BDJ InPractice
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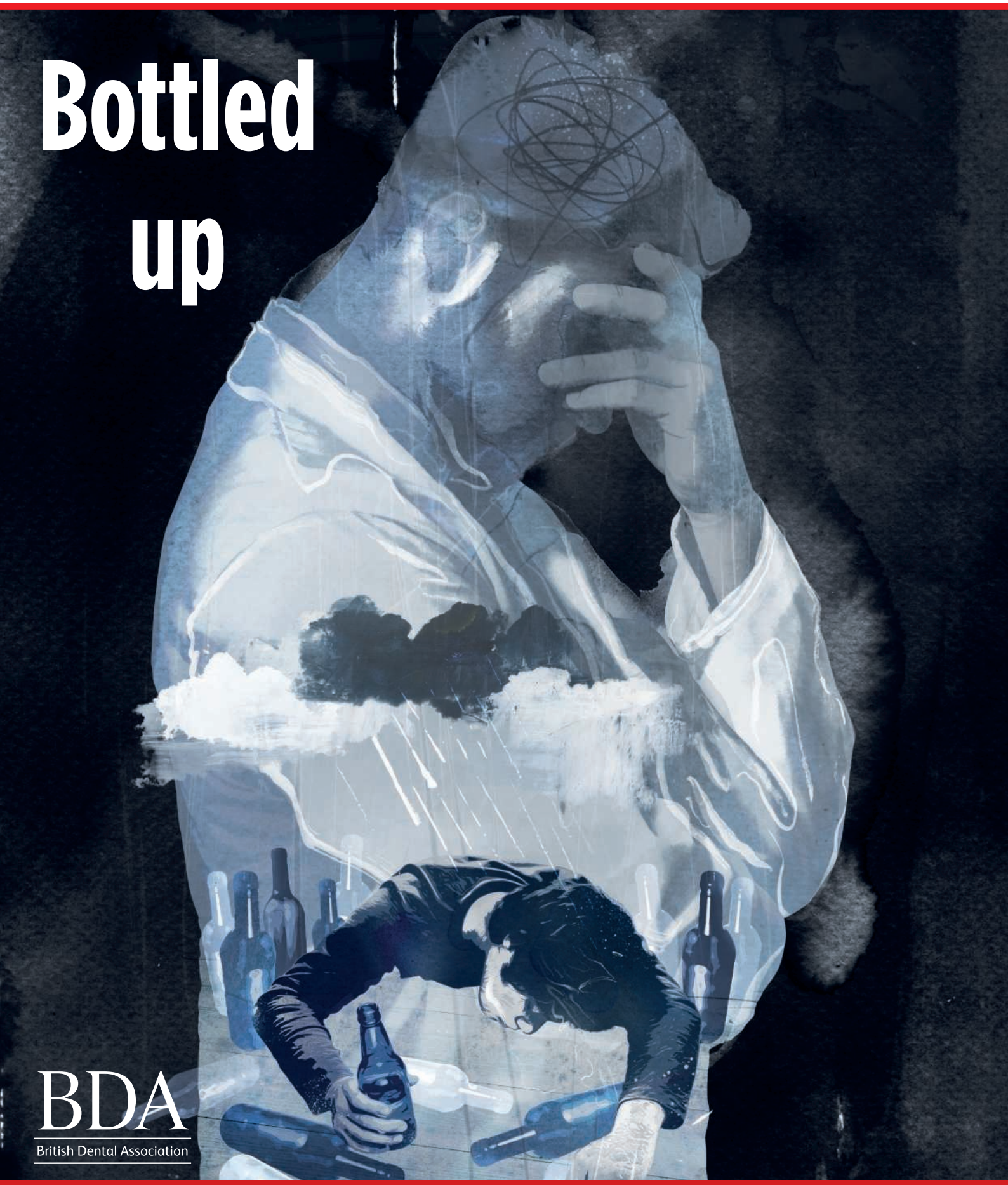
# Bottled up



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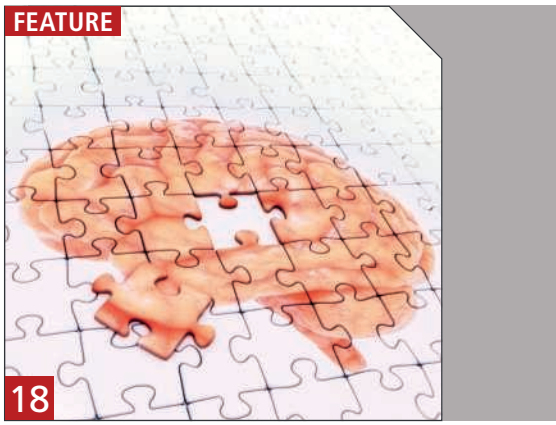



