BDJ InPractice

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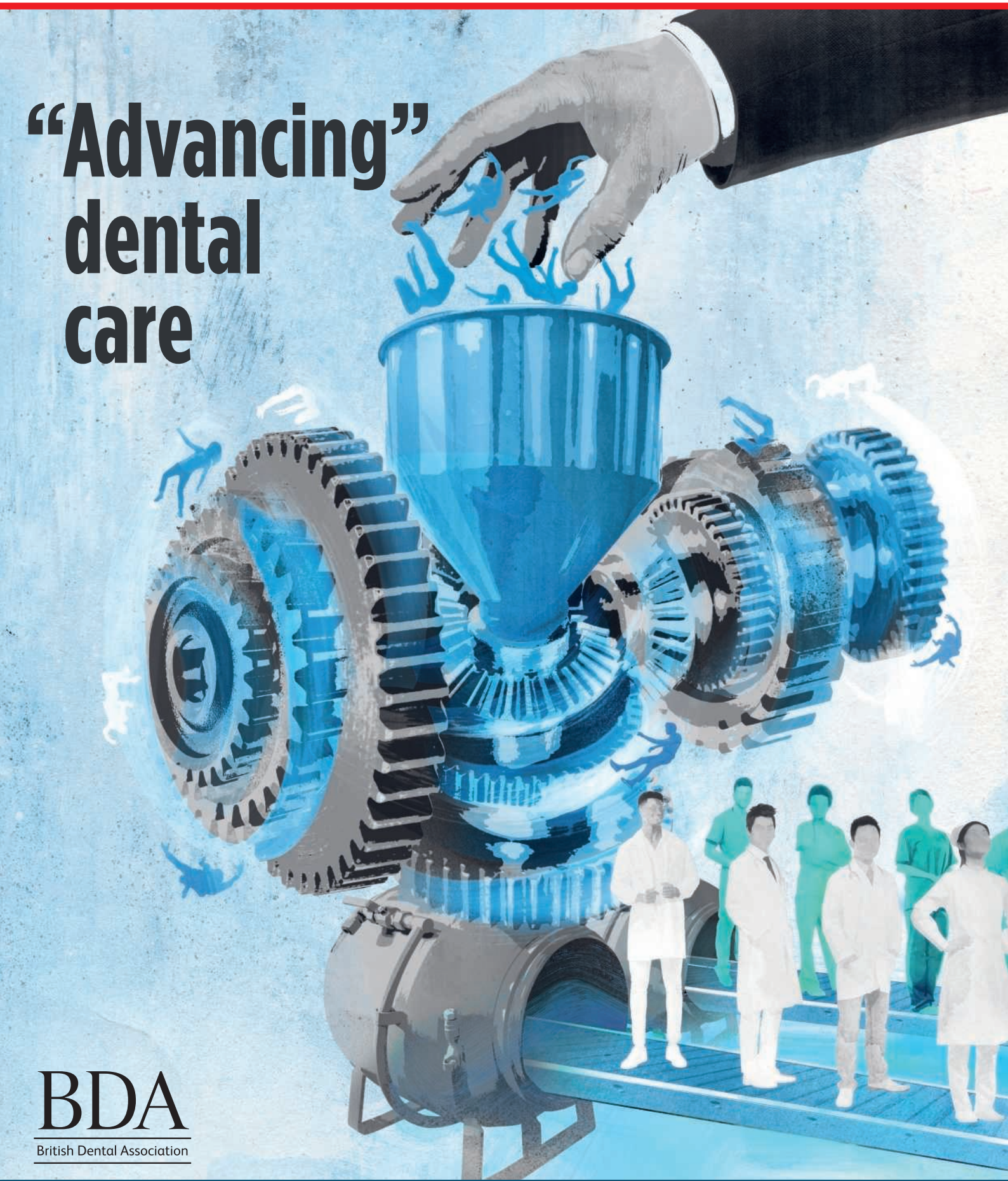
"Advancing" dental care



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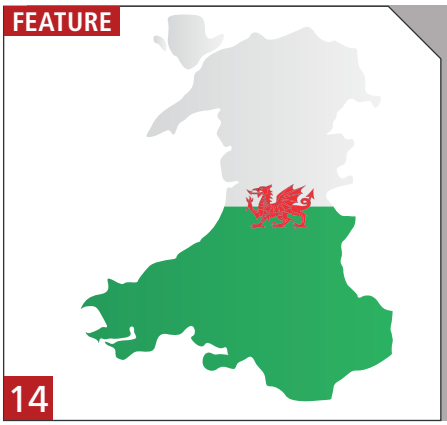

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Marathon ready

By Aubrey Craig,
Head of dental division and dental adviser, MDDUS

November's *BDJ In Practice* carried an interesting article about a historic indemnity crisis in Australia drawing comparisons with the indemnity market in the UK.[1]

If, as Fenella Barnes suggests, that the health of the indemnity industry in the UK can and should be gauged on the transparency of each MDOs incurred but not reported (IBNR) liability, then we at MDDUS are marathon ready.

> 'Instead of supporting choice and proposing concrete actions on legal reform that would make a real difference, the Government is seeking to impose a cost increase on health professionals – including dentists – by moving to an insurance-based model that will attract a 12% insurance premium tax.'

Contrary to what Fenella said in her article about the UK indemnity industry, two of the three MDOs provide details of the value of their IBNR liabilities – not one as was stated last month.

MDDUS has regularly published our liability details and how these are and will continue to be adequately funded and our latest annual report released in the summer set a new benchmark of transparency.

Unlike statements from some MDOs, we show the details that illustrates that our reserves are more than comfortably adequate to meet both our known and anticipated liabilities; that is, the claims and non-claims matters that have already been reported to us as well as those where the incident has occurred but is not yet on our radar.

Over the last decade our revenue and membership numbers are at the highest in our history with an increasing number of dentists putting their trust in our professionalism, responsiveness and value in an increasingly tough environment where claims and GDC referrals continue to rise. We have cemented our position as the fast-growing dental defence organisation with our dental membership rising 76% over the last five years.

That coupled with over a hundred and fifteen years of assisting members, MDDUS provide peace of mind for dentists, offering access to occurrence-based professional indemnity as well as unlimited settlement of damages and uncapped legal costs.

MDDUS' expert team of dento-legal advisers, backed by in-house and external lawyers, understand the challenges faced by healthcare professionals and can help members avoid risk and respond efficiently and sensitively to any professional difficulties that arise. We continually adapt and change with the times, while maintaining a focus on providing our members throughout the UK with access to a quality, personalised service at reasonable costs.

MDDUS is a mutual membership organisation. Unlike commercial insurers, we're not in it for the profit, and we don't have shareholders to pay. We are run entirely for the benefit of our members, and we pride ourselves on providing better service and greater protection than the commercial alternatives available.

Over the past year, our team has successfully maintained the registration of 100 per cent of members engaged with the GDC relating to Fitness to Practise (FtP) issues where the member has requested support and assistance in matters relating to the practice of dentistry. We've also ensured that a far greater number of complaints entering the GDSC FtP process do not progress to an FtP hearing.

Looking to the future, the state-backed indemnity scheme is now only a handful of months away from its planned implementation, yet it remains a great unknown and we share the frustration of our members over this complete lack of detail and its impact on primary care services and staff.

Further change is coming with the Government also announcing a consultation on the regulation of clinical negligence indemnity cover which is yet another missed opportunity to tackle the real issues that drive rising costs for healthcare professionals.

Instead of supporting choice and proposing concrete actions on legal reform that would make a real difference, the Government is seeking to impose a cost increase on health professionals – including dentists – by moving to an insurance-based model that will attract a 12% insurance premium tax.

Patients will not be better protected – the document acknowledges that there is no evidence of harm in the UK from the current discretionary model. Doctors and dentists will gain no benefit. The only winner is the Treasury with its additional 12% premium tax income.

But we will not let this unnecessary distraction interfere with our vital work of supporting our members day in and day out. We are ready and able to continue to offer them excellent service and value for money.

1. Barnes F. Lessons from history: Why you should be concerned about the GP indemnity crisis. *BDJ In Practice* 2018; **31:** 16-17.

Penny pinching on HPV 'catch-up programme' for boys will cost lives

Dentist leaders have lambasted the government for failing to back a catch-up programme to protect up to 2 million boys still in school from the human papillomavirus (HPV) – as new data show nearly 1 in 5 school-aged girls have missed out on the vaccine.

In a letter to shadow public health minister Sharon Hodgson, public health minister Steve Brine MP has confirmed there will be no catch-up programme for boys, arguing boys will benefit from 'herd protection.'

Girls in England are offered free HPV jabs at school during Years 8 and 9, when they are aged between 12 and 14. The latest Public Health England (PHE) data show just 83.8% of girls were given the recommended two doses of the vaccine by the end of Year 9 in 2017-18 – less than what's required for herd immunity – with nearly 50,000 (48,545) girls missing out.

The British Dental Association has been a leading advocate for expanding the programme to boys. HPV is a leading cause of oral cancers, which cause more deaths in the UK than car accidents.

Mick Armstrong, Chair of the British Dental Association said: 'The latest data on vaccinations among girls illustrates precisely why we've needed a gender-neutral approach. It also shows why penny pinching on a catch-up programme will leave many school-aged boys unprotected.

'There can be no guarantees of 'herd protection' when nearly 1 in 5 girls are missing out on the vaccine. A catch-up programme remains the best way to protect all our children from this cancer-causing virus'.

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'Tax on cancer' unfair for patients, charity says

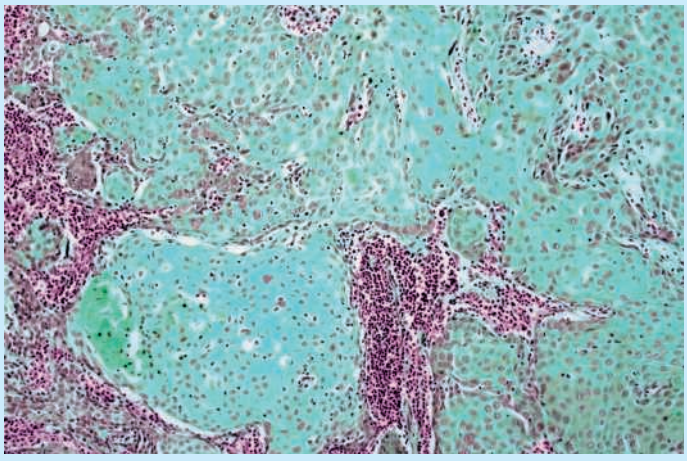
Ongoing dental checks that mouth cancer survivors are often burdened with amounts to a tax on cancer, a leading charity claims.

Following treatment for mouth cancer, patients are faced with a series of long-term oral health issues, that often result in complex and expensive dental work.

The Oral Health Foundation estimates that mouth cancer sufferers could face dental costs of up to £1,500 over five years – around five times higher than that of the national average, and believes government should be supporting cancer patients financially in their aftercare.

New research, conducted as part of November's Mouth Cancer Action Month found that 81%Brits believe that mouth cancer sufferers should be financially supported for their ongoing dental treatment.

More than half (57%) believed those diagnosed with mouth cancer should not have to pay anything to address their complicated oral health needs.



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Dr Chet Trivedy, trustee of the Oral Health Foundation and consultant at Kingston Hospital says: 'In addition to the overwhelming emotional and psychological impact that mouth cancer can have, survivors can also be challenged with several oral health issues. Chronic toothache, tooth loss and dry mouth are just some of the common problems that require long-term dental care.

'Frequent dental treatment is often a necessity for mouth cancer victims. With NHS dental charges ranging from £21.60 to £256.60 in England, the recurring costs over the course of a year can be staggering.

'The financial impact of mouth cancer is often overlooked. As it stands, there is a tax on mouth cancer. This is highly discriminatory and extremely unfair. We are urging health ministers to address this inequality. Free dental care will go a long way to support mouth cancer patients in their aftercare.'

Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, adds: 'There are significant ethical and moral issues around paying for the privilege to be examined for cancer.

'Cost remains a significant barrier for why people continue to avoid regular dental visits. These are crucial for frequent mouth cancer examination and for diagnosing cancer as early as possible.'

Dental implants market projected to reach $5.9bn by 2028

The global dental implants market is expected to reach $5.9bn by 2028, growing at a Compound Annual Growth Rate (CAGR) of 4.9% between 2018 and 2028, according to GlobalData.

'Dental Implant Devices, Global Outlook, 2015-2028' reveals that Asia Pacific will be one of the fastest growing regions at a CAGR of 6.4% between 2018 and 2028, with North America and South America following closely behind at 4.5% and 4.9% respectively.

Market growth is fairly strong despite low global penetration of dental implants. In most countries, dental procedures are out-of-pocket expenses, but improved reimbursement policy has stimulated especially high growth in South Korea.

