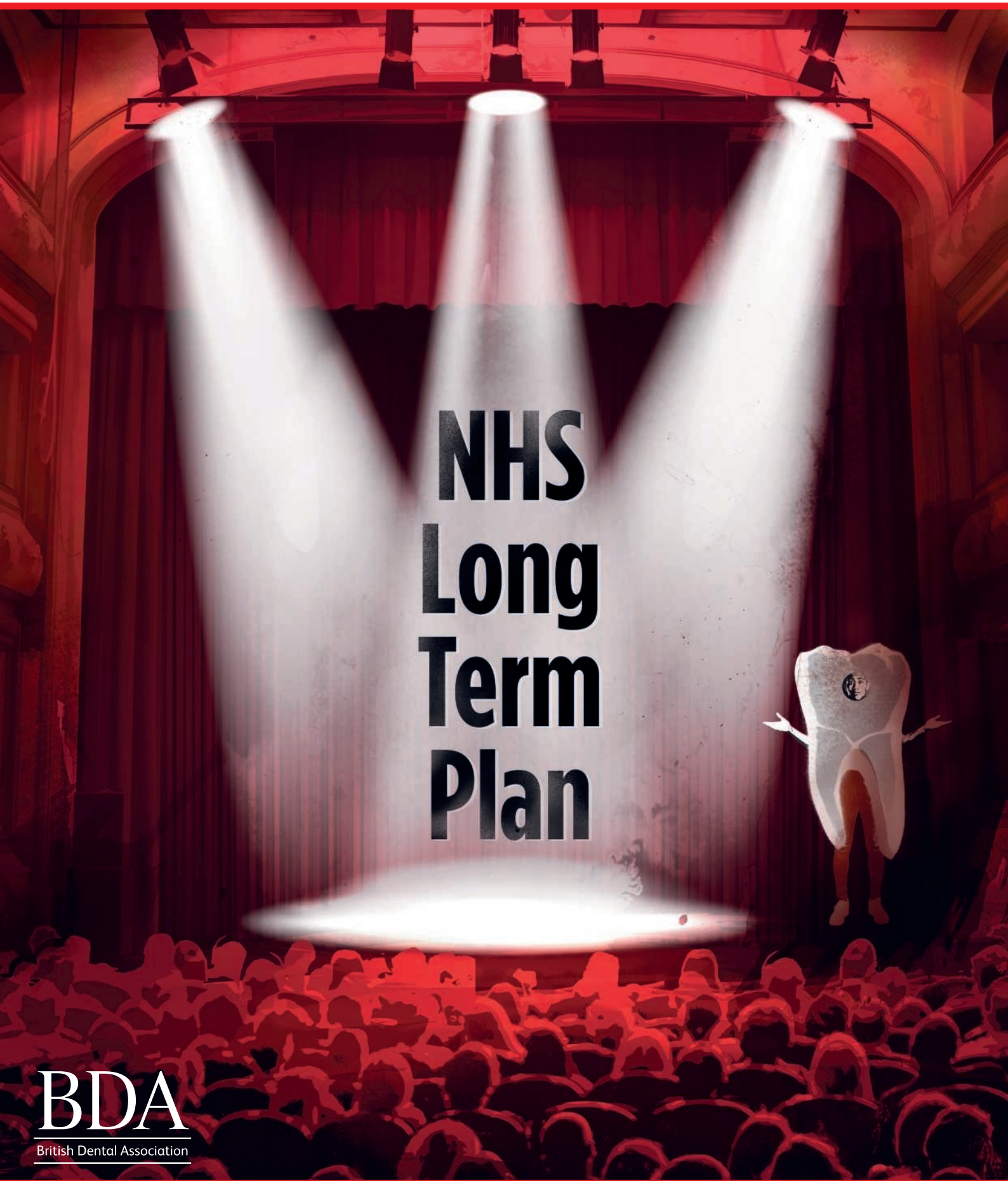
BDJ InPractice
Vol 32 | Issue 2 | February 2019




BDA
British Dental Association

Contract killers ■ The patient experience ■ Hygienists and nurses ■ Orthodontics and millennials

# Get **maximum value** for your practice

- Fee Structure Maintains Total Impartiality
- **Valuations Free of Charge & Commitment**
- No Gold Plus / No Priority
- Only Agent Using Secure Data Rooms
- Bespoke Bidding Process by Practice

## ‘I can help you sell your practice’

- Alison Willcock, Practice Consultant

**Get in touch with Dental Elite today for your free valuation to see the amount you could command for your practice.**

| North West | South Coast | London |
|---|---|---|
| Sold Price | Sold Price | Sold Price |
| **£2,150,000** | **£820,000** | **£915,000** |
| Turnover | Turnover | Turnover |
| **£988,873** | **£356,418** | **£429,955** |

Google ★★★★★ 4.8/5

## Get your **FREE valuation**

DentalElite

01788 545900 | valuations@dentalelite.co.uk | www.dentalelite.co.uk

BDJ InPractice

VOL 32 | ISSUE 2 | FEBRUARY 19






**Cover illustration** Danny Allison

**Editor** David Westgarth | **Production Editor** Sandra Murrell | **Art Editor** Melissa Cassem | **Publisher** James Sleigh | **Global Head of Display Advertising & Sponsorship** Gerard Preston | **European Team Leader – Academic Journals** Andy May | **Display Sales Executive** Paul Darragh | **Production Controller** Stewart Fraser | **Editor-in-Chief** Stephen Hancocks OBE.

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

 ISSN 2057-3308.

BDA
British Dental Association

# Public prevention, no?

Sir, I have read with interest the latest copies of *BDJ* and *BDJ In Practice* featuring articles on prevention, oral cancer checks in Scotland, behaviour change, as well as Peter Ward's article regarding supporting young dentists from sharks and the GDC.

After more than 35 years as a GDP, you can't help but get a little cynical, and the announcement by the government Health Secretary regarding prevention in November and the negative comments by the opposition party has a familiar ring to it. At our level, little will change. From what little information is available with the NHS Long Term Plan announced last month, and outlined by the deputy CDO in December, it saddens me that dentistry is not on the agenda.

Before I retire, I want to have some positive impact despite the governing body of the day. I initially made a webpage for my patients, and my hobby gradually got out of hand. The result is the teeth4life App. It has a scorecard and a traffic light system for early tooth loss, a score for risk of oral cancer, a video on self-monitoring, and a section for setting the appropriate monthly reminders for cancer as well as when to disclose the children or your own teeth. It's an attempt to engage the 48% of adults who don't have a dentist but do have a phone, as the App can be easily distributed using social media on the front page.

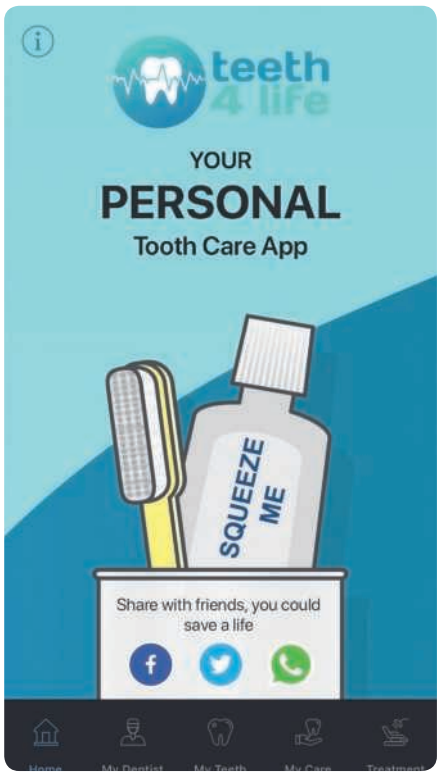
If we want to get lawyers off our back, change the GDC, reduce our indemnity fee, enjoy our working day and retain enough young dentists to look after us when we retire, we need to get the public on our side. This information – and more – is explained to the public in the app.

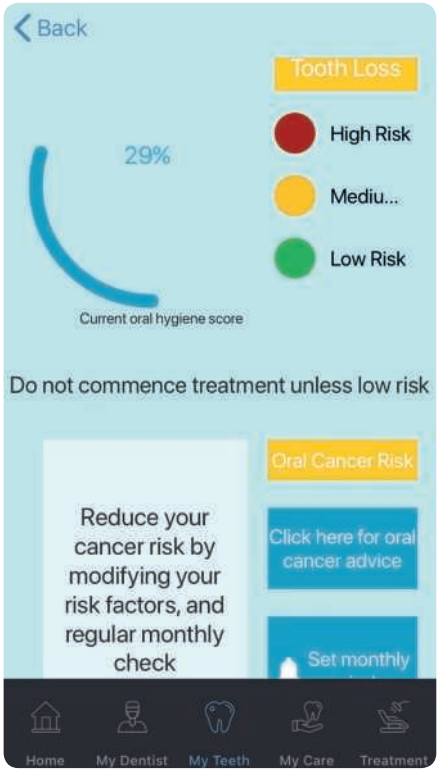
The App is an attempt to help you restore some form of work-life balance to use the massive improvements in IT over the last 30 years. As Peter Drucker said, there is nothing so useless as doing something efficiently that which should not be done at all. We spend more time typing when we should be working and enable improved productivity and enjoyment.

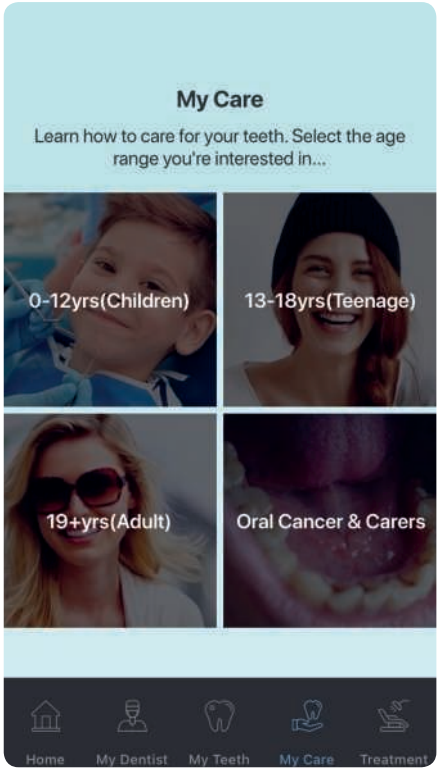
Why can't we have the database from the GDC for all practising dentists available for the national LDC? The national LDC would then have the ability to set up a survey for all dentists on – for example – what they think is adequate treatment for specific procedures within the time and material constraints available. Also, the dentists could then opt-in to engage their local dental community, who we could advertise local courses and support adequately. The GDC shouldn't hide behind GDPR. And the government's ability to continue overseeing the majority of dentists by a divide and rule policy could potentially be undermined and possibly under duress bring in a core service. An online survey is something all dentists could all engage in, for establishing what loosely termed dental fitness was. We could even get CPD for it. A lot of the ambiguity that the lawyers feed off, enabled by the loose NHS guidelines, could be vastly reduced. Now that would be a bit of typing I would be keen to do.

This is an individual effort, but as a collaborative project, we could engage the public to improve their oral health appropriately on smartphones, not the one envisaged 70 years ago when NHS dentistry was invented, and gradually ignored ever since.

**Antony Smith BDS DPDS, via email.**



# Review of RQIA 'a welcome opportunity' for dentistry

BDA Northern Ireland has reacted positively to a major review being undertaken of the Regulation and Quality Improvement Authority (RQIA), and the policy and legislation that underpins healthcare regulation by the Department of Health.

Chair of the Northern Ireland Dental Practice Committee (NIDPC) Richard Graham, and Director of the BDA's Northern Ireland office Tristen Kelso met with officials from Department of Health's Quality, Regulation, Policy and Legislation Branch, as part of a pre-consultation stakeholder meeting.