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BDA
British Dental Association

# A welcome from the editor

David Westgarth,
Editor, *BDJ In Practice*

If you hadn't already heard, an article published in last month's issue of *BDJ In Practice* has caused quite a storm. The piece, 'Can a hygienist work without a nurse?', received universal and almost unanimous discrediting from the dental hygiene and therapy community.

To say the scale of the reaction was a shock is somewhat of an understatement. I have been overwhelmed by the volume of correspondence I have received. I speak for myself and on behalf of the authors when I say we are sorry for the outrage this has caused. In a number of the letters received, there are calls for the article to be retracted. It is the decision of the publication that there are no grounds for a retraction; there is nothing incorrect or erroneous about the article.

And yet, beyond the personal vitriol aimed at the co-authors and myself, it leaves me with a feeling of better things to come. Regardless of whether you are a principal dentist, an associate, a dental hygienist, dental therapist or dental nurse, can you think of another topic that has united the profession to such an extent? I cannot.

This collective coming together was reflected in the number of letters submitted to me. Besides the official response from the BADT and the BSDHT, many excellent points were made. Here follows a number of exerts from letters, highlighting the depth of concern from the breadth of the hygiene and therapy community the article prompted.

*'We truly believe that a huge percentage of dentists and dental professionals do not realise the pressures we are under as newly-qualified professionals. We are constantly faced with being refused nursing help which you would not expect when you have just graduated and ready to take on the world.*

*'When you work between different practices it is very difficult to feel part of the team so without having a nurse it is even more isolating and lonely. Without nursing support we are not able to deliver the quality of care we have been trained to do as we are always trained how to work as a team and feel we are unable to give the best care to a patient when we are having to do everything and are extremely stressed out.*

*'Some graduates avoid pocket charts if they have no nursing support and some graduates are faced with patients being very annoyed that they have to help by holding an aspirator when they are paying privately.'* – **Amber Ojak and Katie Louisa Radford, via email**

*'Many of us feel undervalued, we are often taken on as self-employed members of the team but without the flexibility or control a self-employed person should have (usually everything is decided in favour of the practice, by the practice owner) and many hygienists do not get the choice of having a nurse. I have taken a pay cut to have that luxury and refuse to work alone when cover isn't available as treatment is compromised.'* – **Lucy Neshan, via email**

*'In a time of increased litigation, it is more important than ever that all clinicians are chaperoned. Furthermore, with the ever-increasing evidence of links between periodontal and systemic disease, the role of the hygienist is vital.* – **Kelly Skinner, via email**

*'As a student who is soon to graduate and enter the practical world of dental hygiene and dental therapy, I was disheartened to read the recent article which suggested hygienists can readily practise without the need for a dental nurse.*

*'Patient care, comfort and happiness should always be our number one priority, it saddens me that sometimes the world of dentistry seems to be increasingly business orientated rather than targeted towards patients.'* – **Hassan Raza Shariff, via email**

*'I have been a working hygienist for over 50 years seen many changes and value the nursing support I have had for at least 40 of these years.*

*In my experience few DHTs would take a position without this support unless they absolutely have no choice of another position.'* – **Maggie Jackson, via email**

*'And furthermore, we have striven over the decades to raise our profile to the public. Who we are. What we do and why. Therefore, striving forward should we not do our very best for our patients and if that means having assistance then so be it.'* – **Charlotte Garbutt, via email**

*'I will complete this email by letting you know that fortunately I work with two brilliant, forward-thinking principal dentists who are very appreciative of my contribution and knowledge that I bring to their practice and most importantly that we are happy and support every team member, regardless of what they do.'* – **Karen Fallon, via email.**

As you can see, a whole range of thoughts and perspectives. And a platform for engaging in debate. Yes, there are fundamental aspects of the piece people will disagree with – and that is to be expected – but to be unanimous in calls for a change in the wording regarding the provision of nursing support for hygienists and therapists from 'should' to 'must' and subsequent adequate funding?