Sarah Janer, Medical Devices Analyst at GlobalData comments: 'The titanium implant segment will continue to grow strongly due to the material's biocompatibility, strength, versatility and cost. Zirconia implants will also show growth, but this will be limited by associated problems that limit durability and placeability.'

Barriers to market growth include a lack of dentists trained in implant procedures, and little to no reimbursement for implant procedures in many countries.

Janer concludes: 'There is a large potential patient pool for dental implant procedures due to the high prevalence of periodontal disease in the global population. Growth in this market is due to the increasingly educated patient population that seek treatment, and the growth of emerging economies.' ◆

Review of RQIA 'a welcome opportunity'

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.

NIDPC Chair Richard Graham, and BDA NI Director, Tristen Kelso recently met with officials from DoH Quality, Regulation, Policy and Legislation Branch as part of a pre-consultation stakeholder meeting.

A DoH 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 3 yearly inspection periods elsewhere - has perpetuated the feeling among GDPs 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 DoH 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 2 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'. ◆

Dentists win clarity on 24-month appointment plans

The British Dental Association Scotland has welcomed clarity from the Scottish Government that it will not proceed with 24-month recall intervals for 'low risk' patients by default.

The Oral Health Improvement Plan (OHIP) had cited NICE guidance that patients not considered to be 'at risk of or from oral disease' may be extended over time up to an interval of 24 months.

Since OHIP was published in January 2018 the issue has been a source of deep concern among the profession. In a survey of dentists that featured in BDA Scotland's recent Oral Cancer Action Plan 97% of respondents said they had concerns this would undermine detection of oral cancers. 77% identified it as a major or severe risk.

Dentists are often the first health professionals to detect oral cancers, which kill three times as many Scots as car accidents. In 2016 1,240 people in Scotland were diagnosed with the condition – nearly five cases every working day. While other cancers have seen marked improvements there has been a 37% increase in oral cancer deaths in the last decade.

Speaking to STV following the launch of BDA Scotland's Oral Cancer Action plan, Deputy CDO Tom Ferris said: 'We have not said 24 months. The research said it's a possibility. That's for the decision that will be made by the patient and dentist together about what is the best interval between check-ups...so they are right to raise their concerns. We will have another period where we discuss with the profession.'

Robert Donald, Chair of the BDA's Scottish Council said: 'We welcome assurances that 24-month dental recall intervals will not be introduced - and that 'high-risk' patients will be seen more frequently than those in good oral health. The Chief Dental Officer has been explicit that it will be for the dentist and patient to jointly decide on the appropriate recall interval.

'The Scottish Government has acknowledged publicly that we are right to raise our concerns on this issue. The profession will have a further period of discussion with government to explore these concerns and hopefully come to a sensible solution that does not put our patients lives at risk.

'This will come as welcome news for patients and practitioners. Our members were clear that telling 'lower risk' patients to come back in 24 months would only undermine efforts to meet a growing threat, while putting needless pressure on NHS cancer services.

'We believe that patients should ideally be seen every six months, and that 'high-risk' patients should be seen more frequently. We remain convinced the many worthy ambitions in the Oral Health Improvement Plan will not be achieved without new investment.

'It is now more than 10 months since the Plan launched – and, apart from the introduction of occupational health services for dentists and their teams - which we have campaigned for and welcomed – none of the 41 actions in the Plan have been completed.

'Yes, it's a long-term plan but the Scottish Government needs to provide greater clarity around priorities, budgets and timescales for all its key proposals. And we'll be keeping the pressure up.' ◆

GDC changes approach to setting fees

The GDC has moved to clarify the manner in which it sets its fees for dental professionals.

The policy, which sets out this new approach, saw a positive response in a public consultation earlier this year, and will be introduced in 2019. It is based on three main principles, and these are:

1. Fee levels should be primarily determined by the cost of regulating each professional group
2. The method of calculating fee levels should be clear
3. Decisions on the allocation of costs should not lead to undesirable outcomes (e.g. in the form of unacceptably high or variable costs for some groups of registrants).

There are several changes that will be introduced under these core principles.

The GDC is moving to a three-year planning model, which will provide clearer information about the cost of proposed regulatory activity. The plan will inform a three-year costed corporate strategy which will be consulted on before it is approved. In practice, this means the GDC will set out plans on how it intends to achieve its objectives every three years. Prior to the Strategy being approved, anyone with an interest will have the opportunity to express their views about its high-level aims, and the associated expenditure, which will provide the basis for setting the Annual Retention Fee. The first of these consultations will take place in spring 2019.

Ian Brack, Chief Executive and Registrar at the GDC, said: 'I'd like to thank those who responded to this consultation. We will be consulting on the three-year costed corporate strategy this spring – it will be an unrivalled opportunity to understand and critique the GDC's strategic priorities, the associated costs, and the use to which cost-savings will be put. We really want to hear the views of the public, the professions and other stakeholders so I hope as many people as possible engage in the process.' ◆

To regulate or self-regulate, that is the question

Dr Paul Charlson
FRCGP DRCOG DPD DOCCMED MBCAM, President, British College Of Aesthetic Medicine

Regulation in aesthetics is something everybody knows needs to happen but then on the other hand, nobody wants as this would mean that healthcare professionals would have to produce yet more evidence to prove they are competent. So why do we need regulation in aesthetics?

Increasing numbers of healthcare professionals provide increasingly diverse aesthetic procedures. Non-professionals are seizing opportunities to provide procedures beyond what they have traditionally provided. The public are confused about who is competent and inevitably there has been an increase in avoidable complications and poor results. We do not have statutory industry regulation and sanctions for non-professionals are fairly ineffective. There is scant incentive for some to practise safely and to a good standard. This allows the unscrupulous to provide 'attractive' low priced treatments to some of the more vulnerable members of society.

The Department of Health asked BCAM – which now includes dentists – BACN, BAD, BAARPS and BPRAS to create a framework for the aesthetics industry and the Joint Council for Cosmetic Practitioners (JCCP) and Cosmetic Practice Standards Authority (CPSA) were formed with the help of non-clinicians to create a body to set and police standards in aesthetics.

The CPSA has created a framework of standards across the whole industry from skin peels and micro-needling to laser and injectable work. There is a competence framework set at various levels of procedure. The JCCP has two registers; one for non-professionals who cannot be registered to inject dermal fillers or botulinum toxin (level 7) and another register for professionals. There is also a register of training providers who will be able to deliver training to various levels.

From February 2018 when the JCCP was launched there has been established a set of standards for the whole aesthetics industry which has been endorsed by all the professional bodies including the GDC and supported by Government.

The problem lies with voluntary standards and relying on self-regulation. Until it is mandatory many practitioners for various reasons have not and probably will not join the JCCP register. Some are not practising to the required standards, some are too busy or 'will get around to it' and some resent further regulation or simply cannot see the financial benefit, all entirely understandable.

There are countless clinicians 'doing a bit of Botox'. Namely they attend a short course and treat a few patients as very much a side show to their main job. Their professional training provides an understanding of infection control, ethics and consultation skills. Less have the training and the ability to deal with emergencies, complications or have a basic understanding of dermatology. Furthermore some operate from inappropriate premises and lack experience which inevitably results in substandard aesthetic results and a greater likelihood of avoidable complications. The point of JCCP registration is to ensure that everyone is at least at a minimum safe standard and have more than very basic training. Currently some professional colleagues performing the occasional treatment probably consider they are not likely to get into any performance issues. However aesthetics is difficult as patients can be very demanding which makes them likely to complain if they are not happy. If this results in say a GDC complaint the GDC will rightly expect that the dentist has adequate training to perform the procedure. Now there is a framework of standards from the CPSA the GDC may well refer to these in their investigations. Hence I would suggest that if you are a dentist 'doing a bit of Botox' you might consider more training and registration with the JCCP.

Furthermore as the public becomes more aware of the potential risks of seeing poorly qualified practitioners they will look to see if someone is registered with the JCCP.

It has always been of concern that non-professionals are injecting dermal fillers. It is for this reason the JCCP will not register them for level 7. Even if they can learn the techniques required they rarely have the depth of understanding which healthcare professionals have as part of their general training. In particular anatomy, recognising complications and being able to deal with emergencies, ethics, psychological assessment, understanding the impact of other diseases on the use of dermal fillers. Of course, healthcare professionals also need to ensure they have the correct knowledge and skills.

For those dentists who are striving for demonstrable excellence, BCAM is currently establishing qualifications which would set its members apart. They will have an aesthetic medicine qualification at specialist level which the public can rely on. This will be launched next year. BCAM is also lobbying for statutory regulation in aesthetics. ◆

For more details on joining BCAM please visit www.bcam.ac.uk.

A to Z of some of the ways we can help you

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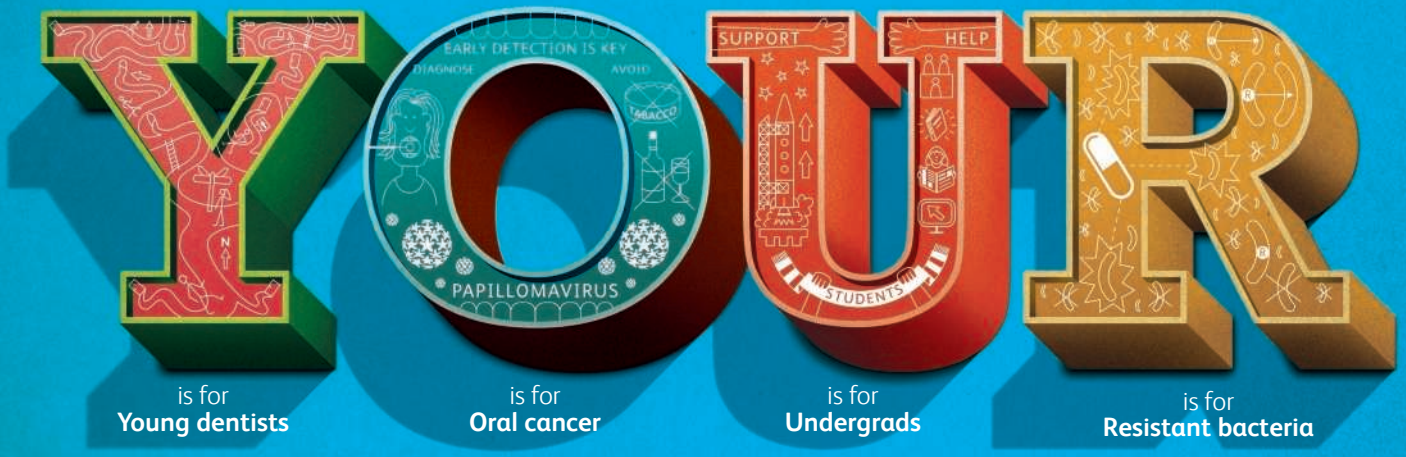

is for **Young dentists**

is for **Oral cancer**

is for **Undergrads**

is for **Resistant bacteria**

is for **British Dental Conference and Dentistry Show**

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Campaigning for dentists and the nation's oral health | Giving you the advice and services you need to succeed

Is it really advancing dental care?

By David Westgarth,
Editor, *BDJ In Practice*

My family home is tucked away in a beautiful part of West Cumbria. It's a five-minute stroll down to the marina, and the bungalow I grew up in is certainly big enough to cope with an expanding family.

As much as I enjoy my jaunts to the back end and beyond, the house – and indeed all those on the close – were built on an old sand quarry, and rather ironically the project lead for the construction was a man named Jack. You couldn't make it up.

Some 30 years ago, what Jack failed to take into account was the porous nature of the foundations our house – and the other four on the close – were going to be built on. This is, after all, Cumbria. It's not exactly the Sahara. It has been known to rain a drop or two from time to time.

As a result, all of the houses have, to varying degrees, large settling cracks that run through living rooms, dining rooms and kitchens. Was there sufficient thought given to the foundations before they went ahead and built on it?

A point that brings us nicely onto another absurd project; Advancing Dental Care.