A Department of Health discussion paper produced as part of the Review acknowledges the existing, 'uniform approach to registration and inspection', developments in regulation policy, as well as existing 'gaps' mean a radical overhaul of the policy and legislation underpinning RQIA is necessary.

Richard Graham, NIDPC Chair commented: 'Being classified as 'independent hospitals,' and subject to annual inspections despite being considered 'low risk' (while we see three-yearly inspection periods elsewhere) has perpetuated the feeling among general dental practitioners for some time that the inspection regime is overly onerous, and not fit for purpose.

'We welcome the root-and-branch approach as proposed, not least the acceptance of moving to a 'right-touch' regulatory regime - and the acknowledgement of the issues associated with dental practices being classified as independent hospitals'.

BDA Northern Ireland has been calling for the 2003 Order to be reviewed for some time.

An opportunity to engage with senior Department of Health officials was secured following representations made to the Permanent Secretary to reduce the frequency of dental inspections.

Following a review of 'Fees and Frequency Regulations' in 2017, a move from annual dental practice inspections to inspections every two-years appears to be in the offing in the short-term, subject to sign-off by the Permanent Secretary.

An opportunity to look at having this extended even further will be progressed under this latest review, which recognises the range of regulatory tools in improving quality and reducing risk, including professional regulation, quality assurance/reporting processes and use of data.

BDA NI Director, Tristen Kelso added: 'While this process is still at an early stage, we welcome the opportunity to engage with the Department of Health in shaping the future of regulatory policy, and the subsequent primary legislation that will follow on behalf of the profession.

'The stated direction of travel by the Department is extremely encouraging. We intend to input fully into this process to ensure regulatory policy is much more closely aligned with the accepted low-risk nature of dental practices, and where the regulatory burden can be reduced by taking cognisance of regulation in the round'. ◆

# Savage public health cuts 'perverse'

The British Dental Association has slammed news that the government will proceed with £85 million of cuts to public health grants, which have disproportionately hit oral health services.

Local authorities in England are responsible for public health, but dentist leaders believe councils have been denied resources to make an effective stand against preventable conditions like tooth decay and obesity.

130 out of 152 local authorities (85%) reduced their public health budgets in 2018/19. Studies by the Kings Fund have found the single biggest areas for cuts have been miscellaneous services, including dental public health.

Tooth decay is the number one reason for hospital admissions among young children, with paediatric tooth extractions costing the NHS £205 million since 2012. Effective long-term investment in early years oral health programmes in nurseries and primary schools in Scotland has shaved millions off treatment costs. While these policies have been adopted in nations from Chile to Israel, the vast majority of local authorities in England continue to lack resources to embrace similar models.

British Dental Association Chair Mick Armstrong said: 'Matt Hancock says he wants prevention to be the focus of a 21st century NHS. Public health should be the foundation for that approach, but in place of investment Westminster has simply devolved savage cuts.

'It's utterly perverse that wholly preventable conditions are now going effectively unchecked. Starving local authorities of needed resources is hopelessly short-sighted, and is only piling pressure on NHS services.

'The NHS70 birthday present makes for nice headlines, but the reality is ministers giving with one hand while taking away with the other.' ◆

## Clarity, and clarity of itself

Sir, I read with interest the excellent advice article entitled 'A Botox overview'[1]. In it the author states '*The administration of Botox is not the practice of dentistry, so does not appear in the GDC's Scope of Practice document.*'

If we accept the definition of 'dentistry' as 'that which a dentist normally does', it seems logical that treatment involving injectable cosmetics should not be classified as dentistry. It follows then that any such treatment should be out with the interest of the GDC. The Scope of Practice document, however, states:

Additional skills which a dentist could develop:

- Providing implants
- Providing non—surgical cosmetic injectables.[2]

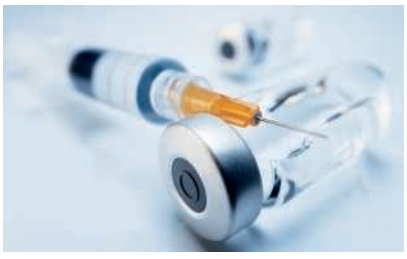
Crucially, these two points do not feature in the 'additional skills' for other registrant groups, e.g. hygienists. On this analysis the administration of Botox is considered to be the practice of dentistry and furthermore, limited to registered dentists.

The Senior Customer Advice & Information Team at the GDC, when questioned, stated that 'The application of Botox, dermal fillers, etc. is *not* considered to be the practice of dentistry and, as such, is not regulated by the GDC'.

This surely begs the question as to why then it is mentioned in the GDC's own Scope of Practice document? Perhaps an opportunity for the GDC to clarify its own position? ◆

**J. Ingham, dento-legal advisor, Dental Protection, via email.**

1. Purdie, H. A Botox overview. *BDJ In Practice* 2019; **32:** 22.
2. General Dental Council. Scope of Practice. Available online at: www.gdc-uk.org/professionals/standards/st-scope-of-practice (Accessed January 2019).





## Use plain English to avoid confusing patients

Dental professionals are being advised to use plain English when communicating with patients and colleagues by the Dental Defence Union (DDU).

An article in the latest issue of the DDU journal explains that using plain English not only improves communication with patients but can help to avoid potential misunderstandings that can lead to a complaint or claim.

Leo Briggs, deputy head of the DDU, said: 'Jargon, acronyms and technical language are commonly used in dentistry. Because we are using the words day in day out, it can be difficult to distinguish what is and isn't jargon. For example, dental professionals all understand what composite, amalgam and radiographs are, but they are not words widely understood by patients.

'By making the effort to communicate clearly and concisely, dental professionals can give patients a greater sense of involvement in their own care. When you consider that communication issues are also a regular factor in complaints faced by DDU members, using plain English can also minimise the risk of a simple misunderstanding becoming something more serious.

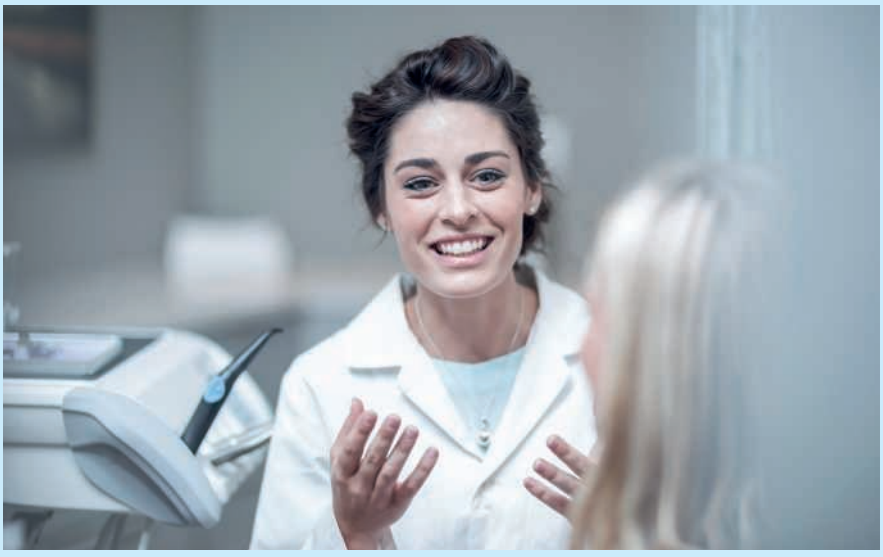
'However, it's not only patients who will benefit from dental professionals adopting a plain English style. Avoiding acronyms and technical language in referral letters and other correspondence with colleagues can also help to avoid misunderstandings and save time in interpretation.'

Advice on writing outpatient clinic letters to patients in plain English from the Academy of Medical Royal Colleges was published earlier this year. While aimed at medical professionals, the DDU explains that the advantages apply as much to dentistry as they do to medicine.

The Academy guidance explains that it is okay to use some medical jargon but that plain English should be used wherever possible. It recommends explaining acronyms because 'these are often incomprehensible to non-specialists as well as to patients'. ◆

Examples of words commonly used by dental professionals that may not be understood by patients include:

- Amalgam – a material commonly used to fill teeth which is silver in colour
- Composite – an alternative filling material which is tooth-coloured
- Restoration – a filling or a crown
- Radiograph – X-ray
- Periodontitis/basic periodontal examination (BPE) – gum disease/a screening test to look for the disease
- Caries – decay in the tooth
- UL5 (or another number) – the notation system used to identify teeth, in this case the fifth tooth back on the upper left of the mouth
- Temporomandibular disorder (TMD) – a condition affecting jaw movement.



# Senior clinicians warn of no-deal Brexit dangers to NHS

Members of one of the UK's leading royal medical colleges have warned of the dangers of a no-deal Brexit in a new survey.

The membership of the Royal College of Physicians and Surgeons of Glasgow have sent out the call as Brexit negotiations in Brussels reach a critical stage.

In a membership survey carried out online by the College:

- 79% of respondents say that a no-deal Brexit will have a negative or strongly negative impact on the NHS
- 44% of respondents report that their employer is failing to plan effectively for the potential impact of a no-deal Brexit
- 67% of respondents report that the UK Government is failing to plan effectively for the potential impact of a no-deal Brexit on the NHS.

The survey was carried out of the College's UK-based membership, and was prepared as part of the College's submission to the House of Commons' Health and Social Care Committee's inquiry into the potential impact of a no-deal Brexit on the health sector in the UK.

In the submission, the College's Honorary Secretary, Dr Richard Hull, stated: 'The Royal College of Physicians and Surgeons of Glasgow is deeply concerned that Brexit may have a seriously negative impact on health and social care across the UK if the UK government is unable to negotiate a comprehensive agreement with the remaining EU member states on our future relationship.

'It is of significant concern to us that our membership clearly lacks confidence in the current contingency planning process for a no-deal Brexit. We believe that both NHS employers and the UK government should reflect on these results, and take immediate action to ensure that everything possible is being done in the coming weeks and months to ensure that the high standards of care currently provided by our health and social care system are able to be maintained when the UK leaves the EU in March 2019.

'This should include:

- Agreeing a cooperative regulatory framework between the Medicines and Healthcare products Regulatory Agency (MHRA) and the European Medicines Agency (EMA), which would allow the smoothest transition in terms of the authorisation of medicines for use in the UK, safety and pharmacovigilance
- Maintaining close working links with the European Centre for Disease Prevention and Control in order to maintain public health
- Avoiding a situation where there is a need for the imposition of trade barriers, including non-tariff barriers, on medical goods and services
- We also remain particularly concerned about the potential impact of a no-deal Brexit on patient care in Northern Ireland given the current level of cross-border cooperation with the health service in Ireland.

'We also remain concerned that there is significant uncertainty within our membership on the future status of EEA nationals who have already chosen to come and work in the health and social care sector across the UK. This has the potential to significantly exacerbate existing workforce issues in the sector, with additional implications for the standards of care our membership is able to provide to our patients.

'A no-deal Brexit would not deliver these essential actions. We believe that this would have the potential to significantly hamper the work of the NHS and its staff and would present a real and present threat to patient safety.'

# Out of the spotlight

By David Westgarth,
Editor, *BDJ In Practice*

I love the phrase 'conspicuous by one's absence'. It covers all manner of sins. Sources credit its origin in Roman times; it was expressed by the Roman writer Tacitus, concerning the absence of Junia's brother and husband at her funeral procession in the mid-1800 BC.

You only need to look at the column inches devoted to Meghan Markle's father being absent from her wedding day to identify the impact of being absent. He was certainly conspicuous by his absence. If a leading sportsperson was missing from the team they represent, you could bet your bottom dollar it would be the topic of the first question put to the manager pre- or post-match.

