients a healthier mouth and stronger teeth from day one with continued use.

Oral-B Pro-Expert is a prevention and protection toothpaste that provides 24-hour protection to the whole mouth. In terms of Cavity-Protection the soluble fluoride helps to re-mineralise areas of weakened enamel and makes it more resistant to future acid attacks. Its stabilised stannous fluoride formulation prevents and inhibits plaque bacteria, as well as reducing the toxins released to help prevent gum problems. It has also been proven to deliver up to 33% less plaque 12 hours after brushing vs. ordinary toothpastes. The unique stannous fluoride complex formulation helps block dentinal tubules minimising sensitivity. Pro-Expert also helps create a long-lasting protective shield on the dentine and enamel surfaces to provide superior acid protection, which is beyond that of fluoride alone. Added to its benefits Pro-ExpertPro-Expert helps prevent calculus build-up and staining and improves breath freshness by up to 71% after just three weeks.

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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.

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This includes a thorough test of the conometric connection over time under cyclic loading with all tested samples maintaining their stability.

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To find out more about the extensive range of implant solutions, materials and equipment, please visit dentsplysirona.com or call us on 01932 853 422.

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Mr Paul Stone BDS (Hons) Lpool, FDS RCSEd, FDS RCPS (Glasg)
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On Specialist List: Yes, Oral surgery (60534)

Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants
On Specialist List: Yes, Prosthodontics (66211)

Dr Marilou Ciantar BChD (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel
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Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA
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Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd
Interests: Endodontics
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Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR
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A If you have more than 2 employees
B If you have more than 3 employees
C If you have more than 4 employees
D If you have more than 5 employees.

Q1: What regulation must antimicrobial handrubs conform to?

A BS EN 150
B BS EN 1400
C BS EN 1500
D B EN 1500.

Q3: What is the role of the appointed person?

A To call the emergency services when required
B Look after the equipment and facilities
C Re-stock the first aid kit
D All of the above

Q4: How long does Glucagon keep at room temperature?

A 12 months
B 18 months
C 24 months
D 30 months

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