The detail

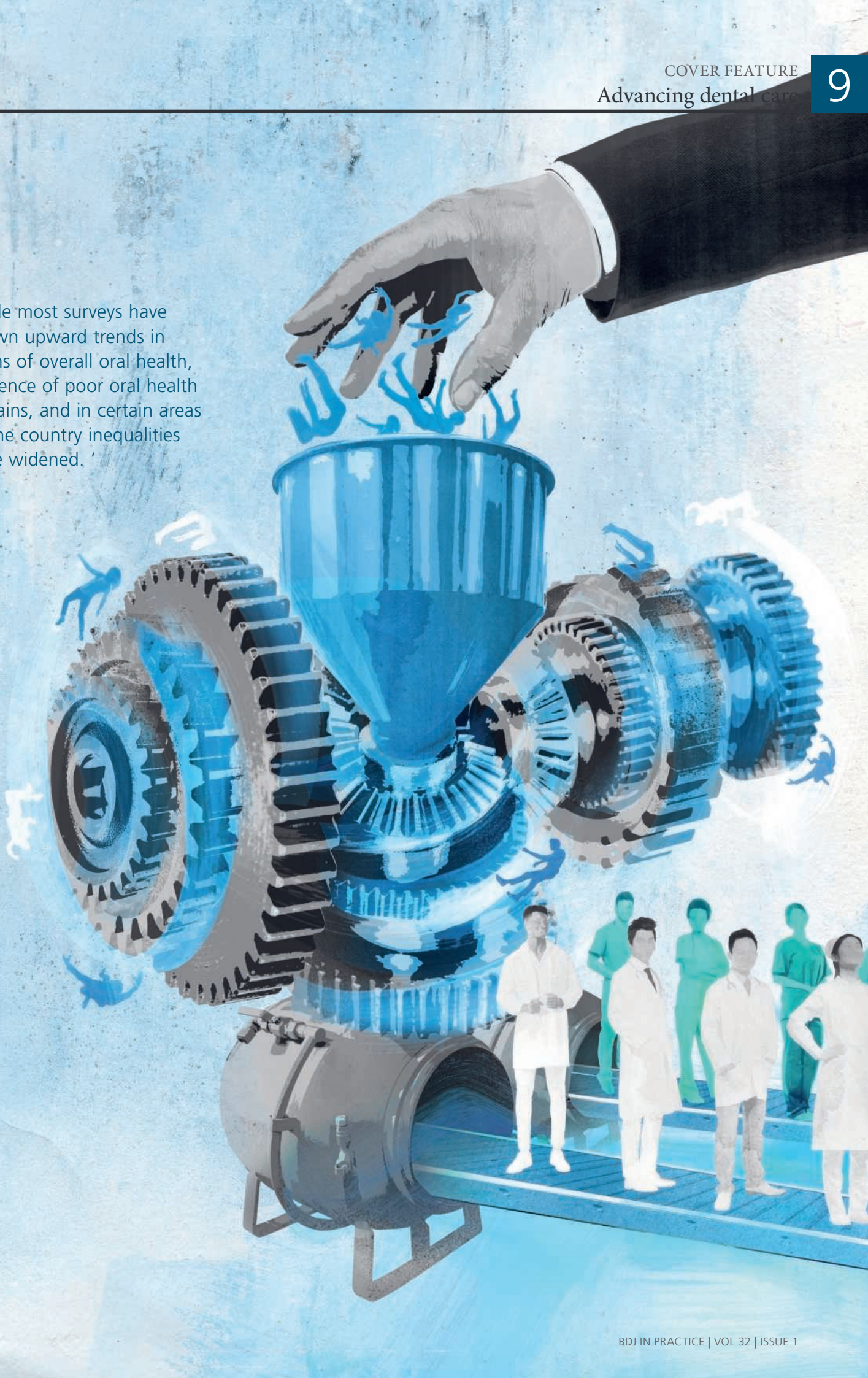
Instigated by Health Education England (HEE) through a project team with input from the Committee of Postgraduate Dental Deans and Directors (COPDEND), Advancing Dentistry Project as it was first known, proposed some fundamental changes to dental training that may affect dentists' future career paths as well as patient care. It explores the possibility of introducing a 'common point of entry' to shared undergraduate courses for dentists, dental therapists, hygienists and nurses, with opportunities to progress to more advanced learning for different roles based upon projected demand for those roles.

According to *Advancing Dental Care: Education and Training Review*, the case for change is due to a looming triple threat – a necessity to meet changing dental health needs, the profile of the dental workforce, and training pathways. Largely based on Professor Jimmy Steele's independent review of dental services in England[1] and the GDC's Scope of Practice document[2], the review 'begun to explore whether it would be possible to reflect the true Scope of Practice through new models for training pathways and ways of working based upon projected demand for those roles'.

Looking at the three pillars of change, let's take their case for 'changing dental health needs'. While most surveys have shown upward trends in terms of overall oral health, evidence of poor oral health remains, and in certain areas of the country inequalities have widened. The report cites austerity and diminished funds for the NHS, while the population ages and dentitions become more complex. The emphasis on clarity of roles within the dental team, and fully utilising the prospect of skill mix – a phrase intrinsically linked with workforce planning.

As the demand for different services increases, the report adds, 'has informed the need for substantial service redesign in the NHS'. It goes onto suggest that the planning and delivery of education and training must be responsive to the substantial redesign and changing needs. Given the average length of time it takes to train a dentist (five years), a dental therapist (three years), and a dental hygienist (two years), Health Education England – through ADC – needs to try and 'anticipate the change, identifying what the business of dentistry will need in the future

'While most surveys have shown upward trends in terms of overall oral health, evidence of poor oral health remains, and in certain areas of the country inequalities have widened. '



in terms of staffing and skill mix'.

And yet the most intriguing basis for the report comes in a sentence under the 'training pathways' case for change. Here it talks about the Review providing 'an opportunity to explore new training structures and pathways with the aim of increasing flexibility (both for individual trainees and the service) and efficiency and the use of significant sums of taxpayers' money'.

Well, money had to be in there somewhere I suppose.

Sandy foundations

On the surface, all relatively valid reasons to review what is currently being done – the needs of the patient are changing, it is wise to anticipate changes in the workforce to meet the needs of the patient. In fact, this publication has on more than one occasion asked if the future workforce is fully equipped to meet the challenges ahead. So you would imagine that ADC would take a significant portion of time to fully assess the current landscape before deciding whether to see if we should be – and if there is a need – to advance dental care.

The reality appears to be an entirely different story. In late September 2017, HEE invited a select 'invitation only' bunch to its launch meeting in Liverpool. Amongst a great deal of information it laid the timetable for what Nicholas Taylor, Chairman of COPDEND, referred to as the 'direction of travel' – next steps for the project. This was to be done by March 2018 – six months to announce a direction of travel for a seismic project.

Alas, if the evidence base is there, and the direction is grounded in a thorough review of the multitude of complexities that makes up the profession, it would be difficult to criticise the review for the apparent pre-determined nature of the process.

However, according to Taylor, at the point of launch, there were no proposals nor even a general direction of travel, that it was the role of HEE to pose these tough questions and conduct a thorough review for the good of the profession and the future, all with no pre-conceptions of the answer to those questions. Even in the Review, Taylor stated: '*To avoid any premature implementation of a new training model in dentistry, an initial exercise to review support and feasibility of these reforms has been conducted*'.[3]

The Review goes on to state that when it was launched in 2017, HEE 'did not have a pre-determined conclusion and was open to suggestions and debate, although some ideas were put forward as a starting point to work from based on early discussions within HEE, with the Chief Dental Officer (CDO) and with a range of stakeholders.'

The phrase 'the lady doth protest too much' springs to mind.

As if that wasn't enough, fast forward to October 2018 and the BDA's Young Dentists Committee meeting. Malcolm Smith, Dental Training Pathway lead on the project, updated those in attendance on phase two of the project – with one recurring theme: nothing had been decided yet, these were all questions and hypotheses that HEE wanted input from the wider profession on. No direction of travel had been set.

> 'Research presented with bias, pre-determined outcomes and weak evidence bases should not make the threshold for published articles. You simply wouldn't write your recommendations and conclusion before doing your research.'

Yet it may come as no surprise that the Review from March 2018 contained a summary of recommendations derived from phase one, with a detailed breakdown of who would be responsible for delivering phase two, what the time frame was and where the funding is coming from. No pre-conceptions? No direction of travel set? Nothing has been decided yet? Sandy foundations indeed.

If you talk to anyone who has ever submitted research, they will tell you the same thing; you pick your topic, you set your parameters, you go off and do your research and you present the results before concluding. Research presented with bias, pre-determined outcomes and weak evidence bases should not make the threshold for published articles. You simply wouldn't write your recommendations and conclusion before doing your research.

Yet that is the approach the Review appears to have taken. Smith's presentation contained swathes of assumptions, rhetorical questions and ideas, some of which had the aforementioned research as a basis for the statements. All of them were blue-sky thinking, and what you'd expect to see in phase one of a project, not phase two.

In the summary of recommendations, the review states: '*Commission a number of research and/or evaluation studies in order to further build up and refine the evidence-base for change*'.[3] If that doesn't sound like conducting research to support the theory they've already decided on, I don't know what does.

In a formal response to ADC, the BDA wrote: '*…we have remained very concerned about the 'evidence' used to back up some of the assumptions and initial findings. As we outlined in our earlier letter, we were not impressed with the 'pre-reading pack' for which the 'evidence' was particularly biased towards a message of increasing skill mix. There have clearly been evidence-gathering exercises in some of the work streams, but much of this, it has been stated, is incomplete. Some of the detail has also not been shared with stakeholders, and we are concerned by some of the apparent conclusions drawn from the incomplete evidence.*'[4]

You could be forgiven for thinking the project team bears an uncanny resemblance to Jack and his merry band of builders. One must ask serious questions of the way in which phases one and two of the project have been

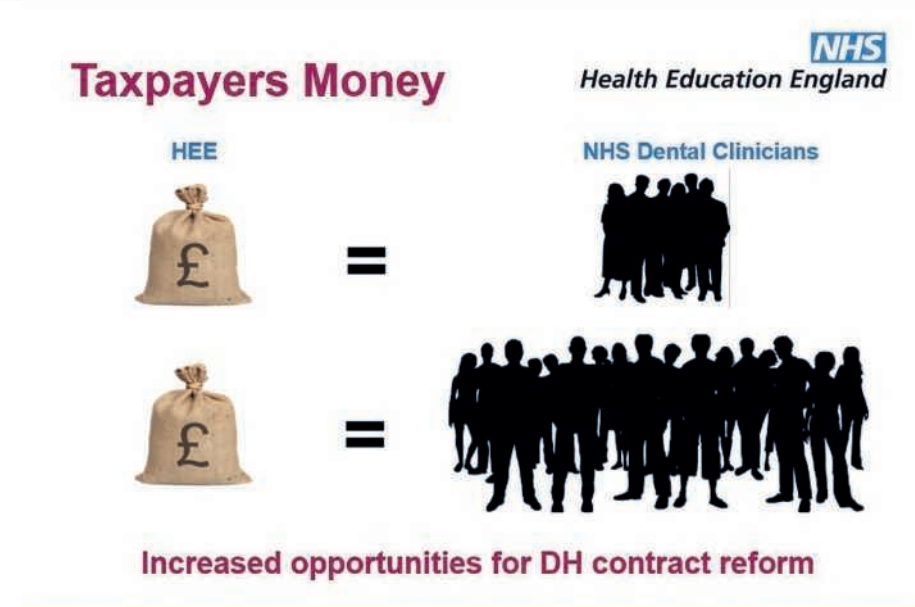


Figure 1: Slide from N. Taylor presentation dated September 2017

carried out – with the apparent blessing of the Chief Dental Officer in England – and whether the outcomes have not already been decided.

A common point of disagreement

Besides the obvious questions surrounding the project management and delivery side of Advancing Dental Care, there lies a more fundamental question that needs to be asked – why is there such a need for the project?

The citations to Professor Steele's report and Scope of Practice aside, it isn't too hard to argue that the need for the project itself appears to remain unexplained in full. The Review makes sweeping statements such as 'the current workforce is not fit for purpose', and on multiple occasions, but no reason or evidence for this assertion has been given.

Where is the evidence base for this? Surely if anyone knows the value in an evidence-based approach it is Health Education England? Speaking to many members of the dental profession simply highlights that it's not those carrying out the work who must change – it is the contract under which they work that does.

For this reason, a 'common entry' nor a 'modular training' approach are acceptable options nor reasons for the change. Qualified dentists trawl through a five-year programme which builds on and deepens knowledge of very specific areas. Dentists do not just learn about 'dentistry'; the holistic approach to dentistry means professionals are expected to know and have medical knowledge past their area of specialty. After all, the CDO does keep reiterating that the mouth needs to be put back in the body – is ADC a reflection that her message isn't getting through to these very highly-trained dentists so a shift in the workforce and empowerment of those who might is the answer?

> 'If one can only become a dentist by being a DCP through a common entry point, even if funding for training dentists is therefore cut to pay for more DCP places, that would leave very little for dentist/dental surgeon training.'

Far from being a slight on dental care professionals too. The scale of the changes proposed have far-reaching consequences beyond the composition of the profession – an approach of inter-professional education and common learning modules where dental students and therapy students learning and practising together for those treatments that exist in both their scopes – is often done already. Patient safety and indemnity implications must also be considered in a profession that is already highly litigious. Can universities provide training to DCPs that would be outside their scope of practice – and that they could therefore not use after graduation? The simple answer is no – this would have clear indemnity issues both during training and in the practising world. An undifferentiated common training for three years, with two extra years to become a dentist, would not produce the highly-qualified profession that leaves dental schools today, as the in-depth dental models are not 'bolt-on' models.