So when Prime Minister Theresa May launched the new NHS Long Term Plan from Alder Hey Children's Hospital in Liverpool on Monday 7 January, despite a heavily trailed focus on both primary care and prevention, a coherent strategy for dental services was rather conspicuous by its absence from the 136-page document.

## No real surprise?

For those close to the coal face of politics in dentistry – while disappointed – the omission no doubt came as no real surprise. Indeed, the BDA expressed their disappointment at the omission, while going on to dismiss a claim the government's *Starting Well* initiative supports 24,000 dentists across England to 'see more children from a young age to form good oral health'. The reality is the programme is not receiving any new investment, and is active in a handful of wards in just 13 English local authorities. BDA Chair Mick Armstrong said in a statement: 'The Prime Minister launched her strategy at a paediatric hospital, serving a city that spends £1 million a year extracting rotten teeth from children. We have faced year-on-year cuts, a recruitment and retention crisis, and have patients travelling over 50 miles to secure access to basic services. Now a single unfunded scheme is being offered as a substitute for proper resources and a coherent plan.

'If government really intends to put the mouth back in the body they need to work with this profession on implementation. The alternative is to keep treating dentistry as an afterthought, and let the NHS pay the price.'

Since taking office Health Secretary Matt Hancock has consistently pledged to put prevention at the heart of NHS strategy – but has failed to invest in or pledge a commitment to dentistry. It's not like tooth decay is the large non-communicable disease globally, nor entirely preventable. Prevention was *meant* to be at the heart of the new NHS Long Term plan, and dentistry is conspicuous by its absence.

The Westminster Government's spend per head on NHS dentistry has fallen by £4.95, from £40.95 to £36 in the last five years. Academic research has pointed to significant pressures placed on both GP and A&E services, in part thanks to NHS charges pushing large volumes of dental patients to other parts of the health system.

I don't think it's too simplistic to point out investment in these areas would clearly reduce the burden on an already stretched to breaking point system. Yet rather than being viewed as an investment to deliver for NHS patients, one has to wonder if NHS dentistry is simply viewed as an investment in the lining of the government's pockets.

## Or is it surprising?

Although the plan contains no chapter or even paragraph heading for oral health, that didn't stop the British Society of Paediatric Dentistry welcoming mentions of dentistry in the context of holistic care which for children represents significant progress, considering that it has been excluded from earlier strategies for the NHS.

Claire Stevens, spokesperson for BSPD stated 'It's really good to see recognition for oral health in the NHS Long Term plan. I am delighted that there is a mention for Starting Well, the prevention programme launched in 2017 in high priority areas. We would like to see this extended into other areas where there are high levels of dental decay.'

On first glance, this looks nothing more than clutching at straws. It's like waiting an hour for a train to arrive, only to find it's packed and not stopping at your station and passing through at high speed once you're on board. But is it all doom and gloom? Ian Mills, Dean of the Faculty of General Dental Practice (UK) (FGDP(UK)), said: 'While consideration of dentistry in the new plan is scant, we are nonetheless pleased to see the laudable commitments to ensure that children with learning disabilities can access dental services, and that individuals in care homes are supported to have good oral health – this is something for which FGDP has been campaigning for some time.'

Charlotte Waite, Chair of the England Community Dental Services Committee (ECDSC), saw some reasons to be cheerful.

'While the term 'community dentistry' didn't feature anywhere in the NHS Long Term Plan, the issues we confront on a daily basis did. The plan engages on the challenges facing children and vulnerable adults that we have to make our own.

'We finally have recognition of what's being faced on the coal face in care homes, treating the 'heavy metal generation'. Forecasts predict one million people will have dementia in the UK by 2025. We know from Healthwatch reports that some of their very basic oral health needs are not being met. I know from colleagues within the community

dental service needs are not being met. Only recently new research findings links gum disease to Alzheimer's.

'We see the evidence first-hand; the residents with dentures that are never taken out, the staff rushed off their feet, the policies still at the 'to do list' stage. The result is people left in pain, experiencing dehydration or malnutrition, difficulties in eating, communicating, and with it can come loneliness and isolation.

'It's easy to get fatalistic but we've seen progress is possible. The NHS England Enhanced Health in Care Homes framework does appear to be making inroads, with reports of 29% fewer A&E attendances and 23% fewer emergency admissions in areas where it's undergoing trials. It sets out to ensure every resident's hydration, nutrition and oral health is reviewed regularly and is up front in their care plan.

'That model is set to be applied to oral health of care home residents by 2023/24, with staffing and funding attached. A consistent team of professionals is pledged to be on hand to address needs – with oral health part of the package. Action here is a real opportunity to improve not only oral health but also general health and wellbeing, of some of our most vulnerable patients.'

BDA research shows care home owners and managers report current commissioning of domiciliary care is incredibly patchy.

The acknowledgement of this in the Plan – however small – is an opportunity to ensure all care home residents have access to regular mouth care and dental services.

## Catchphrase

It is almost as if the Plan itself is clutching at dental straws. There are exerts in the Plan that if you look really closely feels like an attempt to join up oral health with the wider health system. But does it go far enough to put the mouth back in the body?

> 'It probably wouldn't be a stretch of the imagination to hear rhetoric along the lines of 'this plan has put the mouth back in the body' being mumbled through the corridors of dental power.'

Ian added: 'Putting the mouth back in the body' has been on the agenda for a while, and rightly so – but tellingly, it's only an agenda in dentistry. While realistically we must expect other healthcare professions to lag well behind our own understanding of the associations between oral health and wider health, the good news is that as the bounds of our knowledge are expanding rapidly, these links will over time become more universally understood across healthcare.'

Take children's oral health, for example. It's a problem that costs the NHS millions – and not just in dentistry. There were 45,077 extractions of multiple teeth in under-18s across England in 2017/18 at a cost of £38.9 million, according to NHS spending data. Extractions, accident and emergency appointments, GP appointments – all areas carrying the burden. An easy win one would reasonably assume, yet no specific plan to tackle the problem. It is lumped in with promised investment to ensure that children with learning disabilities have their needs met by dental services. Dental services will be included within reviews, as part of general screening services, which will be supported by easily accessible ongoing care.

Yet every primary and secondary care dental practitioner knows this simply is not enough. Nor is the pledge to bring dental checks to children based in special residential schools. There is a promise to work with partners, to deliver these checks. Charlotte added: 'These children and young people are usually cared for within community dental services. The NHS must work with us during the implementation of this part of the plan, so that we can ensure these checks are developed appropriately, to deliver the best outcomes for our patients.

'With these promises must come action. Services must be properly funded and commissioned to an appropriate level, which will meet the needs of the population. Appropriate training will be required for those involved with the screening processes, as well as dental input into the pathway development. At the heart of this there must be appropriate commissioning of community dental services, to meet the needs of the population.

'Over 1.2 million people in England have a learning disability and 600,000 people have autism. If this group of children and young people are retained by the community dental service for ongoing care, which is often the case, then the cohort of adult people being cared for will also increase.

'Delivery of this pledge will depend on investment in the community dental service workforce. Figures show 58% of the workforce is over the half-way point of their careers with over a quarter of the workforce in the likely final stages of their careers. There will be a need for increased specialist input both in paediatric and special care dentistry and the development and funding of specialist training pathways in primary and secondary care.'

It probably wouldn't be a stretch of the imagination to hear rhetoric along the lines of 'this plan has put the mouth back in the body' being mumbled through the corridors of dental power. Let's be clear; reasons to be cheerful are not reasons to laud Starting Well, particularly when councils at the coal face have just been handed swingeing cuts to public health budgets – and oral health initiatives have been one of the top casualties.

Yes, it is hard to disagree with the stated intentions behind the programme, yet it's impossible to square a limited number of schemes in a handful of local authorities with a claim to be 'supporting 24,000 dentists across England to see more children from a young age to form good oral health'. It is a programme that has received no new funding and is simply recycled money from elsewhere.

Perhaps this is their attempt to 'be greener'.

You only need to have a peek over Hadrian's Wall and across the Severn Bridge to see the true value of laudable programmes that have received fresh funding. It's also

difficult to escape the irony that no child in Merseyside will currently benefit from Starting Well.

## Prevention

Since taking office Health Secretary Matt Hancock has used the 'P' word time and again – but we have been waiting for a tangible commitment to prevention relating to dentistry. He even said it was to form the cornerstone of his approach to a 21st century service, with the plan promising to 'future proof the NHS'. Yet this Plan as it stands doesn't really begin to put prevention into action. It risks offering more of the same.

The omission of dentistry speaks volumes for how it is viewed by the government.

'For colleagues in community dental services, that approach could prove a square peg in a round hole', Charlotte said. 'Many of the patients we treat have complex needs and depend on others to help with their oral care.

'For them prevention is often not a question of personal responsibility. Frequently, it is determined by the value placed upon it by their family or carers. We must not forget those who can't take 'personal responsibility' for their own health, the provision of the right support is essential, along with an understanding of their individual needs.'

Ian suggested: 'In the interests of patients, FGDP(UK) would like to see contract reform which rewards a preventative approach. While I am not convinced that popular concern over NHS dentistry is yet at a level to force the political agenda, we should see opportunity as a profession in the Secretary of State's focus on preventative and primary care. The Public Health Minister has already suggested that we may see progress towards a more prevention-based contract as a result, which is grounds at least for hope.'

He added: 'The public are understandably concerned about provision and waiting times for cancer, mental health and other under-resourced services, so it should be no surprise that the government's priorities for such a high-profile launch reflect these concerns. As dental care professionals, we know how important oral health is too, but we also know that the separation of general dentistry from other NHS health services reinforces a separation in people's minds between oral health and general health – and unfortunately, but entirely predictably, the document reflects this view of the world.'

While it is entirely appropriate that cancer waiting times are prioritised, the Plan stops short of protecting two million boys from a cancer-causing virus.

Mick went on to say: 'After years of campaigning on the human papillomavirus (HPV) vaccine, a welcome roll out to boys aged 12-13 will start this year.

'The government has said it's passing on the opportunity to extend a one-off catch up programme to older school aged boys. This was the approach adopted when girls were first offered the jab, and adopting any other model smacks of penny pinching. The result is two million boys who could have been protected will miss out.

> 'It is clear to all onlookers that contract reform needs to offer a break from the past – GDPs cannot be given second class status when it comes to funding or priority.'

'The document also commits to increase screening for major cancers. This is good news, and we will seek to ensure this logic applies consistently to oral cancers. Any further talk of extending recall intervals just to stretch budgets further is at odds with our patients' best interests, and this Plan.'

## It's off to work we go

Leaving the aforementioned aside, with projections of increases across Alzheimer's and dementia – to name but a few – and no tangible progress on NHS dentistry, therefore letting the wildfire spread, who is exactly going to deliver the Plan?

The plan fails to address the NHS's workforce issues, including the growing recruitment and retention crisis in dentistry, fuelled by the discredited NHS dental contract. The system, based on hitting tough activity targets for curative treatment, has helped fuel access issues across England and has stifled prevention. BDA surveys have estimated that 65% of practices who tried recruiting in 2017 experienced difficulties filling vacancies, leaving patients without access to NHS care. In Wales, patients from Aberystwyth are facing an 87-mile round trip to the nearest NHS dentist.

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

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

The BDA has previously reported that 58% of NHS dentists say they are now planning to leave the service in the next five years. Failure to reform the target-driven system in England and Wales, and the 35% real-terms fall in practitioner incomes continue to threaten retention, recruitment and the long-term sustainability of the service.

To cut a long story short, no effort to apply the Plan's rhetoric directly to primary care dentistry or contract reform appears to have been made. It is clear to all onlookers that contract reform needs to offer a break from the past – GDPs cannot be given second class status when it comes to funding or priority.