The issue is one clearly at the very heart of the future of skill mix, something covered in these pages before. If ever there was an opportunity and a platform for discussions to begin in earnest about – amongst other things – the financial assistance necessary for NHS practices to be able to fully equip their teams – that time is now. ◆

Send your letters to the Editor, BDJ In Practice, 64 Wimpole Street, London, W1G 8YS. Email bdj@bda.org.

Priority will be given to letters less than 500 words long. Authors must sign the letter, which may be edited for reasons of space.

## Right of reply

### A response

Sir, we write in response to the article, 'Can a hygienist work without a nurse?' written by Len D'Cruz and Reena Wadia.[1]

It seems that article attempts to allay the fears of practice owners and dental hygienists that working without dental nursing support is acceptable as there is no legal or regulatory necessity to do so. The authors quote: '… *the GDC envisages clinicians such as dentists, hygienists and therapists not working in isolation but with other members of the team who can assist primarily with a response to a medical emergency.*'

The authors acknowledge that, *'Clearly 'support' can be provided for administrative tasks, chaperonage and chairside assistance…'* and that GDC Standards for the Dental Team 6.2.2. clearly state: '*You should work with another appropriately trained member of the dental team at all times when treating patients in a dental setting.*' However, there are no further references to the remaining GDC standards which state:

The only circumstances in which this does not apply are when:

- Treating patients in an out-of-hours emergency
- There are exceptional circumstances – these are unavoidable circumstances which are not routine and could not be foreseen.

The authors, by their own admission, agree that these standards apply to dentists, dental hygienists and therapists. Therefore, there should be no distinction between any of these clinicians when this standard is applied.

A periodontal specialist treating a patient non-surgically would expect to have dental nursing support, however, for many years there has been an acceptance that dental hygienists can work alone without the support of a dental nurse. Now the authors are recommending a risk assessment to be carried out in these situations. A risk assessment cannot fully assess every patient that the dental hygienist treats but would give a general view of the risk associated with treatments delivered. BSDHT and BADT find this situation and justification for lone working unacceptable.

Furthermore, suggesting that as a referring dentist they should volunteer their own mouth to be the test bed of the skillset of the dental hygienist they wish to refer to and that, '*if nothing else you will end up with clean teeth and a greater empathy for all dental patients who see you and sometimes cough and splutter their way through treatment because you didn't give them chance to breathe or swallow or wince in pain when you are a bit heavy handed with the scaler*' is a patronising and demeaning statement which has no place in this article.

We acknowledge the authors do make the point that the ideal is to employ a full-time dental nurse to assist (we prefer the adjunctive 'support') the hygienist and that this should not be precluded due to financial considerations. There is also consideration to acknowledge the daily struggle a lone hygienist faces. The 'helpful' strategies imparted were predicated with, *'a hygienist that can do just that* (working without assistance) *would certainly be seen as an asset to any practice and valued professionally amongst the team'*. This implies that a dental hygienist who works with dental nurse support will not be an asset or valued professionally.

The suggested strategies, whilst seeming to be written to help the dental hygienist work more smoothly through the day, still require valuable additional time for preparation, challenges with infection control, safe patient management and contemporaneous record keeping.

An important issue, not discussed in the article, is the stress that lone working places on dental hygienists. This is particularly pertinent to our newly-qualified colleagues who have had full support throughout training but are then expected to work in an environment without nursing support whilst trying to build confidence and competence in their chosen profession.

Despite one of the authors being a dento-legal advisor, our members report that their indemnity providers have advised it would be difficult to support them in any litigation brought against them because they did not have nursing support.

Following publication of this article, as you would expect, we have been inundated with reports of such difficulties from our members and non-members: all are concerned that this 'in depth' piece on 'regulation' gives further justification to their practice owners to refuse nursing support.

*BDJ in Practice's* strapline is 'This popular publication aims to inform and educate dentists and dental students about developments, trends and issues affecting dental practices in the UK'. The article was aimed at dental hygienists whilst being published for dentists. It begs the question: Why?

As clinicians we are not asking for anything different to what the dentist expects daily: simply parity among the clinical team.

BSDHT and BADT request an apology from the authors, acknowledging the concerns and strength of feeling their article has created among the dental hygiene and dental therapy professions. We would also like to write an article to be published in BDJ in Practice to redress the balance.