But don't forget, these are all ideas – nothing has been decided yet.

More for less

Which brings me back to an earlier observation; money.

In Taylor's launch presentation in 2017, this slide in figure 1 was shown:

The implication is clear – HEE wants to do more for less. A closer look reveals this simply is not feasible.

If one can only become a dentist by being a DCP through a common entry point, even if funding for training dentists is therefore cut to pay for more DCP places, that would leave very little for dentist/dental surgeon training. Would they need to self-fund? Where would the specialists and specialties come from? Are they willing to take sizeable pay cuts in an already squeezed finance sector to step back for training? NHS dentistry is already at rock bottom prices, so I can't imagine they would.

At a more basic level, training more individuals involves more staff and resources. Increasing the number of NHS performers will involve more superannuation costs and the increased number of performers would require an increased number of surgeries to ensure the training costs are not wasted on those who cannot find work. The increased number of performers would also require an increased number of nurses, as registrants can't work unassisted.

Add some simple economics into the mix and the picture becomes clearer still. Therapists aren't that much cheaper than associates, so the 'savings' don't add up.

Take chair occupancy. Privately, costs are anywhere between £70-120/hr. For an NHS dentist, £40-60/hr, and a therapist £25-35/hr. If a dentist takes 20 minutes to complete a filling, and a therapist slightly longer at 30 minutes, a therapist would cost £47 to do a filling and a dentist £36.

Unless the project is also investing in overheads, where is the money going to come from? A redistribution of currently available funding – which the BDA believes to be one of the aims of this review – to create a different approach for which

there is no evidence that it will lead to the (apparently) desired outcome, will lead to destabilising the system further – which is not a service to the patients who need professionals to treat them.

As with most discussions about the current state of NHS dentistry, the current contract is fundamental to the environment in which all members of the dental team operate. Yet the Review states 'The ADC Review was not initiated to generate new evidence to feed into the GDS contract reform process'.

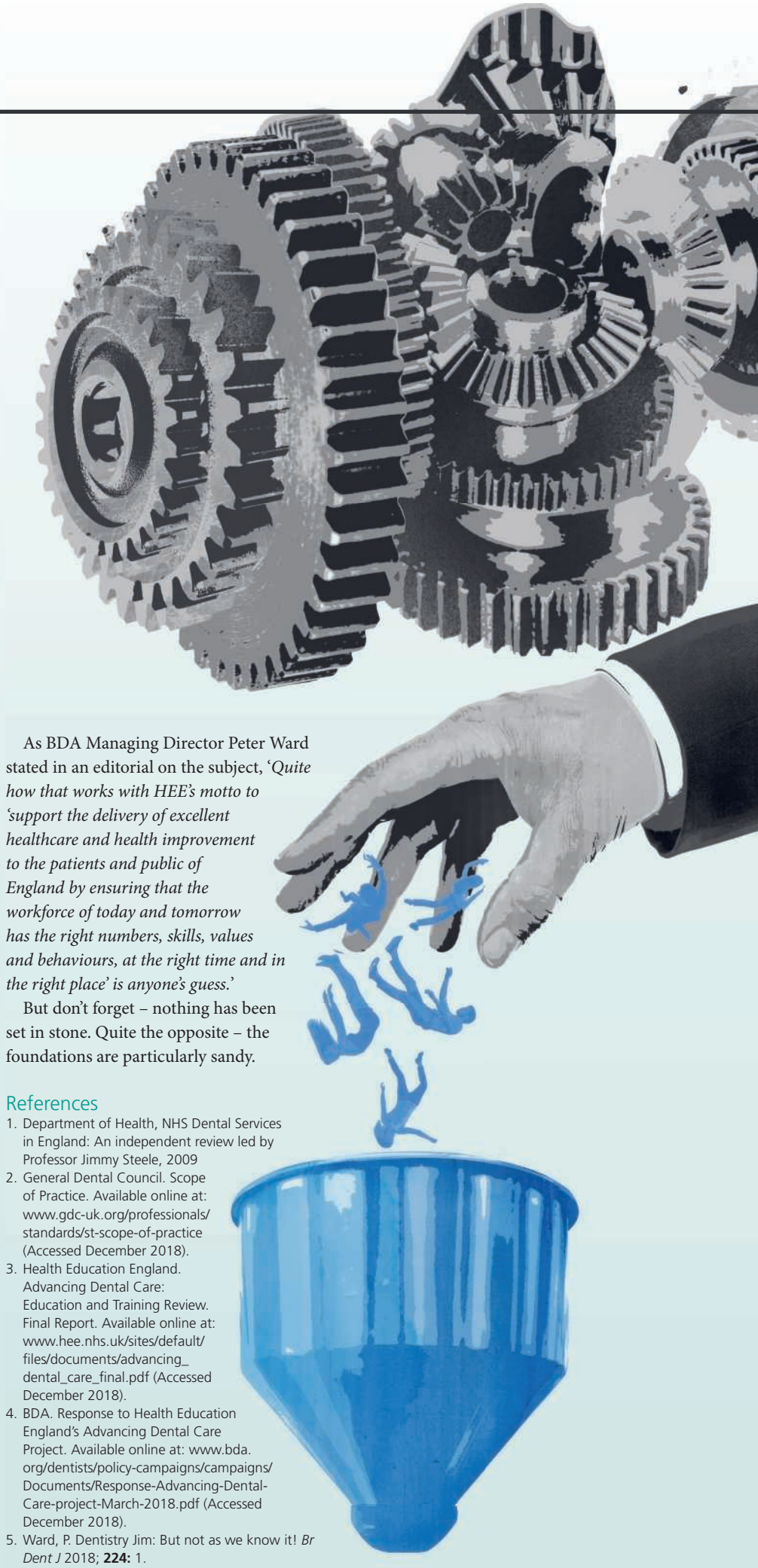
How can the proposals and the review be taken seriously when they don't intend to feed into, influence, mould nor work with contract reform – a project that for all its shortcomings has been done in a way that the ADC simply has not?

'As with most discussions about the current state of NHS dentistry, the current contract is fundamental to the environment in which all members of the dental team operate.'

The current contract creates an environment in which new graduates want to work part time hours and build portfolio careers. The contract creates an environment in which moral is at an all-time low. The contract creates a situation where dentists are 35% worse off financially than they were a decade ago. The contract creates these things which drives people out of NHS dentistry – something BDA research has shown 58% of NHS dentists are planning on doing in the next five years. The same research also highlighted 53% of young NHS dentists (aged under 35) intend on leaving the NHS, and almost 10% say they will leave the profession entirely, in the same period.

Perhaps a better working environment would encourage more dentists to remain in the profession and would aid recruitment concerns. Just a thought.

So what's the solution? Phase two of the project is underway, with a significant amount of time and money already invested. As Smith stated in the YDC meeting, reputations – including his – were on the line with this. Do we as a profession believe we will have a stronger workforce once the outcomes of ADC are complete? The evidence we have suggests not.



As BDA Managing Director Peter Ward stated in an editorial on the subject, '*Quite how that works with HEE's motto to 'support the delivery of excellent healthcare and health improvement to the patients and public of England by ensuring that the workforce of today and tomorrow has the right numbers, skills, values and behaviours, at the right time and in the right place' is anyone's guess.*'

But don't forget – nothing has been set in stone. Quite the opposite – the foundations are particularly sandy.

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Providing an integrated service to members

Henrietta Alderman
from the Association of Optometrists (AOP) on the value of member organisations

Membership organisations can no longer count on professionals to stay with them for life. The AOP has members aged between 18 and 80. Some 82% of eligible professionals are members and we have a 98% retention rate – but we don't take any one of those members for granted. People now have much more transactional relationships with the organisations they join. They want tangible benefits and need to see value for money.

The reasons that people join organisations will differ from profession to profession. In our case the top reason is medical malpractice insurance and the market-leading legal and employment support we provide. Our defence and legal package ensures that members are supported on any legal issue – civil, regulatory, NHS and employment. We metaphorically wrap our arms around our members with a blanket of support. They know that we have their best interests at the heart of all our advice and actions. The vast majority of optometrists understand that purchasing their support package independently through us gives them greater protection than they can expect if they rely on a package provided by their employer. Members know we have their backs.

But however good the package, professional insurance is nonetheless a grudge purchase. Nobody enjoys writing that cheque or signing that standing order. How do we ensure that people sign up to us year after year with, if not enthusiasm, at least the minimum of pain? Above all we work hard to make sure that our support remains the best and we make clear that we are not just here for the emergencies.

We also provide support to our members to help them avoid getting into trouble in the first place. Our legal videos and roadshows, education and published guidance are all designed to help members be aware of, and avoid, potential professional pitfalls. And to feel that we are looking out for them.

Beyond this offering, we have asked our members what else they want from us as their membership organisation. We know many optometrists feel undervalued and that their role is not understood. One of the main things they want is for us to raise the profile of the profession, for example through media work and campaigns. We use traditional and new media to create and respond to news stories and to let our members know what points we are making to the industry and wider news outlets.

Less publicly visible but equally useful are the resources we provide to help optometrists in their day to day practice, including patient leaflets, template letters, and a daily 'Eyes in the News' email for anyone who wants to know about the latest media coverage of eye health issues.

Our members also want us to argue on their behalf. We do this in several ways. We respond to government and regulator consultations; we provide briefings on eyecare for media and politicians; we attempt to influence opinion and legislation. Such efforts are not always successful, but they all increase knowledge among politicians and civil servants and raise the profile of our profession.

And we are a constant source of information. Our award-winning journal *Optometry Today* drops through our members' doors on the first week of every month and adds on-line stories day by day. We email our members as sparingly as possible but ensuring that no important industry development is missed. We are a major source of Continuing Education and Training, through our member events all over the UK and through our national exhibition and conference, 100% Optical, where exhibitors sit alongside a packed education programme. Members know that if they have a query about a clinical or regulatory matter they will be able to find the answer on our website, by asking a question on our web forums or phoning the team. And if in distress for whatever reason, they can call on our peer support line, speaking in complete confidence to another optometrist.

We must ensure that all our members can find what they need from us. The demographic of the profession is changing as are career aspirations and we need to reflect that in all our activities and communications. Over a quarter of respondents to our Optometrists' futures survey are working as locums, which is one symptom of an important shift in attitudes to working life. Newly qualified graduates are looking for a work-life balance and a degree of flexibility in their working patterns which simply didn't exist forty years ago. We need to cater for those members as much as we do to members who are ambitious to run their own business or progress clinically. And we need to stay relevant to our older members while adapting our offer and our communication methods for the younger ones.

What makes a membership organisation relevant? There is no one size fits all but there are some basic principles that apply to all. And understanding the needs of the membership and the constantly changing environment in which they practice comes at the top. The challenge is for membership organisations to keep pace, adapt and remain relevant at every stage of the career life cycle. ◆

The claw of the dragon

By Christie Owen,
Policy and Committee Officer,
BDA Wales

In August, *BDJ In Practice* presented and discussed the startling clawback figures for England. Shocking as they may be, those involved in delivering dentistry were perhaps unsurprised by the figures, not least by the scale of them. With its own set of challenges, access problems and a constant drain on funding, the story is no different in Wales.

£20 million lost from NHS services

The BDA has analysed data on NHS budget allocated to general dentistry in Wales taken away from direct patient care in 2014-17. Via processes of clawback, handback and contract reductions this amounts to £20,645,987 of the dental budget removed in just three years.

If a dental practice failed to achieve 95% of their targets for Units of Dental Activity (UDAs) they face 'clawback', with budget returned to Health Boards. Boards have a variety of different ways of handling clawback. Some clawback everything owing, others allow the dentist to carry 5% over to next year and only claw back the excess, some deal with dentists on an individual basis.

So how bad is it? Data from Health Boards show that, 31% of practices experienced clawback in 2017 which compares with 41% in 2016 (Table 1). The data also reflect the level of handback, which occurs where an NHS dentist, struggling to achieve their UDA target for that financial year, chooses to give back a percentage of their UDAs to the Health Board. Handback may also occur if a dentist chooses to close their practice or if they retire, for example.

After two years of clawback such practices are then at risk of permanent 'contract reductions'. The BDA has discovered that all Health Boards were applying permanent contract reductions to a greater or lesser extent.

BDA research also shows that over a quarter (26.5%) of all NHS practices in Wales have experienced contract reduction in the last 3 years. This amounts to approximately **£4,323,078**. Hywel Dda Health Board alone effected more than half of this contract reduction.