Yet even with the questions surrounding the workforce and its composition, Ian believes there is an area of the Plan that could make its way into dentistry.

'The proposal for more doctors to train as generalists rather than specialising in a specific area of medicine also caught my eye, and I await the much-delayed workforce strategy with interest to see if it envisages similar changes across the dental profession.'

It is clear from the Long Term Plan dentistry remains an afterthought, out of the limelight. Is it a missed opportunity or symptomatic of the general malaise that patients and government have to oral health? Perhaps. Yet the time for change has come and gone. The first lines from Hancock's speech when he addressed the International Association of National Public Health Institutes about his vision to help people make healthier choices read: '*We're here to talk prevention. And if there's one thing that everybody knows it's: 'prevention is better than cure'*.

Maybe he doesn't know that it applies to dentistry. If the Long Term Plan is anything to go by, dentistry will remain conspicuous by its absence. ◆

# The contract killers

Asif Syed explains the brand new value in the same old contract

## 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.

'The King is dead, long live the King!' I dutifully scribbled this down at school but the truth is this seemingly contradictory phrase irked me – as a pre-adolescent I liked things in black and white. Like most of us, it takes the onset of maturity to become comfortable with nuanced shades of grey; to see this phrase as an intelligent soundbite announcing the sad passing of an old monarch and simultaneously heralding the reign of a new one.

However, when it comes to the current NHS contract I see dentists up and down the country reacting in black and white terms with one of the two following narratives: The UDA system doesn't work so we are either going to 'speed up' or 'go private.'

Certainly, the math is compelling. Without polarising into one of the two camps many NHS based dental practices would struggle to stay viable.

As such, either response appears entirely justified. For those opting to speed up, the 'efficiency deficiency' beckons.[1] For those opting to go private, there is a more picturesque but no less predictable route offering a selection of the following stopovers:

- → Dental courses – to do better work on private patients
- → Marketing – to get private patients
- → Sales training – to convert private patients
- → Refurbishment – to impress private patients
- → Branding – to attract private patients
- → Patient membership schemes – to retain private patients
- → Specialists or specialising – to justify private patient prices.

As the above constitutes a formulaic approach the math can prove costly when this prescription comes without guarantee of universal success.

Interestingly, extensive market figures used by the BDA paint a markedly different picture.

For those of us that glaze over at tables and data we can summarise that:

- Private practices and practitioners make up around only 20% of the front-line profession
- NHS-based practices are larger than their private practices
- The high street spend privately overall is around £4m
- The high street spend at Private practices is under £1.98m.

From these calculations, we can draw a couple of striking conclusions.

Importantly, many are eschewing the NHS and pursuing the holy grail of purely private practice seemingly unaware it currently sustains around only around 20% of the profession.

Paradoxically, the majority of high street private spend is not occurring at purely private practices but in NHS-based mixed practices i.e. practices with an NHS contract based on a UDA system that apparently 'doesn't work.'

This reasoning can be independently cross-referenced by searching for industry reports from leading dental practice sales agents who all detail that, on average, mixed practices have larger turnovers, higher profits, and still attract the highest valuation multiples in the UK.

If success can be measured financially, it seems the most profitably robust in our industry are not making a simple black and white choice between NHS or private, but are operating in shades of grey.

This business model is not an entirely new idea outside of the dental field. An Indian company called 'Aravind Eye Care' has long been a darling of Harvard Business Review. They specialise in cataract removal but operate in a special way; they provide 70% of their procedures free or at cost for the neediest in the country. Consequently, Aravind Eye Care have justifiably earned a reputation as one the most experienced cataract surgical units in the country – this allows them to charge a premium to paying patients.

They are now they largest eye care provider in the world and when the board of Aravind are faced with a Robin Hood analogy that they profit from the rich to help the poor, they are quick to point out that it is in fact the opposite; *it is the poor who allow them to service the rich so profitably.*

**For UK data obtained by the BDA and presented Dec 2017 relating to the year 2015/16**

| | All | NHS based | Purely Private |
|---|---|---|---|
| Numbers of GDPs | 34,120 | 28,664 | 5,450 |
| Numbers of Practices | 11,960 | 7,179 | 3,000 |
| Numbers of GDP per Practice | 2.85 | 4 | 1.8 |
| | | | |
| Total High Street Patient Spend (all) | £7,608M | | |
| NHS: Private split (all) | N:45.4% : P: 54.6%. | | |
| Average turnover per practice (all) | £636,120 | | |
| Average Annual gross revenue per GDP (all) | £223,000 | | |

The intriguing success of Aravind Eye Care may hold many learning lessons but three intersecting themes stand out as particularly instructive to dental practices:

**Hand skill:** Surgeons don't become more skilled only by seeing better lecture slides and completing more days on a phantom head. They become better by *in vivo* practice on patients – by experience. The NHS contract allows dentists to complete a higher volume of intervention work and so accelerate their psychomotor skills through the learning curve. This is lost when exiting the trajectory too early - many accomplished private practitioners will gladly share how they 'cut their teeth' on the NHS.

**Patient attraction and retention:** I have seen many dental business scenarios where a practice owner has become so disillusioned with the NHS contract they have knee jerked into going entirely private. This results in the practice losing a lion's share of their patients overnight and then spending £3-5k per month on marketing to recapture some of their nicer patients. When it comes to patient footfall, the best marketing campaigns find it difficult to compete with smallest NHS contracts.

**Recession proof:** The BDA reports that private practices are particularly sensitive to economic events and can easily cycle through net profit drops of 10-30% per annum whereas in the same period NHS based practices will report drops of nearer 1.4%. In an era of looming economic instability, austerity and uncertainty, banks, agents and even buyers have come to prize the security provided by a government backed contract.

When faced with the tricky task of reconciling the delivery of healthcare with commercial outcomes it may be enlivening to see how embracing social responsibility might produce superior financial results.

The above said, it is not my intention to portray the NHS contract through rose-tinted spectacles but to offer an opportunity to see it through a lens other than doom and gloom.

Understandably, there are many in the profession who have come to loathe the current bean counting delivery of NHS dental care and there is laudable work being undertaken by the BDA alongside other respected bodies and individuals to rectify this through a political process.

However, I would like to prioritise the practical over the political. When dentists are faced with the question 'do you think they will ever fund NHS dentistry properly?' most will look down sullenly and kick their feet together.

Which means we may need to consider a response other than lamenting the loss of a lucrative NHS contract from a bygone era.

Without doubt the dental market is maturing and it will ensure that businesses and practitioners that are agile enough to move with the times will be rewarded and those that stand fast will be rendered obsolete.

Currently, all UK dental market data trends indicate a movement towards private practice but there is also market inference that this might occur by patients successfully transitioning through the trusted familiarity of the NHS contract.

Over reliance on the NHS contract may still prove problematic but deployed as a stepping stone to a brighter future it may prove invaluable. It may help you to look at the old NHS contract through fresh eyes. In short, 'The NHS contract is dead, long live the NHS contract.' ◆

1. Syed A. The efficiency deficiency. *BDJ In Practice* 2018; **31:** 20-22.

# Innovating the patient experience

Guy Meyers
Director, Customer Success & Marketing at Software of Excellence

**Guy Meyers** of Software of Excellence gives dental teams some tips to keep them focused on patients' evolving demands

Reports of the death of the UK high street might be premature for a good while yet, but the grim financial tidings from over the holiday period and on into 2019 show the clock may be ticking for many businesses.

'Experience' is now one of the most important concepts on the high street. Shops struggling to win the battle with online competitors are focusing on the unique experiences they can provide to their face-to-face consumers, in a spirited fight-back against online retail and its inherent lack of personal interaction.

Spending on leisure and entertainment within concept stores is increasing. Take John Lewis for example, its recently opened Oxford store offers services and experiences including eye tests, personal styling and free tech training workshops, with imagination and innovation the key emphasis in this brave new world.

We can be sure that the ever-growing obsession with 'the experience' creates similar demands and expectations when it comes to personal services, and it's becoming clear that dentistry must also evolve to keep pace. The question is, how?

To best answer this, we need to look at how to raise the level of service provided by all of the different members of the dental team; from the clinician and the nurse to the practice manger and receptionists. Each one needs to take responsibility for different, but complimentary tasks which can contribute to innovating 'the patient experience'.

## First things first

Innovation can and should start before the patient even reaches the practice. Most prospective patients turn to the internet, even if they have received a personal recommendation, and in many cases, it falls to the practice manager to ensure the practice has a strong online presence. This includes having an update-to-date, responsive website, optimised for SEO purposes, with a good number of recent reviews of a decent length. Remember, when a prospective patient sees your website, it is the first glimpse they have of your practice and they will expect to see a well-designed easy-to-navigate site with concise, informative content, that positively reflects your brand.

People now expect to be able to communicate at anytime and anywhere, they demand a wide choice of options and want to be able to do everything on their smartphone. Modern day reception teams need to understand and embrace these concepts of accessibility and responsiveness and require the appropriate tools, available within practice management software, in order to adequately respond to patients' needs.

Patients no longer want to be constrained by working hours – remember they work too, so make it easy to book an appointment online at a time and from a place that suits them. Your goal? To make booking an appointment at your practice as simple as a booking a table at a restaurant.

Making a good first impression is vital in retaining clients, so immediate, relevant and useful communication prior to the appointment is essential. Automating communications direct from your practice management system makes sending recalls, reminders and general communications simple yet effective, creating real impact when patients receive them. Now, with the advent of mobile communications the patient's experience can be further enhanced by sending pre-appointment forms direct to a mobile.

You also need to consider the steps a patient goes through when they arrive at reception and treat them as 'customers'. In this sense the practice manager and reception team need to work hard to ensure the patient's arrival and check-in is smooth and fuss-free. The technology helping with this process now enables the patient to self-scan a check-in bar code, sent prior to the appointment, on a terminal at reception. No more queuing – just a simple, straightforward, hassle free route that could reduce anxiety and makes patients more relaxed before their appointment.

## Clinician communication

When a patient moves from the reception area into the surgery the 'experience' mustn't stop. Patients rightly expect excellent chairside engagement with clinicians and there are many different digital aids that can help explain different treatment options. Even something as small as having all the patient's information, including previous notes, treatment plans and images readily available, conveys a sense of confidence to patients, enabling them to relax, knowing they are in the hands of a capable professional. Everything you do adds to the patient's experience and remember, they might not just tell their friends about your practice, they may also post an online review or give feedback on social media or a third-party review site, all of which will have a much wider impact on your reputation. These facts make it more important than ever to try and be a highly effective communicator.

> 'We can be sure that the ever-growing obsession with 'the experience' creates similar demands and expectations when it comes to personal services, and it's becoming clear that dentistry must also evolve to keep pace.'

## Checking out process

Practice managers need to have in place an effective system for pre-booking follow-up appointments as soon as the patient is ready to leave the practice. A practice management system that automatically sends the dentist's recommended recall interval to reception when treatment is complete, is just another example of how streamlining internal processes can help create a lasting, positive impression. Following this with automated communications sent via email, text or post after the appointment reduces stress for receptionists and frees them up to spend more quality time with patients.

When it comes to follow-up communications, in particular after complex treatments, the practice should call the patient the next day or at least send a text message or email to keep the patient fully informed about what they can expect and what happens next. To encourage treatment uptake, treatment plans should be shared after the appointment, so patients can access the details at any time. A series of automated follow up emails, reminding patients that outstanding treatment is available, will also help prompt a swift decision, by proactively providing the patient with all the necessary information.

Consumers now expect to be the central focus for retail organisations and patients seeking dental treatment are no different. They have choice and if their current practice is not delivering the service they desire it is very easy to move to an alternative. Getting the whole team to understand the specific role of each individual in delivering a great patient experience and appreciating the roles that others play, helps create a team dynamic that always makes the patient the central focus – and for healthcare providers this can only be a good thing.