J. Deverick, D. McGovern, via email

1. D'Cruz L, Wadia R. Can a hygienist work without a nurse? *BDJ In Practice* 2019; **32:** 14-15.

Editor's Note – the full list of 444 co-signatories is available at: www.bsdht.org.uk/news-1/BDJ.

## Time for a change

Sir, I am writing in response to the article published which appeared to give 'useful tips' for practices to implement hygienists working without nursing support.

The indemnity advisor author is interpreting GDC 'guidance' on lone working to the benefit of practice profits, and not acting in the best interest of patients.

Dental Protection have published information on lone working and stated that 'it would be difficult to defend' in these situations.

I would be interested to hear a solid answer from all indemnity companies to whether or not a lone working clinician would be defended, a pay-out made, or left high and dry should a case arise under lone working conditions.

I am a GDC registrant with multiple DCP titles and predominantly work as an Orthodontic Therapist. No orthodontic

practice would consider orthodontic therapists working solo, and some principals provide two nurses to each therapist as well as a sterilisation assistant.

As a male clinician working with a high number of female patients and children, I would refuse to work alone in case of spurious claims. It is high time the GDC review their guidance and change the wording from clinicians 'should' be supported to 'must'.

B. Blum, via email.

## Addressing the balance

Sir, regarding your article 'Can a hygienist work without a nurse?' I felt this analysis by the authors helps the many hygienists who do work diligently in such circumstances. We know from CQC reports for eight years now that over 90% of dental practices consistently meet all safety and team standards fully, so clearly this is not a safety or ethical issue.

Whilst this article did recognise that having dental nurse assistance all the time was the ideal, it could have gone on to explore the advantages of that. However, it could have also looked more at the difficult economic aspects, especially within the NHS GDS system.

When some 300+ NHS dental practices are already getting paid less for a UDA than the NHS patient charge for say a Band 1 scale and polish, the reality of losing out to see NHS patients and then additionally fund hygienist provision plus a dental nurse in such limited circumstances, is simply charity work. I have seen arguments to the contrary, but the reality is economics do come into it. Or does such a 'two-person' hygiene service price itself out of the NHS and into private provision only?

On reflection, and again to the contrary, I feel the article addressed the GDC aspects reasonably; throwing existing hygienists under the GDC bus of an intrinsically traumatic Fitness to Practise case is clearly folly. Indeed, if it was so binary for hygienists as some suggest (no dental nurse = no hygienist care delivered), then all dental nurses would have to also have another dental nurse assisting them, when they use their full Scope of Practice skills for taking impressions or applying rubber dams. Whilst ideal, that could economically end that provision too.

It is time we had a grown-up conversation about ideal versus acceptable in what are often the challenging economics of a high-overhead dental practice. I would suggest this has begun.

T. Kilcoyne, via email

## Corrigendum

In the article entitled 'Can a hygienist work without a nurse?'[1], Reena Wadia's affiliations included King's College London.

This should have read King's College Dental Hospital.

We apologise for any inconvenience this may have caused.

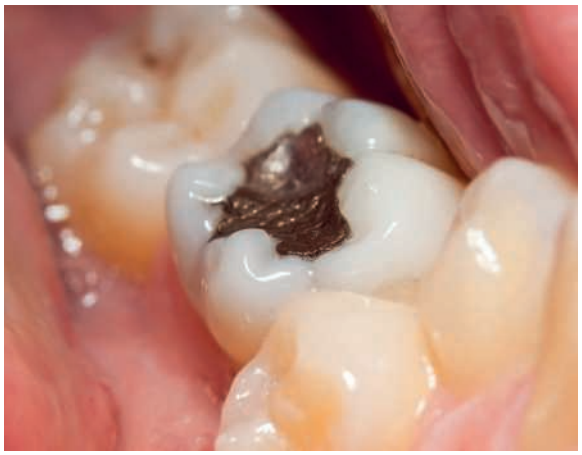
1. D'Cruz L and Wadia R. Can a hygienist work without a nurse? *BDJ In Practice* 2019; **32:** 14-15.

## Share your views on the phase-down of amalgam!

Newcastle University, in collaboration with the British Dental Association and the British Society of Dental Hygiene and Therapy, is calling on general dental practitioners, community dentists, salaried dentists, foundation dentists and dental therapists to assess current material use and techniques employed in the direct (non-laboratory) restoration of posterior teeth.