In September the British Dental Association Wales told the Health, Social Care and Sport Committee that patients across Wales are now facing a 'postcode lottery' of care –fresh analysis of data from the official NHS Direct service shows that new patients are facing wholly unacceptable journeys to see an NHS dentist, with residents in Aberystwyth facing a 90-mile

Table 1 Clawback data by year and Health Board

	Cwn Taf	Aneurin Bevan	Cardiff and Vale	Hywel Dda	Abertawe Bro Mortannwg	Powys Teaching	Betsi Cadwaladr
2014/15							
1.Amount of funding recovered relating to underperformance of UDAs	£259k	£520,111	£344k	£23,000	£739,551.08	£271K	£645,000
2. Monies handed back from GDS Contracts	£0	£19,657	£0	£80,000	£0	£0	£196,181
3. Number of practices that repaid Health Board due to underperformance of UDAs	8	16	17	7	32	11	35
4. Number of practices handing back funding to Health Board	0	4	0	1	0	0	8
5. Location of practices that repaid funding to Health Board	3 Taff Ely locality 3 Merthyr Tydfil locality 1 Cynon locality 1 Rhondda locality	1 Abertridwr 1 Caldicot 1 Bargoed 2 Chepstow 2 Blackwood 2 Cwmbran 2 Monmouth 2 Pontypool 3 Newport	**Cardiff Area** 5 South/East 7 North/West **Vale of Glamorgan Area** 2 East 6 Central 1 West	**No Location Given**	**Bridgend** 3 Bridgend West 1 Bridgend North 3 Bridgend East **Neath Port Talbot** 1 Upper Valleys 8 Neath 2 Afan **Swansea** 3 Cwmtawe 2 Penderi 7 Bay 2 City	Newtown Hay On Wye Builth Brecon Knighton Llandrindod Llanfair Caereinion	10 West (Gwynedd and Anglesey) area 10 Central (Conwy and Denbighshire) area 15 East (Wrexham and Flintshire)
6. Location of practices handing back funding to Health Board	Na	1 Blackwood 1 Chepstow 1 Cwmbran 1 Pontypool	1 Vale of Glamorgan (Central)	**No Location Given**	NA	NA	3 West (Gwynedd and Anglesey) area 3 Central (Conwy and Denbighshire) area 2 East (Wrexham and Flintshire)
2015/16							
1.Amount of funding recovered relating to underperformance of UDAs	£614k	£408,245	£736k	£279,000	£1,047,064.91	£718K	£845,000
2. Monies handed back from GDS Contracts	£70k	£47,615	£30k	£1,371,000	£7,778	£870	£486,500
3. Number of practices that repaid Health Board due to underperformance of UDAs	13	16	26	10	31	12	36
4. Number of practices handing back funding to Health Board	2	4	1	10	1	1	2
5. Location of practices that repaid funding to Health Board	3 Taff Ely locality 5 Merthyr Tydfil locality 2 Cynon locality 3 Rhondda locality	1 Bargoed 1 Caerphilly 1 Caldicot 2 Chepstow 4 Cwmbran 2 Monmouth 2 Newport 1 Pontypool 1 Ponthir 1 Ystrad Mynach	**Cardiff Area** 8 South/East 8 North/West **Vale of Glamorgan Area** 2 East 6 Central 2 West	**No Location Given**	**Bridgend** 2 Bridgend West 2 Bridgend North 3 Bridgend East **Neath Port Talbot** 2 Upper Valleys 6 Neath 1 Afan **Swansea** 1 Cwmtawe 2 Penderi 7 Bay 1 Llwchwr 2 City	Welshpoo Crickhowell Builth Brecon Llandrindod Knighton Newtown Llanfair Caereinion	15 West (Gwynedd and Anglesey) area 4 Central (Conwy and Denbighshire) area 17 East (Wrexham and Flintshire)

6. Location of practices handing back funding to Health Board	1 Taf Ely locality 1 Rhondda locality	2 Cwmbran 1 Monmouth 1 Pontypool	1 Cardiff (North/West)	**No Location Given**	1 Afan	Machynlleth	1 West (Gwynedd and Anglesey) area 1 East (Wrexham and Flintshire)
2016/17							
1.Amount of funding recovered relating to underperformance of UDAs	*	£584,781	£410k	£1,452,696	£563,209	*	£1,045,106
2. Monies handed back from GDS Contracts	*	£124,574	£0	£8,074	£367,301	*	£719,435
3. Number of practices that repaid Health Board due to underperformance of UDAs	*	21	12	8	17	*	35
4. Number of practices handing back funding to Health Board	`*	0	0	1	0	*	1
5. Location of practices that repaid funding to Health Board	*	1 Blaenau Gwent 4 Caerphilly 9 Monmouthshire 2 Newport 5 Torfaen	**Cardiff Area** 2 North 1 South West 2 East 2 South **Vale of Glamorgan Area** 1 East 3 Central	3 Ceredigion 1 Pembrokeshire 4 Carmarthenshire	**Neath Port Talbot** 5 **Swansea** 4	*	No location specified
6. Location of practices handing back funding to Health Board	*	NA	NA	1 Carmarthenshire	NA	*	1 Gwynedd

round trip. New patients in Newtown face 80-mile journeys, while even those in the Welsh capital Cardiff face a nearly 30 miles trek. In November images of locals queuing around the block in Llangollen went viral – some queued for as long as five hours – serving as a stark reminder of the very real nature of the problems caused by a failed NHS dental system.

How can a developed nation with universal healthcare see situations like this? Access to basic services should be a given. The reality is an entirely different story.

BDA analysis from last year showed that only 15% of NHS practices are taking new adult NHS patients, with just 28% accepting new child patients.

While BDA Wales has praised initiatives like *Designed to Smile*, which has narrowed deep health inequalities among young children, it has criticised the Welsh Government for failing to apply these effective preventive principles to wider strategy and reform of the failed NHS system.

Ministers are advocating modest 'tweaks' to the current target-driven NHS contract – which effectively caps patient numbers – rather than root and branch reform. The model has fed recruitment and retention problems across Wales, with recent official data revealing morale in the profession has fallen to its lowest levels since 2000 and more than half of dentists are considering leaving the profession.

'How can a developed nation with universal healthcare see situations like this? Access to basic services should be a given. The reality is an entirely different story.'

Tom Bysouth, Chair of the BDA's Welsh General Dental Practice Committee, has previously said: 'The Welsh Government talks about prevention, inequalities and sustainability. But we require deeds not words to guarantee the future of this service and end the postcode lottery of care.

'It's utterly perverse that £20 million has been lost from local services, while some patients are travelling 90 miles to see a dentist under the NHS. Sadly, it's the inevitable result of a failed system, where officials bank on dentists missing their targets just so they can plug holes in other budgets.

'Wales has secured major breakthroughs investing in prevention among children, with health inequalities narrowed and a chance to shave millions off treatment costs. What's missing is the willingness to apply that logic to fixing the rotten system at the heart of this service.

'Any progress hinges on the Welsh Government honouring its pledges and delivering real reform. We need a model that puts patient care ahead of tick boxes and targets, that can guarantee access for all who need it.' ◆

A traveller's tale

The top 5 roundtrips to the nearest practice accepting new NHS patients

From:	Miles to nearest practice
Aberystwyth	87.6
Newtown	80.2
Rhayader	80
Llanidloes	75.2
Llandovery	56.4

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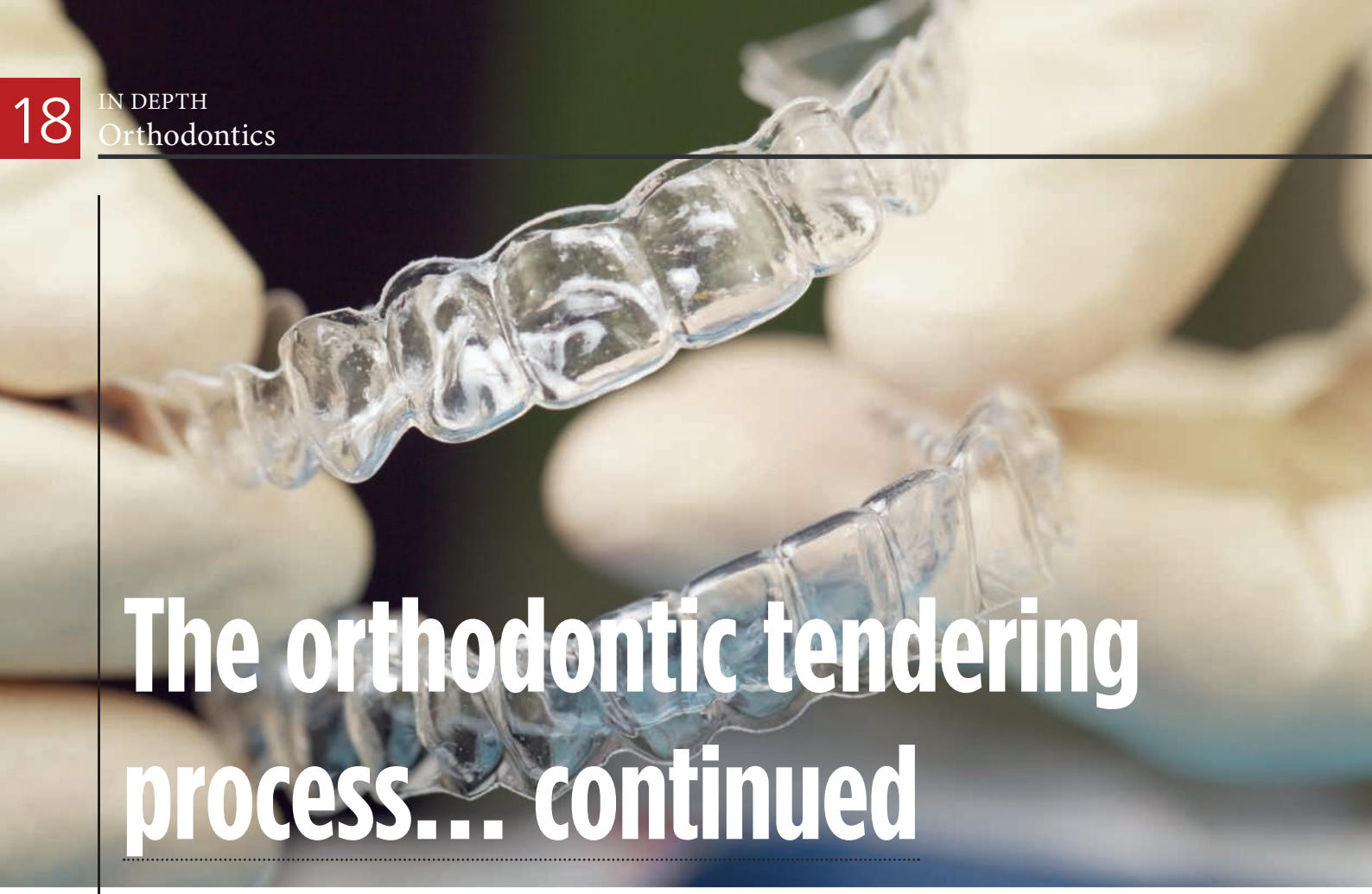


The orthodontic tendering process... continued

In the second article, **Paula Slinger** explains some of the nuances of the bidding process

Imagine for the purpose of your bid response that you are setting everything up from scratch – assumptions will not score you points. It is important you think about all the areas you have to have in place when establishing a new practice and use that for your response to help gain maximum points.

A short example is in table 1.

Alternatively, the old CQC outcome titles (below) can be useful to get your brain thinking about areas you need to cover. For instance, look at the first one listed below relating to involvement and information.

Have a little patience

It's quite likely you will need to write about dealing with patients at some point in your bid. When you are asked about patients, you can now think about the treatment process from start to finish; how you explain their care, how the information you give allows them to make informed decisions before consenting to treatment.

So just from that small point alone you can already see how a bid writer needs to be thinking. And it is that evidence that needs to go into your bid.

Consider access as an example of how to think like a bid writer. If you are asked to demonstrate how you ensure access to services, this is not just about being open between 9am-5pm. Consider things like:

- Is your practice visible?
- Is it well located on bus routes or with suitable parking?
- Do you meet the requirements of the Equality Act?
- Are your opening hours suitable? What are they?
- Do your opening hours allow for people who cannot access appointments between 9am-5pm?
- If you are an orthodontic practice do you help to have appointments at times to avoid patients missing school and if there are requirements in the service specification regarding opening hours and appointments, show you meet them.
- Have you formed partnerships within the local community and with other health care providers?
- What is your marketing and promotional plan?
- How will you cater for the different needs of the population, for example hearing loops, leaflets in different languages, braille, translation services, religious requirements?
- Will you have a business continuity plan to prevent access to service issues that may arise through staff absence, fire, flood for example?
- Do you manage your NHS contract in a way that ensures access over the year?
- Do you have designated emergency slots?
- Do you minimise the risk of Fail to Attend appointments?
- Do you not discriminate?
- How do you consider hard to reach groups?
- How can patients make an appointment with you?
- How do you train your staff to make sure appointments are allocated in line with NHS regulations – for example when is an appointment urgent?
- If you are an orthodontic practice do you minimise inappropriate referrals? How do you do this? Do you educate referring practices? Do you audit assessments/case starts?
- Signposting to other services or providers.