Developing internal processes and using tools that help streamline communications and improve efficiency all contributes to the smooth running of the practice and therefore has a positive impact on patients' perceptions. I can say with some authority – and for obvious reasons – that **EX**ACT **V13** from Software of Excellence is innovating every aspect of the patient experience, and in doing so leading the way. New modules, automated marketing communications and smartphone integration make it the UK's leading dental software system. Now, with its emphasis on putting the patient experience at the heart of the practice, **EX**ACT **V13** can help the whole team make every patient feel valued. After all, they are the lifeblood of everything we do. ◆

For more information about practice management software solutions, visit www.softwareofexcellence.co.uk

Guy has over 15 years' experience working in Marketing Services and has spent the last 5 years at Software of Excellence in a variety of Marketing, Product and Customer Success roles. He has helped shape the development path for SoE's flagship EXACT practice management software, and heads up the Customer Success Team which supports the company's ethos of helping to turn good practices into great businesses.

# Can a hygienist work without a nurse?

Len D'Cruz

BDS LDS LLM MFGDP DipFOd PGCert Med Ed qualified from the Royal London Hospital in 1989 and owns a seven-surgery practice in Woodford Green that has been part of the NHS new contract pilots/prototypes since September 2011

Reena Wadia

BDS Hons (Lond) MJDF RCS (Eng) MClinDent (Perio) MPerio RCS (Edin) FHEA. Specialist Periodontist at RW Perio & King's College London

Len D'Cruz and Reena Wadia on the nuances both practice owner and hygienist need to know about employing a nurse

There is a saying that you can think problems into existence. This was very much the case when the Standards for the Dental Team[1] guidance was issued by the GDC in September 2013 and astute observers picked out Standard 6.2 under the general principle of 'Work with colleagues in a way that is in patients' best interest' which said simply 'You must be appropriately supported when treating patients'.

Commentators determined that since GDC guidance applied equally to all members of the team this must mean that hygienists had to work with a nurse. To do otherwise would put their professional registration at risk. Unsurprisingly at the time hygienists felt their only course of action was to down their instruments and demand a nurse, both for their own protection as well as that of their patients.

A careful review of the wording and the intent behind it should reassure practice owners and hygienists alike that whilst there may be sound practical reasons for having a nurse to assist them whilst they work, there is no legal or regulatory imperative to do so.

The first clue to the intent behind the guidance is the word 'must' which is qualified by 'appropriately supported'. Here the GDC envisages clinicians such as dentists,

hygienists and therapists not working in isolation but with other members of the team who can assist primarily with a response to a medical emergency.

Clearly 'support' can be provided for administrative tasks such as making of appointments as well as chaperonage and chairside assistance, all of which adds to the efficiency of the delivery of care.

Further on at 6.2.2, the GDC guidance says: 'You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting'. The instruction is a 'should' rather than a 'must' which the GDC itself distinguishes between.

Registrants are directed not to provide treatment if you feel that the 'circumstances make it unsafe for patients' (6.2.1).

For many years hygienists had been treating patients without a nurse entirely safely and with minimal risks before this guidance was issued. Logically, nothing has changed to make the delivery of hygienist care unsafe and therefore what is required is a risk assessment.

This risk assessment undertaken by the individual hygienist would be to look at the process of delivering care and treatment and to establish if any aspect of it is rendered unsafe by the absence of a nurse.

A hygienist scope of practice is quite wide including, for example, placing rubber dam and administering inhalational sedation and these treatments may well warrant the support of a nurse.

There is an onus on the referring dentist that they should only delegate or refer to another member of the team if they are confident that the team member has been trained and is both competent and indemnified to do what is being asked of them (6.3.1).

There is no better way to assess this than volunteering your own mouth to be the test bed of this skillset. If nothing else, you will end up with clean teeth and a greater empathy for all dental patients who see you and sometime cough and splutter their way through treatment because you didn't give them a chance to breathe or swallow or wince in pain when you are a bit heavy handed with the scaler.

Employing a full-time nurse to assist the hygienist is an ideal that a primary care practice might work towards but it is not the norm in the UK and even less likely where a hygienist is providing periodontal care on the NHS under a Band 2 fee. It is important to remember however that Standard 1.7.1 warns us that we should always put our patients interest before any financial, personal or other gain.

## The clinical side

If you employ a hygienist working without a nurse, from time to time practice owners will have heard about how it can feel like a daily struggle. Hygienists are expected to carry out a full six point pocket chart, perform effective debridement, write up good quality contemporaneous notes, turn over the chair and complete decontamination of all the instruments – without running late.

> 'Employing a full-time nurse to assist the hygienist is an ideal that a primary care practice might work towards but it is not the norm in the UK and even less likely where a hygienist is providing periodontal care on the NHS under a Band 2 fee.'

In most practices, working without assistance as a hygienist is not uncommon and there is often little room for negotiation. However, working efficiently and smoothly without assistance is not impossible and looking at it from a positive perspective, a hygienist that can do just that would certainly be seen as an asset to any practice and valued professionally amongst the team. For this reason, the following strategies will help to allow you to practice successfully without assistance:

1. Arrive 30 minutes before your first patient as this will give you sufficient time to go through the notes for each patient for that day, allowing you to prepare in advance. Whilst going through the notes, look out for anything that may trip you up and make a note on your day list. Set up as many trays as possible. During this prep time you may also need to stock up on any oral hygiene products, so you don't run out in between patients.
2. If you have to complete a six point pocket chart without a nurse:
   a) According to the BSP guidelines, you only need to record probing depths of 4 mm and above so this should save you time.[2]
   b) Use a single-use keyboard cover so you can type whilst still wearing your gloves.
   c) You may prefer to use a paper template pocket chart and a pen with a plastic cover. Once the pocket chart is complete, the information can then be transferred onto your computer system.
   d) Voice record the pocket chart (ensure no patient-sensitive information is recorded) and then transfer onto your computer system.
3. For treatment, work on developing your own tips and tricks that can make your life easy. For example, tucking the saliva ejector tubing under the patient's arm saves you from needing to hold it. Also, be aware of what's out there in terms of equipment. A new suction tip has recently been launched which also has a mirror attached – this might be especially helpful when working palatially.
4. Communicate with your patients that a 30-minute appointment does not mean they will be in the chair for 30 minutes. This is something the reception team and the dentist referring patients to you should also be aware of and support. They will be seen within the allocated time slot. This time also includes time needed to set up for them and potentially decontaminate instruments.
5. If your practice has a shared nurse arrangement this can be helpful for decontamination so make the most of it. If you can also identify at the start of the day those patients you'll need to complete a full six point pocket chart for then you can let the nurse know in advance and perhaps denote this on your appointment book so the whole team is aware. ◆

With a bit of careful planning, you can think through the obstacles that might face a hygienist working without a nurse out of existence.

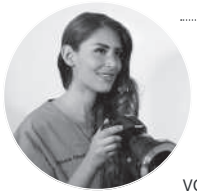
1. General Dental Council. Focus on Standards. Available online at: https://standards.gdc-uk.org/ (Accessed January 2019).
2. British Society of Periodontology. Basic Periodontal Exam (BPE). Available online at: www.bsperio.org.uk/publications/downloads/39_150345_bpe-2016-po-v5-final.pdf (Accessed January 2019).

# A new age techno world

By **David Westgarth**, Editor BDJ In Practice

## Dr Teki Sowdani

Teki qualified from the University of Sheffield in 2009. Since then he has completed the MJDF qualifications at the Royal College of Surgeons. Teki has dedicated himself to postgraduate education to offer his patients the latest in minimally invasive dentistry techniques



## Dr Rhona Eskander

Rhona is a multi-award winning and nominated practitioner in London. She graduated from Leeds University in 2010 and completed her vocational training in Kent. She continues to inspire students in facial aesthetics and dental aesthetics by also providing invaluable knowledge in marketing and ethical sales

Millennials these days get the blame for all sorts. Rental markets. Avocados. 'Portfolio careers'. And the ironic thing is there are a significant number of people out there who don't really know who millennials are.

Whatever generation you refer to, there is one thing you cannot escape from – the huge boom in technology.

Those growing up with information at the click of a finger or the swipe of an app have a distinctly different outlook on life compared to those who did not and have had to adapt to the digital world around them. But how have today's younger generation shaped the demand for orthodontics? **Dr Teki Sowdani** and **Dr Rhona Eskander** offer their take on the future of orthodontics to *BDJ In Practice*.

*Do patients tell you what they want rather than describe the problem they'd like to fix these days?*

**RE** Absolutely. The rise of social media means that people especially millennials do their homework and dictate what they want through watching videos and observing people's experiences. With orthodontic trends, such as predictive Invisalign/ iTero digital demos/outcome simulation,

fit the millennials' demand to see what you're in for and they often know what a ClinCheck or iTero are and talk about them knowledgably.

**TS** Prior to their appointments, patients will do their research. They would have spoken to lots of people as they are more connected these days and can speak to anyone within the country. They tend to diagnose themselves and don't hesitate to go on multiple consultations. So very often they even have an idea of a treatment plan and just want to compare the offers. It could be because they are keen to have a second opinion or they are trying to get a better deal. Patients are more consumers now, not shy and very forthcoming.

Reassuringly only a small group are price driven. The fact that dentists usually offer free consultations prompt people to shop around, check which place is easier to get to, the one that is the most comfortable too.

You also have people who will seek you out specifically from personal recommendations.

### *How difficult – or otherwise – is it to work with their demands?*

**RE** It has its difficulty. They are the 'I want everything yesterday' generation. However, if you learn to meet their demands, they're a delight to work with. For example, many millennial bloggers I treat put their Invisalign journeys on their social media pages. This generates lots of referrals. It's become the digital word of mouth.

**TS** It is sometimes more difficult as the level of knowledge is either wrongly gained from poorly informed sources online or from dentists who have offered differing opinions.

Some dentists who don't do a particular treatment will 'down talk' it as they don't feel comfortable with it or are not good at it. I have had messages on Instagram from patients saying that they had been recommended not to do a specific treatment. Ultimately there is no blank canvas, but offering knowledge to breakdown misinformation is key, and this requires time and tact. You cannot criticise your peers so you somehow have to explain that there are different ways to reach your target.

### *To what extent do you think social media has driven the desire for straighter teeth or whiter teeth?*

**TS** Social media is definitely strong and powerful. I have had many, many instances where patients I know look completely different on their social media pages; the beauty of editing pictures and filters! But there is a reality, and all this creates is perception. They all have nice teeth on social media, and this creates additional pressure to look good.

**RE** I think it's increased the demand by 200%. People can't get away from the camera. They want whiter, brighter, smiles. In fact, the term 'snap chat dysmorphia' was coined by a cosmetic doctor because he recognised that people want to look like their filters. In the past they wanted to look like celebrities but now they want to look like filtered versions of themselves.

> 'People can't get away from the camera. They want whiter, brighter, smiles. In fact, the term 'snap chat dysmorphia' was coined by a cosmetic doctor because he recognised that people want to look like their filters. '

### *If their oral health isn't up to scratch, is this a motivator to send them away and get them back again when they're ready?*

**TS** You get a minority of patients who will not get motivated no matter how hard you try. But most of the time oral health is hugely improved as a result of a cosmetic treatment. They pay a substantial amount of money and they are keen to maintain their oral hygiene, so when you recommend an electric toothbrush, patients don't hesitate. You have to bear in mind the patient's disposable income – so I always advise them that there are a number of choices from the treatment ranges I recommend, from a start-up model to a top of the range like the Sonicare, for example.

**RE** Yes for sure. People like to spend money on what they want not what they need. They spend emotionally. So if they want that smile but can't have it until they're cleaning properly they'll do it.

### *How do they respond to being told no these days?*

**TS** Patients already have knowledge, so they ultimately are coming for a treatment and not a discussion. So yes, they don't respond very well when you contradict them.

**RE** Not well. They will try and coerce you into doing what they want but if you explain with passion and give them a positive experience then they'll respect it. Millennials and the z generation are all about experiences. So really if you want to give them a more comprehensive plan and give them a team experience, they'll comply.

### *Has technology at your disposal driven demand, or has demand necessitated that technology keep up?*

**RE** I think technology has driven demand. The millennials and z are about self-education and that's through social media and digital word of mouth. People trust people. If you're treating someone with a high following they'll trust what that person is saying.

Visual platforms like Instagram mean people can form their own opinions on the work you do. This means that I have pushed the boundaries and now use videos on my media to educate my patients and the public. When Instagram introduced videos 5 million were uploaded in the first 24 hours. This pushes you to keep up with constant technology interaction.

**TS** I would say both. Demand has increased in the last two to three years. We always have to develop and keep up with the latest technology or risk losing patients. Because they use social media, they can travel all over the country because of what a dentist offers to meet their demands. This is a driving factor for me as a dentist, and that keeps us on our toes.

### *Is compliance an issue, even with the financial investment patients make these days?*

**TS** Compliance is still an issue for a minority of patients. Reassuringly I would say that compliance is better than ever and it is probably attributed to the fact that there is a lot of pressure to look good.

There is also a reversal of trend, you do not tend to recommend products to patients as they often initiate the steps and ask for your advice on a specific product they would have seen online.

**RE** It depends on the case. Some comply and some don't. But that's like patient who have perio or lots of fillings. Motivation can be instilled but not forced. ◆

# Reviewing staff pay

By James Dawson

James is head of advice publications in the Practice Support team at the BDA, responsible for the Association's guidance documents for members in general practice on legal matters including associate contracts and staff employment

Pay is a key factor affecting relationships at work, and with spring coming along and the end of the tax year (and in England and Wales the NHS contract year) in sight, employees might hope for an annual pay rise. However, whether practice finances can oblige or not will depend on the practice circumstances, the sort of year you have just had and your expectations for the next year. Most employment contracts do not commit the employer to awarding annual pay rises, so, as long as pay rates remain at least in line with the National Minimum Wage there is no legal reason to increase pay.

Nevertheless, you should review pay rates on a regular basis since what employees earn has a considerable effect on their efficiency, motivation and morale. You should aim to offer competitive rates of pay but understand the associated costs and effect on your cashflow. Paying staff is the highest single item of expenditure for dental practices, according to NHS Digital accounting for about a third of practice costs.

Reviewing pay rates should be considered alongside the current economic climate and your recent performance. This allows you to look at business costs, check whether your rates are competitive with other employers and shows your team that you are thinking about them. Any review must be objective, your review should take into account the:

- Practice's performance in terms of patient numbers, treatments and revenue
- Inflation and cost of living changes
- Average wage increases across the economy
- Local job market and remaining competitive with other practices and other potential employers
- Effect of differentials between different job roles
- Individual performance.

Official statistics on national wage and price movements are widely reported in the press and will influence staff expectations. The Consumer Price Index (CPI) and the Retail Price Index (RPI), published by the Office for National Statistics, measure the average cost of living. Maintaining pay increases in line with the CPI or RPI will help you to maintain the spending power of your staff. The Office for National Statistics also publishes statistics, which provide information on employee earnings, recent figures from the Annual Survey of Hours and Earnings show:

If you are able to increase pay rates you must ensure that you do not discriminate against any employee on grounds of age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex or sexual orientation. You must provide the same *pro rata* benefits to full-timers and part-timers in the same role, including the same basic hourly-rate. All differentials or variable pay rates must be objectively justified. Therefore, if you feel that some team members deserve higher pay increases than others, you must be able to give a reason for it, for example, a dental nurse who has gained additional qualifications in radiology or oral health education.

If you conclude that practice costs and profitability mean that you cannot offer a pay rise this year, at least by going through a review you can explain the situation to the team. This shows that the issue has not been forgotten and should, hopefully, gain their understanding.

If you have had a good year and are on target for increasing your current level of income, then the likely conclusion of your pay review is that you will increase wages, in order to share the success with the whole practice team. This helps retain employees and avoid the cost and uncertainty of recruiting replacements and will hopefully allow you to continue working together to maintain the practice's performance.

Of course, pay and financial benefits are not the only performance motivator and you could look at enhancing these.

Employees could be offered other financial benefits, such as:

- Enhanced sick pay
- Enhanced maternity paternity and adoption pay or
- Additional pension contributions.

A basic entitlement to all these are required by law but by enhancing these payments you show an additional commitment to your employees and hopefully receive loyalty in return. Also fringe benefits that you could provide include travel costs, child-care vouchers, dental care, gym or health club membership or the payment of professional registration fees.

There are also non-financial ways to show your appreciation, such as recognising achievement or boosting team morale. Other motivating factors include job security, job satisfaction, training to encourage employee development and recognition. Bear in mind some benefits could have tax implications; seeking independent financial advice is essential.

Your pay-and-benefits package must make your employees feel that the job is worth doing. They will expect fairness and transparency and should know what payments and benefits they can expect and what circumstances might allow them to receive more.

Read more at the updated BDA advice sheet at: www.bda.org/dentists/advice/Pages/employing-staff.aspx

**Hourly rates excluding overtime (ONS, 2018 provisional results)**

| Job | Mean | 25th percentile | 50th percentile (Median) | 75th percentile |
|---|---|---|---|---|
| Dental nurses | £10.47 | £8.82 | £10.00 | £11.58 |
| Practice managers (medical and dental) | £16.97 | £12.95 | £15.85 | £20.44 |

For independent financial advice contact Lloyd & Whyte. BDA members can find out more here: www.bda.org/dentists/advice/lloyd-and-whyte

# What to expect when your employee is expecting

By Samantha Harris

Samantha is a contracts advisor in the BDA Practice Support team. Samantha advises members of their commercial liabilities when entering into associate position

Your employees are entitled to 52 weeks of maternity leave, this is split into two sets of 26-week periods, Additional Maternity Leave ('AML') and Ordinary Maternity Leave ('OML'). The most important difference between OML and ALM is the employee's right to return to work at the end of their maternity leave.

If your employee decides to return to work at the end of OML, they have the right to return to their old job, however if the employee chooses to return to work at the end of AML, their rights to return will be different. If it is not practicable to offer them their old job back, then you are required to offer them a similar job on the same terms. Circumstances when it is not practical for an employer to offer the employee their old position back might be if the old position no longer exists.

## Finding out about pregnancy

In most cases, an employee will inform you of their pregnancy in conversation, however they should follow that conversation up in writing by giving you their MatB1 form. The MatB1 form shows the expected date of birth, and is signed off by a doctor or midwife. The employee is required to give you their MatB1 form by the 15th week before the their expected week of birth. The 15 week period is intended to allow enough time for alternative arrangements to be made while the employee is on their maternity leave.

Within 28 days of receiving the employee's MatB1 form, you should write to the employee confirming the start date of their maternity leave and their return to work date. You should assume that the employee will be taking 52 weeks leave and this is the basis on which you should calculate the employees return to work date. An employee, however, is not required to take the entire 52 weeks and they will need to inform you of their intention to return to work earlier with at least 8 weeks before the date they wish to return.

## Risk Assessments

Working in a general dental practice has a range of common risks, it is your job as an employer to identify, assess and minimise or control these risks for your pregnant employee. Some of these risks include infection control, ionising radiation or chemical products. Note that you should also do a risk assessment for employees returning to work who have given birth in the past 6 months or are breastfeeding. As an employer you should carry out a risk assessment as soon as you are notified of an employee's pregnancy. If a risk cannot be removed or controlled then you will be required to make other adjustments such as offer alternative work or temporarily adjust working conditions.

## Choosing maternity leave dates

Flexibility is fundamental to employees when they take maternity leave. They are able to select the date they would like to begin and end their maternity leave. The employee could even choose to work up until the day before birth. However, if they are not in good health then maternity leave will start in the four weeks leading up to the date of birth. The absolute earliest an employee can start their maternity leave is 11 weeks before the week of childbirth (which is when the employee would be about 29 weeks pregnant).

There are two scenarios where maternity leave might start automatically:

1. If the baby is born before the due date, then the maternity leave will automatically start the day after the day of birth; or
2. If the employee is off work for a pregnancy related illness four week before the week of expected birth.

In both scenarios, the employee will need to inform the employer of the new end date of their maternity leave. It is good to communicate with your employee throughout their leave to maintain a good relationship and to make sure there are no miscommunications. You might even want to make a return to work plan with your employee to try and make their return as seamless as possible.

## Keeping in touch

Employers and employees can agree up to 10 KIT (Keeping In Touch) days. These optional days can be used throughout the period of maternity leave and are a way for the employee to remain in contact with their workplace. It is also a good way to maintain a respectable relationship with your employee. There are no rules about paying for KIT days, so it is good practice to agree in advance about payment for KIT days. Keep in mind that you do need to pay at least the national minimal wage for KIT days.

## Flexible working

If an employee decides that they would rather not return to work, then they are required to give you their contractual notice period. This means they need to give the required notice period in their employment contract for termination.

Quite often, employees will cut down their hours on their return to work after maternity leave. To do so, the employee will need to submit a flexible working request. It is advisable that you touch base with your employee during their maternity leave to establish if they are keen to come back to work as a part time employee, instead of a full-time employee. You should consider all flexible working requests from new mothers fairly. Good communication with the employee during their maternity leave can help you run your business more smoothly. ◆

# Managing frequent short-term absence

By Nashima Morgan

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

Staff sickness can be difficult for small businesses with few employees to manage, its impact affects the whole dental team; the reception and front of house could be left unmanned, associates left without a nurse, nurses having to move around and so on. Sickness cannot be avoided – everyone can get sick, so the return to work interview should not be designed to worry the employee about taking time off for genuine sickness.

This article will give you guidance on how to create a non-confrontational approach imperative in a small dental practice where the HR team is a one-man band of either the practice owner or the practice manager, working in close proximity with the dental team on a daily basis so to maintain those working relationships is essential.

Striking a balance between adopting a firm stance and being supportive is vital to ensure that the fear of taking sick leave is reduced. The fear of taking sick leave itself can lead to further issues – either the illness being spread within the practice if it is a sickness or cold bug; or it could lead to the employee's condition becoming worse, leading to more time off. It also harbours the sense that you or your practice manager are uncaring and this can lead to a demotivated dental team.

Employees should not feel that they should attend work when they are not fit to do so, as this could lead to claims of harassment.

The whole dental team should be treated the same and consistency across the practice is important. Whether a nurse or a receptionist takes an *ad hoc* day off sick, all should have a return to work interview and the practice a well-written and clear absence management policy. BDA Expert members can access a template. Fundamentally, it is at the heart of a proper approach to managing absence. Generally, the formalisation of a back to work interview can introduce the element of a fear factor in an employee this can be reduced by keeping the meeting informal but professional.

© Darren Johnson iDJ Photography / Moment / Getty Images Plus

The employee will know exactly what to expect when they return to work. It will allow you to put in place measures to minimise and control sickness absence.