Table 1 Property, Facilities & Equipment

Mobilisation Description	Lead person	Timeframe	Date required by
D1 licence required	Dentist A	N/A already in place	N/A already in place.
Equipment fitted	Dentist B	N/A already in place	N/A already in place
Equality Act compliance	Dental B	N/A already in place	N/A already in place
Decontamination area installed	Dental B	N/A already in place	N/A already in place
Risk assessments ahead of new contract	Dentist A	1 November – 1 December	4 December.
Phone lines installed	Etc	Etc	Etc
Computers installed	Etc	Etc	etc
Software installed	Etc	Etc	etc

Table 2 Outcome

Involvement and information
1 Respecting and involving people who use services
2 Consent to care and treatment
Personalised care, treatment and support
4 Care and welfare of people who use services
5 Meeting nutritional needs
6 Cooperating with other providers
Safe guarding and safety
7 Safeguarding people who use services from abuse
8 Cleanliness and infection control
9 Management of medicines
10 Safety and suitability of premises
11 Safety, availability and suitability of equipment
Suitability of staffing
12 Requirements relating to workers
13 Staffing
14 Supporting workers
Quality and management
16 Assessing and monitoring the quality of service provision
17 Complaints
21 Records

The pathway

Another useful tip that will really help you is to think about the patient care pathway. This will get your brain into gear to answer the patient and clinical related parts of your tender. Think of it like a conveyor belt, starting at one end and leaving at the other end. For example:

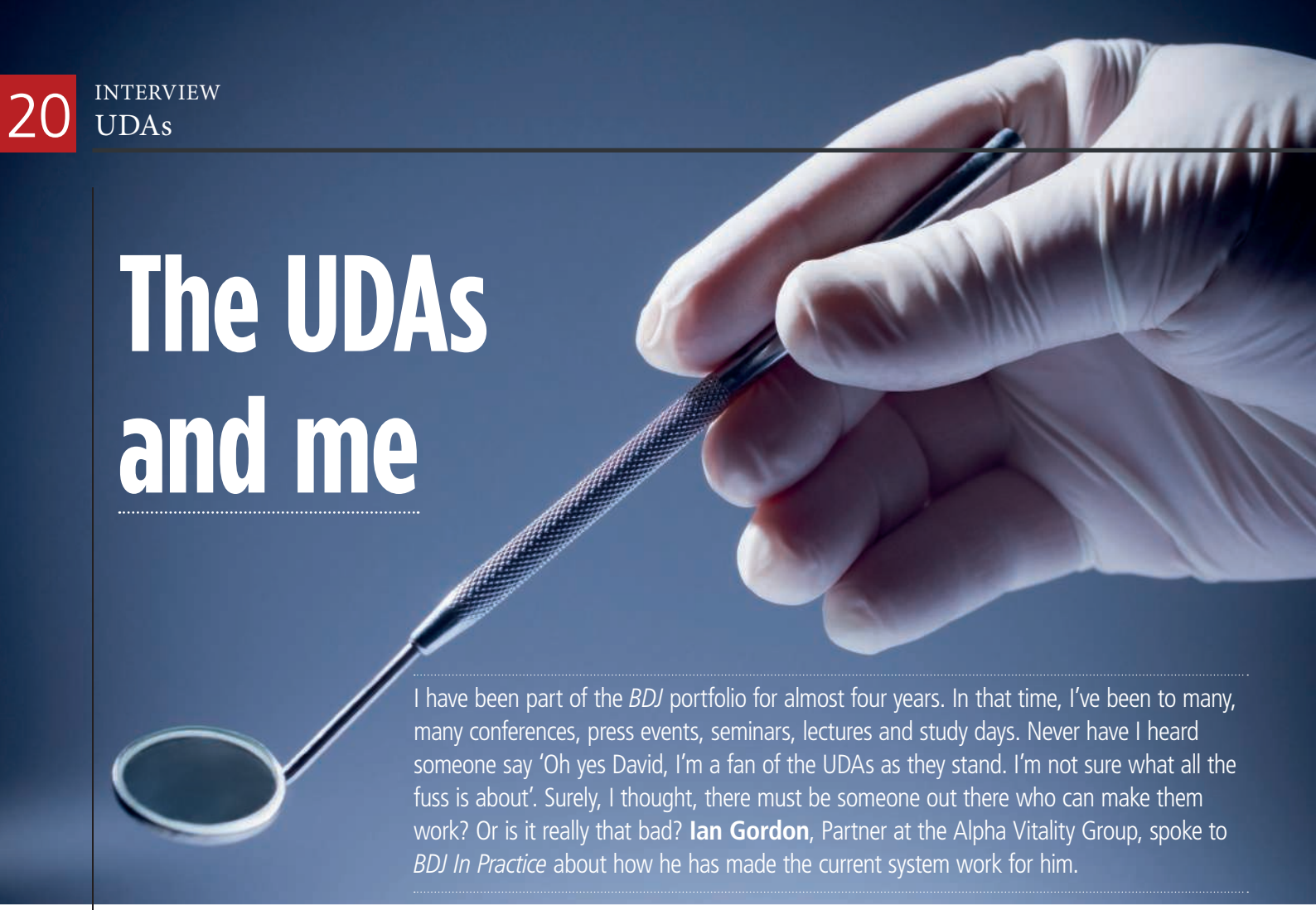
1. Either a patient or another health care provider will want to book an appointment with you. This stage allows you to think about how that will work. Are there referral processes, local patient lists and allocation, do the patients contact you directly. Think about how this is done, who is involved, how you keep it efficient, patient centred, minimise inappropriate referrals, triaging and the associated policies and procedures involved at this stage, have a policy for managing any waiting lists.
2. Next the patient is due for their appointment. Do you send them anything ahead of the appointment? Do you remind them?
3. The patient attends. Think about them getting to your practice and then walking through your door and up to your reception. How do the premises meet their needs? How does the process work? They book in, they sit down and they wait for their appointment.
4. They are seen by the dentist. They are examined. A treatment plan is made, consent is given and either the patient care is completed, on-going or referral is made. How are they involved in their care? How does your practice deal with completed, continuing treatment and referrals protocols? When might you refer? When might you refuse a patient if providing specialist care such as MOS or orthodontics?
5. Are you working to requirements set out in the tender specification? Are you minimising waiting times? Are you seeing a particular group? Are you general or specialised?
6. What then happens when the patient leaves the dental chair? Are there recalls, further treatment, referrals made using local protocols? Records stored etc. If there is a need for a long course of treatment how is this dealt with?
7. If they are referred what happens? Do you keep in contact with patients? Are they likely to come back to you?
8. How do you monitor the service provided? How do you improve?
9. What might you do if you realise a patient is vulnerable and at risk?
10. What might you do if there is a serious incident involving your patient such as reaction to treatment, cardiac arrest etc?

All of the above stages involve facilities, people, policies and procedures. Thinking of your own practice processes will allow you to expand.

If you are one of the practices who has the opportunity to bid for your own contract, or you want to bid for additional UDAs/UOAs, or even start from scratch, this will give you some useful information so that you can give yourself a better chance of success.

Good luck... ◆

The UDAs and me



I have been part of the *BDJ* portfolio for almost four years. In that time, I've been to many, many conferences, press events, seminars, lectures and study days. Never have I heard someone say 'Oh yes David, I'm a fan of the UDAs as they stand. I'm not sure what all the fuss is about'. Surely, I thought, there must be someone out there who can make them work? Or is it really that bad? **Ian Gordon**, Partner at the Alpha Vitality Group, spoke to *BDJ In Practice* about how he has made the current system work for him.

Ian Gordon,
Partner, Alpha Vitality Group

Why does the current UDA system work for you?

It's an interesting question. It's not necessarily the system; I accept there are flaws, and it is swings and roundabouts when it comes to delivering at the coal face. It's a point I often make when I tell people UDAs work for my practice. Before the current contract was rubber stamped I was part of Challenge, and we did all we possibly could to raise awareness of the problems which have been manifest in the contract since 2006

What I have found is there is an optimum environment in which associates within the group can flourish, despite the pressure of targets. Get the environment right in which they can train and develop and you can negate the flaws in the system. We deliver roughly 125,000 UDAs across the Group and generally have no problem with recruitment thanks in part to our commitment to Foundation Training – but I'm aware of the recruitment challenges in the North East, Yorkshire and Humber, Lincolnshire and the South West so our position is an anomaly rather than rule in the North East. You have to think differently, rather than follow a confirmation bias – i.e. that you can't do anything under the current contract.

In your opinion has the negativity surrounding the current contract overshadowed the positives it has for patients?

I think you can have a balanced discussion. Our philosophy has been to spend time improving what we have rather than seek new alternatives and get stuck in a perpetual cycle of waiting for prototypes and contract reform. Prior to the implementation of the 2006 contract, we simply did not need to lose Items of Service. It took away from those in the least accessible areas of society. Direct grants, for example, would have been a good substitute – here's some money to treat patients in the poorest and most deprived areas of the country, go off and do it. We expressed concerns it would lead to that very scenario, and now I am concerned the calls for 100% capitation models are going too far in the other direction.

There is little doubt that the volume of those speaking out about the current contract outweighs those who have found ways to make it work for them. Is it a political vehicle? I've often been dismayed at comments made to me when I suggest we make what we have better – namely that we would be stuck with it, if that were to be the case. That's flawed logic, and there are parallels to be drawn with the current debate surrounding the Brexit negotiations.

I have immense respect for those at the BDA who have spent years trying to find a deliverable model and have been wholly committed to contract reform. There is now an acceptance that whilst this goal should not be abandoned there are ways to commission the existing contract differently while we wait for dental contract reform. Much progress has been made over the past six months since LDC Conference in this regard – there is now a real possibility that Flexible Commissioning will become a part of NHS England Commissioning guidance allowing delivery of at least some of the contract without a UDA target. For me this is consistent with my statement that we did not need to abandon Item of Service because it had flaws – it did – and similarly we can vastly improve the current contract in a cost neutral way for

commissioners whilst benefiting patients and giving practitioners much needed relief from the UDA treadmill. It's small steps and small acorns – contract reform should and must go on but if Flexible Commissioning – which is already working for prevention in North Yorkshire and Humber – is embraced then we could adapt what we have now for the benefit for the many not the few

Do you think some/not enough practitioners don't speak up in support of UDAs because it's not a populist opinion?

I have certainly never been afraid to voice my opinion!

There's a degree of truth to that. GDPC and the BDA have done a lot of work on contract reform to date, but I have always held the opinion that we must truly assess whether we're getting all we can from what we have. And we can have preventive focused work, and we can deliver UDAs. We can attract people to the practice – all the things people say the current contract is at fault for.

My starting point is this: if a practice is failing, one of the first things you do is look at the UDA rate. Is that a problem with the system or with the commissioning? I would argue that's historic commissioning and the need for current commissioners to be brave and innovative – as indeed some are prepared to be. I hear so much that 'we can't work in a failing system', but to me that is not a broken system. There are tales of some appalling commissioning, and you don't need to look much further than the IDH-acquired practices that were formerly the ADP Group. Some of those were based on UDA rates of £18 in the North East and they wondered why they couldn't make them work? I'm not sure what anyone expected – commissioners or providers.

From what you know of contract reform to date, are you encouraged by the results from the prototypes?

I would have to roll back a step and ask why we're so intent on pushing for contract reform. Those involved in the discussions are calling for support on a 100% capitation model. That is not going to happen. You are not going to be given a big bag of money and told 'go off and look after patients'. It does not work for commissioners or HM Treasury and without access targets access would suffer. There would be a significant risk of one unpopular measure (UDA) being replaced by another undeliverable one (how many people can you treat for as little as possible). Again rather like Brexit, I see the obsession with 100% capitation as chasing the undeliverable.

From a clinical standpoint, and from a business standpoint, I don't see how the current wave of prototypes are improving things from where we are today. I'm told 25% of those involved are facing clawback. That doesn't sound like nor represent a step forward in my eyes. The prototype evaluation report of 22 May 2018 states there are two areas that need real work. Firstly, high needs patients. The DH/NHSE has addressed this by putting weighted capitation back in by postcode, gender and age. Secondly the evaluation report states that the prototypes business model is not sustainable, which is key if there is to be long term provision of NHS dentistry. This aspect has not so far as I am aware been addressed. What also needs addressing are the access targets which as the BDA point out, are 15% too high and prevention needs to be more than just a strap line with no funding attached, for you get what you pay for. If DH/NHS attached say 10% of funding to prevention not only would they actually get prevention they would also go some way to gaining business sustainability.