As soon as the employee returns back to work, the first thing you should be thinking about is arranging the return to work meeting on that day. The meeting should only take about 20 minutes of your time. Explain that it will help you to understand the reason for the employee's absence and that you are genuinely concerned about their health. Allow the employee to talk and do not interrupt, except to acknowledge. Be understanding friendly and tactful; these meetings should not be accusatory and should ensure that the employee knows that you will treat their absence as genuine. The point of the return to work interview is not to undermine the employee, it's to ensure that you have an accurate record of all sickness absence and acknowledge that you have taken the time to note it and to identify any underlying problems. If you have an employee that is always sick on a Monday, noting it and then discussing it during the return to work meeting will be less accusatory and it might deter the employee from taking the time off if it is not genuine.

Invest some time now and ensure you have a robust policy with a set of pre-prepared questions to help you manage the *ad hoc* day off work taken by employees. Keep the meetings relaxed and friendly – if the employee has been genuinely ill, they will have already been through a challenging time. The meeting is not intended to catch them out.

Refer to www.bda.org/dentists/advice/Pages/employing-staff.aspx 'Sickness Absence' for further information.

# DBS checks in practice

By James Goldman

James is the Associate Director of Advisory Services. He has represented practitioners in many Employment Tribunal disputes and has mediated in numerous partnership disputes

Do you need to get your own DBS checks done for all GDC registrants in your practice?

Of course you do. At least that is what one local area team is insisting. In England, the Health and Social Care Act 2008 (Regulated Activities) Regs 2014 (which the CQC is responsible for enforcing) states you need: '*…. a copy of an enhanced criminal record certificate issued under section 113B of that Act together with, where applicable, suitability information relating to children or vulnerable adults.*' It does not state you need to obtain your own check. Just 'a copy'. Or is it implied that it has to be one done by you? The requirement for DBS checks arises because, in a very small number of cases, some medical people have caused irreparable harm to people.

Consider Larry Nassar, the US doctor who treated and sexually abused many members of the US gymnastics team and hundreds of others. The university where he worked failed, after a complaint was made, to implement some simple measures that would have prevented further abuse of many other women. It cost them $0.5bn (£380m).

In the UK, we had Ian Paterson, the breast surgeon who was recently convicted for carrying out unnecessary surgery on women's breasts. There were hundreds of victims.

These cases tell us that there are some people, who may appear to be amazing practitioners, who are in high demand, who appear to be invaluable to your business, and who may be causing substantial harm under your nose.

Whilst there are only a very small number of people, like Nassar, Paterson and Jimmy Saville who have caused such a terrible amount of harm to such a large number of people, there will be many more who are less dangerous, but who still need to be stopped.

You can argue that DBS checks are not the only answer, they are not a panacea that will prevent all abuse. But they are an important part of the prevention strategy. They may tell you that someone you are about to trust with patients must not be trusted. They may have information not just about criminal convictions, but other concerns that have been raised with the police.

It is also fair to say that, whilst there have been a very small number of dentists who have deliberately harmed patients, dentistry does not lend itself to abuse as much as the areas that Nassar and Paterson were involved in. It is also more difficult for dentists to cause harm because there is a nurse in the room (not that having a chaperone stopped Nassar).

But, the law is that you need a DBS check for every GDC registrant working under your CQC registration. That consultant who comes in one day a month needs a DBS check.

DBS checks help because they tell you, at the time you get them, that your new recruit does not have a record of doing anything you need to know about. They are, of course, only valid at the time of issue. The theory is that, if one of your dental team was involved in court proceedings whilst working at your practice, you would know about it and you would take appropriate action.

The information in a DBS check is not dependant on the person who applies for it. If one practice receives a DBS check which shows no concerns, it seems unnecessary for another practice to obtain another check to get the same information.

But this raises the question about relying on a DBS check from another practice. And what do you do when someone starts working for you and you are waiting for a DBS check to come through? CQC guidance states: 'People taking up a new position who are currently working in services regulated by CQC can satisfy the expectation that they will have an appropriate DBS check if they can provide evidence of a check, at the right level for their role, that is less than three months old at the point of application.[1]

More often than not, the new person will not have a DBS check that is less than three months' old. Our view is that risks to vulnerable people can be controlled. If someone joins your practice, it is acceptable

© Science Photo Library / Getty Images Plus

to allow them to work until you get your own DBS check done on them if:

- You have a copy of the previous DBS check
- You have a reference from the previous practice or employer stating that nothing untoward has occurred since that check
- You have a risk assessment to consider the harm that the person could cause if they were so minded and how you control that risk. The obvious one is that the new person is not left along with a patient until the new DBS check comes in.

Like anything, each case may depend on its own facts. If you are relying on a DBS check from a previous practice or employer, consider how old it is, whether you can get a reference to cover the period, the nature of the work the person will be doing, whether they will be working alone or with someone else and whether they will be working predominantly with more vulnerable people.

1. Care Quality Commission. Disclosure and Barring Service Checks Guidance. Available online at: www.cqc.org.uk/sites/default/files/20171218_100646_Disclosure_and_Barring_Service_checks_guidance_v6.pdf (Accessed January 2019).

Products and Services In Practice is provided to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ In Practice*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

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

## Reliable vitality testing

Pulpal sensibility testing with Endo Frost is a proven method for accurately and reliably determining pulpal vitality.

For ultimate reassurance when assessing your patients, choose ENDO-FROST from leading endodontic manufacturer and distributor, COLTENE.

ENDO-FROST can be applied directly to cotton pellets using a spray nozzle, offering a quick, simple and effective method of testing the response of nerve fibres in individual teeth.

It's also completely odourless to ensure patient comfort and compliance during use.

To add to your shopping list or to find out more about the essential endodontic accessory, contact COLTENE on www.coltene.com, email info.uk@coltene.com or call 01444 235486.


## Your cabinetry matters

A dental surgery is comprised of many tools and pieces of equipment, but at the centre of it all – along with the treatment unit – is your dental cabinetry.

Integral to the delivery of patient care and surgery workflow, the cabinetry you choose can have a significant impact on your performance. It's also one of the first things your patients see when they walk through the surgery door, so will inevitably have an impact on their overall impression of your practice and the service you provide.

For both of those reasons, quality cabinets should always be at the top of your wish list. RPA Dental, one of the UK's most respected suppliers of top-of-the-range equipment, recommends Tavom cabinetry.

There are a number of ranges available, each of which can be altered to meet your specific requirements and come in a variety of attractive colours and finishes with the option of flush floor or an elevated position base.

For optimal workflow and positioning, RPA Dental will design the best layout, install the cabinetry and provide ongoing support and servicing for lasting results.

Visit www.rpadental.net or call the London and Manchester Sales and Service Centres on 08000 933 975.



## Ask, learn, share

Carestream Dental understands what it means to deliver on-going support and useful resources for all of its clients.

The Exchange is designed precisely for this – it is an online portal that enables users of Carestream Dental technologies and software to ask questions and share experiences with peers. With product experts on there too, The Exchange is perfect for seeking specialist advice and guidance as well.

Whether you are looking to maximise on the CS R4+ features available, or could benefit from practical hints and tips with the CS 3600 intraoral scanner, this platform has something for you.

Join The Exchange for free at community.carestreamdental.com.

## Defend against disaster

The effects of incidents such as fires are more damaging than you might imagine. Not only do you have the property to worry about, but what about the loss of patient data?

Ensure your practice keeps sensitive patient images safe by choosing PROPACS from PRO Diagnostics UK.

A cloud based, highly encrypted storage solution for images, PROPACS not only stores images safely but can also protect said images from cyber threats such as viruses, malware and hackers. This means that even when the unspeakable happens your patient images will be ready when you need them.

For more information, visit www.prodiagnostics.co.uk or email sales@prodiagnostics.co.uk.

## A confident smile for Valentine's Day

To help your patients to achieve a confident smile and fresh breath this Valentine's Day, recommend CB12 mouthwash.

CB12 has been clinically proven to both target and neutralise the volatile sulphur compounds that cause halitosis, and inhibit the formation of biofilm to prevent unpleasant breath for up to 12 hours.

The innovative, patented formula of CB12 contains antiplaque agents and fluoride to enhance hygiene levels and help to prevent caries. Encourage your patients to add CB12 to their oral health routine to enjoy long lasting results – perfect for those with any pre-date worries.

For more information about CB12 and how it could benefit your patients, please visit www.cb12.co.uk.


## Innovating tradition

With technology moving fast, it can feel like traditional values are getting lost.

Castellini, the producer of dental units since 1935, is passionate about combining tradition with innovation, to meet the changing needs of the dental industry.

Its range includes the Puma ELI Ambidextrous (a single unit for left and right-handed users) and the Skema 5, including micromotors and a vast accessory range.


A Castellini unit will help you achieve reliable treatment outcomes, and help your raise the bar.

With excellent customer service a given, find out more about Castellini units by contacting its supplier, RPA Dental on 08000 933 975.

## Stop, look and Lisa

Leading manufacturer, W&H, offers clinicians the all-new Lisa steriliser, which delivers outstanding performance without compromise.

Improving efficiency and saving time, Lisa offers an exceptionally fast B cycle, at half an hour for an average load, or just 13 minutes for unwrapped instruments.

Safety and reliability is assured. Information is easily accessible through a user-friendly touch screen or via the new app, for intelligent and easy handling of traceability.

All you need from a steriliser can be found in Lisa. Start saving precious time on your procedures, safe in the knowledge that this technologically advanced, cost-effective solution will last for years to come.

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

## Widen the options

Traditionally zirconia has been unavailable for NHS patients due to its cost.

However, with Monolith Full Contour Zirconia from CosTech Dental Laboratory this is no longer the case. Thanks to bulk buying, the steadily decreasing cost of zirconia and automating the production process, CosTech can now offer zirconia restorations for under £30 including free postage to and from the laboratory.

Available as both anterior and posterior crowns and up to 3-unit bridges, this aesthetic and strong material is perfect for a wide range of indications, meaning you can provide more patients with a truly trustworthy solution.

Find out more by visiting www.costech.co.uk or call 01474 320076.

## Service, technology and education

As the first dental lab in Europe to operate both the Renishaw AM250 Laser Sintering Machine and DryLtye Chrome Polishing System in one place, Sparkle Dental Labs is proud to be leading the way in technological advances.

It has combined this with a commitment to consistently deliver a prompt, friendly and professional service, ensuring you receive all the support you need to provide excellent patient care.

Through continual education and training of its dental technicians, state-of-the-art facilities and strict quality assurance procedures, Sparkle Dental Labs offers you a service you can rely on. Find out more by contacting the team on 0800 138 6255, or visit www.sparkledentallabs.com.

## Vegan-friendly treatment

Veganism is growing in popularity, but patients might not be aware of the possible oral health implications of this plant-based diet, which can cause dental erosion and decay.

Remind patients to follow effective at-home oral care routines with high quality, vegan-friendly adjuncts supplied by leading oral healthcare specialist, Curaprox. This includes the CS 5460 ultra soft manual toothbrush, which has been innovatively designed with fine CUREN filaments to facilitate efficient, but gentle tooth brushing.

When combined with the Black Is White range, Curaprox delivers the complete dental cleaning solution, so that patients can ensure their teeth always look and feel their best.

For more information call 01480 862084, email info@curaprox.co.uk or visit www.curaprox.co.uk.


## Seeing behind the smile

Adult orthodontics, high-end restorations such as veneers and natural coloured inlays/onlays and crowns are in high demand. But to help your patients to successfully maintain their investments, use the CALCIVIS imaging system.

The CALCIVIS imaging system uses a specific photoprotein that produces bioluminescence in the presence of free calcium ions as they are released from actively demineralising tooth surfaces. This is presented at the chair side as a live, glowing map and provides a means of visualising and tracking any changes to tooth surfaces including those at the margins of restorations at their earliest, most reversible stages.

For an early detection system that helps patients to better understand their oral health, find out more about CALCIVIS visit www.CALCIVIS.com or call 0131 658 5152.

## Become part of something more

When you refer your patients to a specialist practice, you want to know that you can trust the professionals who will be taking over your patients' care. Effective communication is the key to this, which is why, at EndoCare, we are dedicated to keeping you involved with the progress of your patient's treatment plan.

To emphasise this, we have developed the Speciality Referral System that delivers:

- Unique quality of treatment
- Predictability
- Efficiency
- Communication
- Patient satisfaction
- Reliability
- Trust and partnership
- Time saving
- Legal safety.

On top of this, you can rest assured that the team of specialists, led by Dr Michael Sultan, will have the training, experience and equipment to carry out even the most complicated endodontic treatments.

With EndoCare, you can become part of a dedicated community of open and trustworthy professionals.

For further information call EndoCare on 020 7224 0999 or visit www.endocare.co.uk.

# Dentist to Dentist

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

## North West

### DENTAL SPECIALISTS

www.dentalspecialistsmm.com

Dental Specialists Melton Mowbray – Specialist Private Dental Centre

20 Park Rd,

Melton Mowbray,

LE13 1TT, UK

**Dr Adetoun Soyombo** Specialist in Periodontics

**Dr Richard Craxford** Special Interest in Prosthetics

**Dr Ayodele Soyombo** Specialist in Orthodontics

**Dr Carol Subadan** Specialist in Periodontics

**On Specialist List:** Yes

**Services**: Periodontics, Dental Implant, Orthodontics, Sleep Disorder

### ST GEORGE'S DENTAL PRACTICE

www.stgeorgesdentalpractice.co.uk

19-21 St George's Street, Chorley, Lancashire PR7 2AA

**Tel:** 01257 262545

**Email:** info@stgeorgesdentalpractice.co.uk

**Interests:** Dental Implants, Oral Surgery, Orthodontics, Endodontic Specialist, Paediatric Dentistry, Restorative and Cosmetic Dentistry, Sedation

**On Specialist List: Yes, Endodontics**

## South East

### MOUNT VERNON DENTAL SPECIALISTS

www.mvdentalspecialists.co.uk

**Specialist Referral Centre In London**
Mount Vernon Hospital, Gate 1, Rickmansworth Road
Northwood, Middx, HA6 2RN
**Tel:** 01923 840 571
**Email:** info@mvdentalspecialists.co.uk

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

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

### HAPPY KIDS DENTAL

happykidsdental.co.uk

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

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

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

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

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

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

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

### DENTAL SPECIALISTS

www.dentalspecialistssa.com

Dental Specialists St Albans – Specialist Private Dental Centre

96 Victoria St, St Albans AL1 3TG, UK

**Dr Adetoun Soyombo** Specialist in Periodontics

**Dr Carol Subadan** Specialist in Periodontics

**Dr Juanita Levenstein** Special Interest in Orthodontics

**Dr Neil Kramer** Specialist in Endodontics

**Dr Ayodele Soyombo** Specialist in Orthodontics

**Mrs Meena Renka** Consultant Restorative Dentistry

**On Specialist List:** Yes

**Services**:

Periodontics, Dental Implant, Orthodontics, Sleep Disorder, Endodontics

### J SMALLRIDGE DENTALCARE

www.jasdental.co.uk

Childrens Dentistry
82 Berners Street, Ipswich, Suffolk, IP1 3LU
**Tel:** 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Specialist Prosthodontist - including implants for adults
Consultant Orthodontist
Oral Surgeon
Dentist with special interest in Periodontology
Clinical Psychology

## AYUB ENDODONTICS
www.ayub-endo.com

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

## Midlands

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

Pinfold Lane, Penkridge, Stafford, Staffordshire ST19 5AP
**Tel:** 01785 712388 **Email:** info@thepriorsdentalpractice.co.uk
**Dr Mark Emms L.D.S.R.C.S (Edin) MSc (UCL)**
**Interests:** Dental Implants, Fixed and Removable Prosthodontics, Bone Grafts, Sinus Lifts, Full Mouth Reconstructions, Periodontics, Occlusion, Restorative and Cosmetic Dentistry, Implant Mentoring
**Mr Rehan Ullah BDS, MFDS (RCPSG), MPhil, MOrth (RCPSG), FDSOrth (RCPSG)**
**Interests:** Specialist Orthodontics, Temporary Anchorage Devices (TADs), Lingual Braces
**On Specialist List:** Yes
**Dr Lukas Javorskis MSc Endodontology (Kaunas, Lithuania)**
**Interests:** Endodontics (including Instrument Removal), Use of on-site Microscope
**CT Scanner and dedicated implant suite on-site.**

## DENTAL SPECIALISTS
www.dentalspecialistsmk.com

Dental Specialists Milton Keynes – Specialist Private Dental Centre
259 Queensway, Bletchley, Milton Keynes MK2 2EH

| | |
|---|---|
| **Dr Adetoun Soyombo** | Specialist in Periodontics |
| **Dr Carol Subadan** | Specialist in Periodontics |
| **Dr Juanita Levenstein** | Special Interest in Orthodontics |
| **Dr Neil Kramer** | Specialist in Endodontics |
| **Dr Ayodele Soyombo** | Specialist in Orthodontics |
| **Dr. Ulpee Darbar** | Specialists in Restorative Dentistry |
| **Dr Vinsha Patel** | Orthodontics |
| **Dr Peter Yerbury** | Specialists in Prosthodontics |

**On Specialist List:** Yes
**Services:** Orthodontics, Periodontics, Restorative, Prosthodontics, Sleep disorders, Dental Implants, Endodontics, Oral Surgery & Sedation


Lloyd & Whyte

## Home Insurance that offers dentists extensive cover at low rates

As a dentist, Andrew holds a lot of responsibility. But the real work begins on Sunday, when he plays personal entertainer for his son.

We arrange Home Insurance that offers added peace of mind. Along with buildings cover, your belongings are also covered for accidental damage, loss or theft, anywhere in the world.

So, whether losing your laptop on the train to work, or to a rogue indoor cricket ball, you're covered. And, because dentists are considered low risk by insurers, most BDA members save money .

In proud partnership with

BDA
British Dental Association

**What matters to you, matters to us**

**01823 250700 ▪ www.lloydwhyte.com**

# In Practice CPD

**Q1:** By which week should a MatB1 form be submitted?

**A** 7 weeks before expected week of birth
**B** 12 weeks before expected week of birth
**C** 15 weeks before expected week of birth
**D** 19 weeks before expected week of birth

**Q2:** How many Keep In Touch days can be agreed?

**A** Up to 5
**B** Up to 10
**C** Up to 15
**D** Up to 20

**Q3:** Which of these does a pay review not necessarily need to take into account?

**A** CPI
**B** RPI
**C** Inflation
**D** National Living Wage

**Q4:** When should you arrange a return to work meeting after sickness leave?

**A** At the employee's discretion
**B** When they are free to do so
**C** On their first day back
**D** When it is convenient for you

WELCOME ONCE AGAIN to the *BDJ In Practice* continuing professional development (CPD) programme.

To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists keep up with the latest developments in the profession.

All the questions relate to articles in this issue of *BDJ In Practice*. By completing the answers online, you can earn one hour's verifiable CPD. Do so in every issue of *BDJ In Practice* and you can earn 12 hours' verifiable CPD in a year.

This programme is free to members. A record of the CPD you have earned from *BDJ In Practice* CPD is available to view and print at our CPD Hub. Responses must be completed within six months of the publication date because we need to ensure our questions serve their purpose in helping you keep up to date with current issues.

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

## Need help?

To access *BDJ In Practice* CPD online:

Either visit **www.bda.org** and select 'CPD' from the main menu, or type **cpd.bda.org** directly in the long white box at the top of your web-browser screen. When prompted, log into the BDA CPD Hub using your BDA website login email and password details.

**First-time user:** select *BDJ In Practice* CPD on the front page of the CPD Hub and enrol for the service. You will automatically be taken to the *BDJ In Practice* CPD page.

**Registered user:** Log into the BDA CPD Hub and select *BDJ In Practice* CPD to see the available CPD opportunities.

Select an issue and answer the questions. When finished, you will be prompted to view your CPD Record where you can see your result.

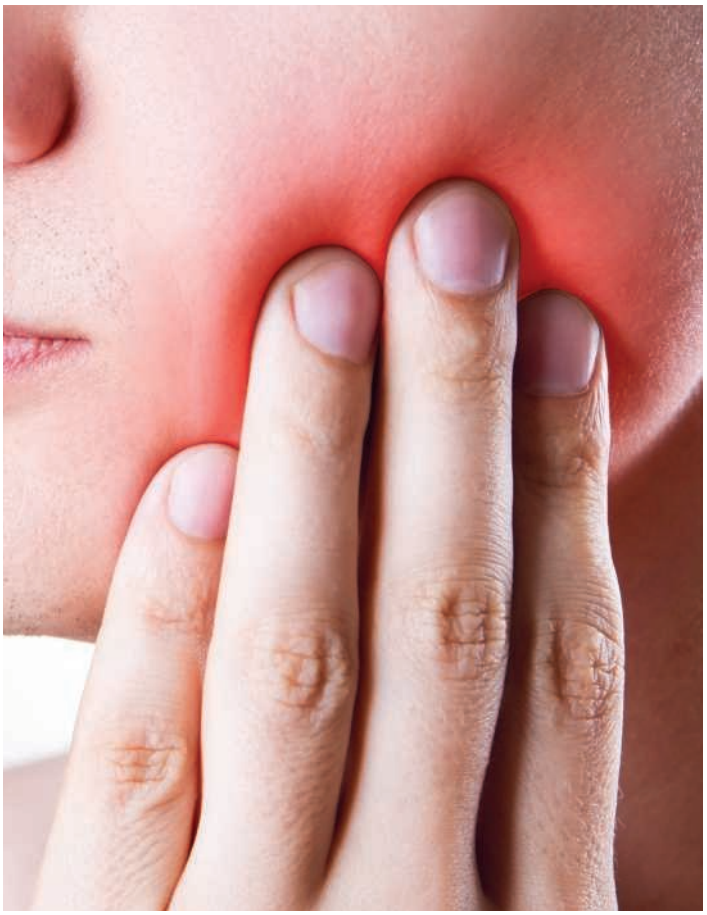
For support use: cpd.hub@bda.org

# Seminar Series

BDA
British Dental Association

# Pain management

## Diagnosing, preventing and treating acute and persistent oral pain




Professor Justin Durham
**Professor of Orofacial Pain, Newcastle University**



Professor Tara Renton
**Professor in Oral Surgery, King's College London**


LONDON | Friday 8 March 2019
MANCHESTER | Friday 20 September 2019

**6 hours**
**verifiable CPD**

DEVELOPMENT OUTCOME A B C D

Price: BDA members: £245 | Non-members: £335 | DCPs: £145

Book now:

bda.org/seminars

020 7563 4590 | events@bda.org

# HAPPY PRACTICE
# HAPPY PATIENTS

## Effortlessly attract new patients whilst providing the best possible first impressions and customer experience!


**Did you know that the average practice needs 20 new patients per dentist, per month just to stand still?**

Software of Excellence not only offers market-leading software, but also ongoing support from expert teams; all designed to **make life easier for the practice team AND your patients**. Our tools automate many manual tasks, from marketing campaigns, to managing your online reputation, along with a seamless online booking system, **giving you more time to spend on what's important – patient care;** whilst streamlining the patient experience both in and out of the practice.

**Talk to an expert today about how we can help transform your practice.**
Visit: **info.softwareofexcellence.com/happy-patients** or call **01634 624267**

www.softwareofexcellence.com

@UKSOE SoftwareOfExcellence SoftwareOfExcellence

SOFTWARE OF EXCELLENCE
A HENRY SCHEIN® COMPANY