Traditionally, NHS dentistry has always been the area of the NHS that over-delivered - and constantly. I get that the system is flawed, but is it really as bad as some people are saying, or have they resigned themselves to getting on a political bandwagon and hoping change happens rather than forcing it through at a practice level?

So what blend would you think would suit the needs of the profession?

There has to be some measure of activity matrix. That cannot be overlooked. If a basic registration fee was re-introduced, that would be a good start. With a measure of activity, a simplified fee scale – not like the ridiculously overcomplicated 400 items of service abomination that was the old SDR - and a chunk of capitation, we could potentially have something that can work for a lot of people. It's similar to Blend B, but with some added activity payments. Indeed Flexible Commissioning could morph seamlessly into this allowing practices to choose what they can deliver. Some who were prepared to see more new patients may elect for a fee per item bias, others with a more stable list a Capitation bias – others with specialists working at the practice could commission more advanced services.

The Contract Reform process when explained is always over complicated by multicoloured unfathomable slides. Dentistry is simple – patients need prevention, treatment and maintenance – that's it – and all we need is a system funded to help deliver this

So does it come down to managing expectations?

We do have to be realistic in what we get. I understand that the negotiating position had to be 100% capitation, get rid of the UDAs and get more money for seeing fewer patients. From that standpoint they can work backwards, but were those responsible for inputting into the contract reform process seriously going to get that? The average GDP will probably hold their hands up and say we've seen nothing from the contract reform process for eight years, and in that time it's become harder and harder for us to claim for the work we do. I'd suggest that is not the kind of progress we'd expect after eight years. The monitoring thumb screws have been turned tighter every year and added to the culture of fear resentment and resignation.

There are positives to take from the prototypes – such as care pathways but challenges have also being identified such as the need for significant additional management time and many Prototype practices report the need to expand their working hours or add additional surgeries if they have any hope of meeting their UDA and access targets.

I think our focus should be directed on both getting what we have right - while we make sure the significant issues in dental contract reform are addressed before it is rolled out to the profession and delivered to patients. All of this has to be considered against the relentless increase in patient charges which if continued at the current rate will see by 2022 most adult fee paying patients paying in PCR 100% of their NHS charge. What will being a NHS patient actually mean in that circumstance? ◆

A Botox overview

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

Injectable cosmetics such as Botox (botulinum toxin) and dermal fillers are becoming more popular and increasing numbers of dentists are offering non-surgical cosmetic treatments to their patients.

The administration of Botox is not the practice of dentistry, so does not appear in the GDC's Scope of Practice document. Botox is a prescription-only medicine (POM) and needs to be prescribed by a registered doctor or dentist who has completed a full assessment of the patient.

© ADAM GAULT/SPL / Science Photo Library Getty Images

Training and Professional Guidance

If you provide cosmetic procedures using Botox or dermal fillers, you must ensure that you are suitably trained and understand the importance of valid consent and appropriate aftercare to ensure patient safety. Each practitioner must satisfy themselves that their training ensures their duty of care can be fully met. It is also essential that anyone undertaking injectable cosmetic treatments has appropriate professional indemnity arrangements in place. All training programmes should be subject to a quality assurance process.

In 2013 The Royal College of Surgeons of England's (RCS) produced a document titled 'Professional Standards for Cosmetic Practice'. It detailed the standards that would reasonably be expected of a dentist performing cosmetic treatments including laser treatments and injectable cosmetic treatments.

Shortly after the College's publication, the Department of Health carried out a review into the regulation of cosmetic interventions and recommended a more robust regulatory framework that provides protection against the potential risks from cosmetic procedures.

Taking forward the recommendations of the review, The Royal College of Surgeons of England, led by a Cosmetic Surgery Interspeciality Committee (CSIC), developed a certification scheme that aims to provide evidence of competences (including professional behaviours, clinical skills, knowledge and experience) in defined areas of cosmetic surgery. The principles of this guidance underpin cosmetic surgery certification and set standards of good practice for all surgeons who perform cosmetic surgery. The guidance addresses key areas of risk identified for cosmetic surgery including communication, consent, professional behaviours and dealing with the psychologically vulnerable patient.

In November 2015, Health Education England (HEE) published two documents in relation to the qualification requirements for delivery of cosmetic procedures: non-surgical cosmetic interventions.[1] The qualification requirements include areas of study which were highlighted as key requirements in the Keogh review, such as;

- Obtaining valid consent
- Information governance and record keeping
- Requirement to operate from safe premises
- Infection control
- Treatment room safety
- Adverse incident reporting
- Physiology and anatomy
- Treatment of anaphylaxis and understanding of existing medical conditions.

The qualification requirements set out in the document correspond with different levels of learning which reflect the complexity and risk level of different procedures, to ensure patient safety and high standards of care. The Levels start from Level 4 to Level 7 and those with a dental degree will automatically be at Level 6.

Voluntary regulation

Key stakeholders within the industry have formed and created the Joint Council of Cosmetic Practitioners (JCCP) whose aim is to set the standards of clinical and practice proficiency in order to provide a safer patient outcome. The JCCP are working towards reaching a point whereby all aesthetic practitioners adopt these standards within their practice in the future.

There are schemes for the voluntary regulation of non-surgical cosmetic procedures. These initiatives are run for the purpose of promoting high standards for the provision of injectable cosmetic treatments, together with principles for training. They are part of the independent healthcare sector and the two organisations that are recommended by the General Medical Council (GMC) are 'Treatments You Can Trust' and 'Save Face'.

Although the Department of Health strongly support the recommendations that have been provided by Health Education England (HEE) the Government have not accepted the case for statutory and mandatory regulation in the non-surgical aesthetic sector.

It is not a GDC requirement of dentists to join these schemes. Dentists may wish to participate in one of the schemes, which is based on registration and certification. From a patient perspective, it could be argued that the use of these schemes will inspire confidence in the clinician involved. ◆

1. Health Education England. New qualifications unveiled to improve the safety of non-surgical cosmetic procedures. Available online at: https://hee.nhs.uk/news-blogs-events/hee-news/new-qualifications-unveiled-improve-safety-non-surgical-cosmetic-procedures (Accessed December 2018).

For further information please visit www.bda.org/dentists/advice/Pages/Health-and-Safety.aspx

Data Security and Protection Toolkit

By Victoria Michell

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

The Data Security and Protection Toolkit replaced the Information Governance Toolkit in April 2018. The new Toolkit is designed with all NHS providers in mind and is thought to be easier to navigate and simpler to complete than it was in its previous incarnation.

Below are the BDA Advisory Team's top tips for completing the Toolkit.

Top tips

1. Providers must complete the Toolkit by 31 March each year.
2. Providers should make sure they are registered in plenty of time to complete the Toolkit. Even where providers were registered for the IGT they will need to register again for the DPST. This can be done via www.dsptoolkit.nhs.uk. In order to register for the Toolkit providers will need an organisation code. This can be obtained from NHS Digital.
3. Providers should make sure their practice personnel undertake the requisite training. All staff and practice personnel with access to personal data should reach Data Security Awareness Level 1. This should be done in advance of the March deadline but must be done in advance of completion of the Toolkit. Remember personnel can be absent from the practice for many reasons and therefore it is ill-advised to leave this training until March. There is no annual requirement to complete the training once personnel have passed the assessment however new starters do need to complete it. Additionally, those returning from a period of leave or those who have not taken the online course for some time may indeed benefit from redoing the assessment as a reminder. Remember it is free training and is an excellent resource for getting staff and practitioners up to speed with the new General Data Protection Regulations requirements.
4. Providers who do not already have an nhs.net email address will need to complete the Toolkit successfully to obtain one. This includes private practices.
5. When providers complete the Toolkit they will be asked who the SIRO is. It is not necessary for dental practices to have a SIRO at the time of writing, although this may be subject to change.
6. Providers will also be asked to detail who their Caldicott guardian is. Remember most practices are not legally required to appoint a Caldicott guardian and if one is not appointed you can insert n/a into the box. However, practices should have someone appointed at the practice to deal with Caldicott issues.
7. Providers will be asked to name a Data Security Lead and Data Protection Officer. These are not necessarily the same person but may indeed be.
8. Each question in the Toolkit requires either a tick in the box at the top of the pop out window or a response to be typed in the response box in the pop out window. Where the tick box appears, there is an optional comment box. Do not confuse the optional comment box with the answer box as failing to tick the box where it appears will mean that the requirement will not be met, regardless of what is typed in the optional box.
9. Not all the questions require responses. Some are optional and some are mandatory. These are clearly labelled so providers should focus their attention initially on the mandatory sections.

Why complete the Toolkit?

Completing the Toolkit is mandatory for all NHS providers and is a great practice management tool for the following reasons:

- The Toolkit ensures that personnel are trained to the requisite standards and this goes to help the NHS protect patient data. The training is free!
- It is a great tool for Providers to use to understand if they have adequate data protection provisions in place to protect data. Gaps can be identified and training needs addressed by completing the Toolkit.
- Private practices are also able to access the learning resources and complete the Toolkit and this is a great idea. In addition to the resources also being free to private practitioners, where a data breach does occur, completion of the Toolkit and training will show the ICO that data protection is a priority at the practice and that the Provider has taken strong steps to prevent breaches.
- The CQC is likely to consider whether a practice has completed the Toolkit when assessing the risk profile of the practice. Completing the Toolkit will have a positive impact.
- In order to obtain an nhs.net email address both NHS and private practices will need to have completed the Toolkit.

It is also important for NHS providers to remember that where data breaches occur these should be reported via the Toolkit's reporting tool which can be accessed by logging into the Toolkit. Another reason not to delay registering with the Toolkit because if providers identify a security breach they will need to avoid unnecessary delays in reporting the breach to NHS England and the Information Commissioners Office.

To obtain an organisation code email dentistadmin@nhs.net or visit https://digital.nhs.uk/services/organisation-data-service/our-services#code%20allocation

Access the E-Learning tool at: https://www.e-lfh.org.uk/programmes/data-security-awareness/

Dental x-ray equipment: An update

By Ian Chell

Ian Chell MSc FSRP was an x-ray engineer with Siemens Medical for over 20 years, was then a radiology Senior Medical Device Specialist with MHRA for 7 years and was then promoted into the Department of Health, until he left last year, as the policy lead for radiations which included the IRMER regulations.

Within the past year, a number of subtle but important changes have taken place with regards to the use of dental equipment with respect to patient safety. This article explains the regulations and non-statutory guidance that apply to the x-ray equipment being used on patients. A patient is specifically defined in the Ionising Radiation (Medical Exposure) Regulations (2017) (IRMER)[1] as being under the care of the healthcare provider and this would apply to dentists.

Their relatives in the waiting room are classed as members of the public but if they have to hold a child patient, they become a 'Comforter and Carer' under IRMER (also new). This article does not discuss the occupational and 'public' aspects with respect to the Health and Safety Executive's (HSE) requirements under the Ionising Radiation Regulations 2017 (IRR). It is important to understand that IRR is in place to protect workers (dentists etc) and members of the public.

IRMER and the Medical Device Regulations.[2] are two other regulations that apply with respect to the patient in terms of the use and installation of the dental x-ray unit.

I was responsible for the latest IRMER regulations policy formation up until I left DH last year which included a number of new policies, two of which are important to dentists. Dentists should be aware that with the 2017 regulations, you need to employ the services of a Medical Physics Expert as well as an RPA. The MPE will give you support on optimising patient exposures and give advice on quality assurance. The other change is that if the patient is unintentionally exposed to radiation due to an equipment fault, you should report this to your IRMER authority (CQC in England). This is done in the same way as you would for incidents due to procedural failures (also under IRMER).

> 'Medical Devices are regulated to high standards throughout Europe and all dental x-ray units that you buy have to be CE marked which means they have been tested to standards depending on the risk to patients.'

In the majority of cases, MHRA will probably end up resolving the equipment failure using the Medical Device Regulations but, the failure may be for other reasons; it may be to do with it not being checked after an engineer has worked on something that affects the dose. Examples include leaving beam filtration out and the MPE does not check this (or is not asked). Dental radiation dose is relatively low compared with other medical x-ray exposures but it is not excluded in anyway – HSE are no longer responsible for patient-related over exposure due to equipment failure.

Medical Devices are regulated to high standards throughout Europe and all dental x-ray units that you buy have to be CE marked which means they have been tested to standards depending on the risk to patients. The two main risks to patients are radiation and electric shock. These risks are minimised by thorough testing and manufacturing quality control. Suppliers and manufacturers have to follow rigorous procedures and labelling protocols. This system is important because it helps to compliment other regulatory frameworks. MHRA has previously issued an alert about cheap imported dental x-ray units. One example bought on the internet, which did not have a CE mark, had insufficient user radiation shielding and was provided with an unsafe power adaptor.

If a medical device fails and the patient is harmed or could have been harmed, you should report this to the UK MHRA. They will then take it up with the supplier or manufacturer and by doing this, it helps them to spot trends and you may be

helping other dentists with similar issues. If your RPA finds problems with the equipment, this is still for the MHRA not HSE. The RPA just won't approve use.

Electrical safety

All medical devices are put into risk classes and are tested to varying degrees dependent on the class. I will not go into the technical tests but you should understand that there is a particular term used in device safety known as an 'applied part'. These are parts of the equipment that will come into contact with the patient. The equipment has to be built to provide electric shock protection and the applied parts will be tested to ensure the electric shock risks are minimised.

The dental x-ray unit will have a mandatory label and one field will be 'Type of protection'. If there is a B next to this, it means it has a type B applied part. Type CF (C = `Cardiac - F = Floating) is the most stringent classification, being required for those applications where the applied part is in direct conductive contact with the heart or other applications as considered necessary. Type BF is less stringent than CF, and is generally for devices that have conductive contact with the patient, or having medium to long-term contact with the patient. Type B is the least stringent classification, and is used for applied parts that are generally not conductive and can be immediately released from the patient. Type B applied parts may be connected to earth, while Type BF and CF are 'floating' and must be separated from earth. This system is about the device design but it does also influence how the electrical supply wiring is designed.

The Medical Device Regulations cover the device up to the mains supply terminals or the 13A plug. The wiring up to this connection point is not regulated by UK legislation but instead by guidance produced to a set standard. The IET are the UK body with the responsibility for this guidance known as BS671, that has been recently updated with a version known as BS7671(2018) which can be purchased online. There is a special section for medical locations in BS7671 and this means particular attention has to be paid to hard-wired dental x-ray units. There is also recently updated guidance for the NHS that compliments BS7671. The IET will soon be releasing additional guidance on this very subject to help clear up ambiguities in this area.

The most recent BS7671(2018) guidance has been changed to make the earth requirements in medical locations simpler. However, the requirements of BS7671 require specific medical devices, that have 'applied parts', to be connected to the building wiring in a specific way. The simplified system has to be complied with from January 2019. The change for those with a technical interest is that the resistance value for the earth conductors in group one medical locations is now the same as group 2 which is 0.2 ohms. Dental x-ray units will have to meet this requirement if the electrical expert decides it is a group 1 medical location.

The general advice for new installations of dental x-ray units is to employ a specialist electrical expert who understands the specific requirements of BS7671(2018). As a purchaser, you should check the labelling, which should conform with the Medical Device Regulations, to establish if the x-ray unit has applied parts. This is usually marked as a 'B' on the labelling for dental equipment. If this is the case, such units should be installed by an electrician who understands these requirements or one under the supervision of a relevant expert who understands the latest requirements. I have discussed this issue with fellow experts at the IET and we have a joint view that dental x-ray equipment should be treated as a group 1 medical location. Medical locations and their groups are described in BS7671 and includes private clinics/ dental surgeries. These requirements are not unreasonable – the earth wiring and the wiring protection (trip) must meet the specific requirement for that medical location. it does not involve expensive equipment – just the right sized earth wires and the correct protective trips (in the fuse board) which your electrical safety advisor will specify. It is always better to fit a new separate earth wire, a dedicated supply wire, connection point and specific trip for fixed x-ray equipment.

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3. 601help.com. The Medical Device Developer's Guide to IEC 60601-1. Available online at: www.601help.com/Disclaimer/glossary.html#AppliedPart (Accessed December 2018).
4. Department of Health. Health Technical Memorandum 06-01: Electrical services supply and distribution. Available online at: https://assets.publishing.service.gov.uk/government/uploads/system/uploads/attachment_data/file/608037/Health_tech_memo_0601.pdf (Accessed December 2018).

The secure way to share

Sharing patient images with other dentists and technicians is a necessary part of providing the best care – but are you transferring images safely?

Common methods such as email are prone to all sorts of cyber risks that could lead to patient data files being leaked.

Make sure you collaborate with other professionals securely by using PROPACS from PRO Diagnostics UK.

An innovative online cloud image storage system, PROPACS helps professionals to share images with others through medical grade encrypted, transfer secure password protected user accounts. Dentists can upload patient images automatically or manually to their encrypted online portal and whomever they are collaborating with can then request a password to access them.

This way, images remain protected throughout the sharing process, leaving no opening for hackers to infiltrate the high-level security and access sensitive patient data.

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

New dental unit announced

The new Planmeca Compact i5 dental unit has been built around five central themes – design, wellbeing, cleanliness, intelligence, and evolution. All of these principles are carried through in every detail of the dental unit, resulting in a perfect combination of functionality, durability, comfort, safety, and aesthetics.

Design – user-centric thinking

Planmeca Compact i5 has been designed not only to withstand time, but also to evolve with time. Its compact and lightweight design complements any dental clinic and can be easily tailored to different working preferences. From smooth delivery arm movements to the intuitive touch panel offering user guidance in 25 languages, every detail of the dental unit has been designed to make every-day work as smooth as possible, both now and in the future.

Wellbeing – a relaxed dental team and patients

Planmeca Compact i5 has been designed to support the wellbeing of both the entire dental team and the patient. The floating chair with a narrowing backrest and the small cuspidor base enable convenient access to the treatment area, while the balanced instrument arms guarantee an ergonomic use of instruments. Patient comfort is by no means forgotten: the foldable leg rest enables easy entry and exit, and the custom-moulded upholstery guarantees an enjoyable patient experience.

Cleanliness – a safe working and treatment environment

In Planmeca Compact i5, all the essential infection control functions are integrated and neatly organised in their own compartments. The cleaning procedures are automated, and the LED indicator on the dental unit informs of their status. These practical solutions help to speed up infection control, which in turn means a faster patient flow and improved quality assurance.

Intelligence – smart tools for smart dentistry

Just like all of Planmeca's digital equipment, Planmeca Compact i5 can be easily connected to a network in order to produce valuable data. With Planmeca's intelligent software solutions, clinics can track and follow their patient flow, optimise their capacity through real-time information, and monitor the use of their equipment. Furthermore, the dental unit's smart sign-in system allows fast access to personalised dental unit settings with a flash of a card.

Evolution – continuous improvement

The rapidly changing world of dentistry – with its increasing quality assurance demands and the constantly growing patient flow – sets new demands for dental clinics, and Planmeca Compact i5 has been designed to cater to these demands. The dental unit is guaranteed to have a long life span: it has been built so that it can be upgraded with new features any time. This makes it a truly future-proof investment.

Dental technology with a sparkle

For any dental practice looking for high quality products and excellent customer service from their laboratory, Sparkle Dental Labs is here to help.

The team's outstanding commitment to cutting-edge technology means they have access to a dedicated CAD/CAM suite, as well as both the Renishaw AM250 Laser Sintering Machine and DryLyte Chrome Polishing System on the same premises. All this enables the technicians to deliver highly aesthetic and precision fit restorations and appliances that will put a sparkle into your patients' smiles.

For more information, contact Sparkle Dental Labs on 0800 138 6255, or visit www.sparkledentallabs.com.

Raise a glass

Although moderate alcohol consumption may have some health benefits, it also dries the mouth allowing bacteria to flourish and make the breath smell unpleasant. Now you can get right to the root of odorous breath by recommending CB12 oral health products.

The CB12 range has been developed by dentists and has a patented formula to effectively target and neutralise odorous smelling oral gases for up to 12 hours. It also contains fluoride to strengthen the teeth and prevent cavities, as well as highly effective anti-plaque agents to enhance any oral health routine.

CB12 mouthwash has been clinically proven to outperform 18 other leading UK and European oral hygiene products.

CB12 White is a non-abrasive, alcohol free mouthwash that has the technology to lifts tooth stains and prevent new ones from developing.

CB12 boost sugar-free chewing gum is ideal to freshen and invigorate the breath after eating and drinking throughout the day.

CB12 Spray can be used to instantly freshen the breath, it fits into a pocket or handbag and is perfect when patients are on the go.

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

New updates announced

Align Technology has announced multiple updates associated with the iTero Element family of Intraoral scanners (Element, Element 2 and Element Flex) which includes a new software upgrade with enhanced functionality, and connectivity with important digital dentistry leader: exocad. With these updates, iTero has strengthened its position in restorative and dental practice workflow and is able to help dentists offer a better and faster patient experience.

Software upgrade

With the 1.7 iTero scanner software upgrade, which will be available through a gradual release, starting in late November, dentists and orthodontists will have access to new features which improve scan quality and provide additional functionality for patient data protection. These improved features include:

- Improved image quality and resolution of restorative model
- Direct visualisation of high resolution scan in 'scan mode'
- Improved scan process for prep segments, and
- Inactivity log out feature that activates after a pre-defined period of system inactivity for greater privacy of patient information

In addition, a separate iTero software update now also provides customers with an improvement in their experience at myitero.com, with clear visibility of file download status.

Exocad connectivity

Align also announced that iTero Intraoral scanner open chair-side milling workflow with exocad ChairsideCAD software offers a fully-validated workflow between iTero Element Intraoral scanner and exocad ChairsideCAD to enable in-house milling of dental restoration on any compatible milling machine. With the flexibility of being able to choose chair-side workflow that works for their practice, dentists can focus on offering a better patient experience and faster treatment through same-day dentistry.

Visit www.itero.com or www.facebook.com/iterodigitalimpressionsystem/

Open children's minds

Having difficulty getting your young patients to understand the impact of oral hygiene and diet on their oral health? Then try the new, advanced CALCIVIS imaging system that can be used with patients from the age of six.

Designed to help the dental team detect active tooth enamel demineralisation by applying a luminescent (light emitting) photoprotein, CALCIVIS serves as a great visual tool as it displays a glowing map of active demineralisation right at the chairside.

This enables children to physically see demineralisation that could lead to dental caries and helps them to understand the consequences of a bad diet and poor oral hygiene.

For more information visit www.CALCIVIS.com or call 0131 658 5152.

Protection when it matters

Have you got patients who attend the gym regularly?

Depending on which activities they participate in, they could be putting themselves at risk of dental injury.

Make sure you offer them the best protection possible by recommending a Saber Protect mouth guard from CosTech Dental Laboratory.

Able to effectively protect teeth against any injuries caused by a stray squash racquet or jaw clenching during weight lifting, this innovative piece of protective kit is custom-fabricated to provide a comfortable fit. Furthermore, due to custom levels of shock absorbency Saber protect mouth guards offer tailored protection unlike any other – ideal for making sure patients keep their teeth safe no matter which scenarios they find themselves in.

For more information about CosTech Dental Laboratory, please visit www.costech.co.uk or call 01474 320076.

Capture every detail

Implementing cutting-edge technology to ensure fantastic results, the new CS 9600 CBCT machine from Carestream Dental is carving its way into the future with a series of impressive features.

Using CS Face Scan, the device can capture fully realistic 3D facial images and automatically superimpose the surface scan with CBCT images and 3D models – ideal for oral and maxillofacial surgery.

The device also uses Live Patient Positioning Assistant – cameras that send real-time images to the professional's touch-screen to aid easy and exact positioning.

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

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COLTENE is synonymous with high-quality restorative materials, and has become a global leader in the development, manufacture and sale of quality, everyday essentials. Through ongoing research and dedication to using the latest technology and techniques, COLTENE has created a complete range of first-class restorative products.

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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)
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Dr Nicole Sturzenbaum
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East Twickenham TW1 2DU
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Email: info@toothbeary.co.uk
Interests: Children

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

Midlands

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Specialist Referral Centre In London
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Specialist in Periodontology: Dr Zanaboni, Dr Stern
Specialist in Prosthodontics: Dr Yerbury
Specialist in Endodontics: Dr Ardeshna
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Interests: Prosthodontics, Restorative and Implants Dentistry, Implant complications, Aesthetic Dentistry, Endodontics, Periodontics, Hygienist, OPG

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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
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On Specialist List: Yes, Endodontics and Orthodontics

East Anglia

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Email: enquiries@devonshirehousedental.co.uk

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Nick Williams
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Q1: At which level will you be entered for delivering Botox if you have a dental degree?

A Level 4
B Level 5
C Level 6
D Level 7

Q2: Which of these is the least stringent classification of electrical safety for medical devices?

A Type A
B Type B
C Type C
D Type D

Q3: What is the name of the guidance for Medical Device Regulations?

A BS671
B BS617
C BS716
D BS761

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