Your responses will be used in a PhD project that is being undertaken at Newcastle University. This will investigate the cost effectiveness of directly placed restorative materials, compared to dental amalgam. The results will be used by the BDA to campaign on the issues for dentists in relation to amalgam phase-down. The BSDHT will use them to inform policy.

All BDA GDP, CDS and FD members have been sent a personalised link to respond to this survey – please check your inbox to participate, it takes only 10 mins to complete. Dental therapists have been sent the survey via the BSDHT.



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Your opinions matter and your participation is vital for the validity of this study, email Research@bda.org if you need to be re-sent the survey link.

Your information will remain anonymous and we will not pass your details on to any third parties. This study has ethical approval from Newcastle University.

Thank you! ◆

## Membership of the BDA Benevolent Fund

All BDA members automatically become members of the Benevolent Fund upon joining the BDA. Members oversee the charity and have the responsibility and authority to exercise voting rights at the Annual General Meeting or other Extraordinary General Meeting. Members elect the Board of Trustees who oversee the charity on their behalf.

Following a clarification of the legal situation, the BDA's membership terms and conditions have been updated to reflect this.

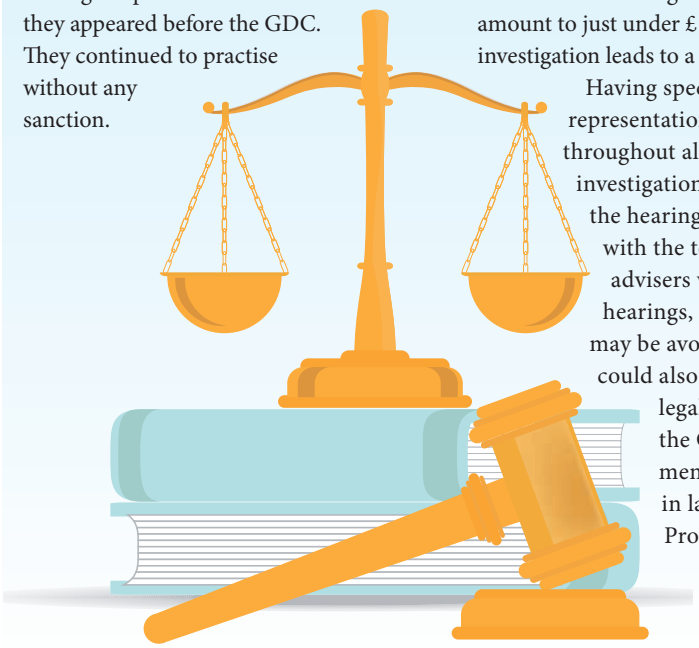
The Benevolent Fund relies upon the generosity of dentists, dental organisations and companies to be able to continue their work.

For further information or to access the updated terms and conditions visit www.bdabenevolentfund.org.uk ◆

# Dentists without legal representation face much tougher sanctions

The results of a Freedom of Information (FOI) request to the General Dental Council (GDC) by Dental Protection demonstrate how important it is for dental professionals to have legal and dento-legal support when faced with GDC proceedings.

It revealed 63% of dentists erased from the register following a GDC hearing in 2018 did not have any legal representation. In contrast, 92% who were found not to be impaired in their Fitness To Practise (FtP) had legal representation when they appeared before the GDC. They continued to practise without any sanction.



These data emphasise the need for dentists to be supported by a dental defence organisation that will protect their interests before the GDC.

Dental Protection regularly defends members on a wide range of matters, providing a significant level of support from experienced dento-legal consultants and representation from lawyers specialising in supporting members in FTP cases.

Dental Protection assists members on different matters including personal conduct matters at GDC hearings. It is not unusual for the cost of defending a dentist at a hearing to amount to just under £100,000 when a GDC investigation leads to a hearing.

Having specialist legal representation is important throughout all stages of an investigation and not just for the hearing. Early engagement with the team of specialist advisers will often mean that hearings, or even warnings, may be avoided altogether. This could also involve bringing legal proceedings against the GDC on behalf of a member. For instance, in late 2018, Dental Protection brought Judicial Review proceedings against the GDC's decision to issue a warning to members who had committed a minor driving offence. In this case, it was successfully argued that a GDC warning would be a disproportionate and unfair sanction by the regulator in these circumstances.

Other defence organisations or insurers may decline assistance to a dentist where it is a personal conduct matter. This would mean that the dentist would have had to pay personally for this legal support and the cost can be prohibitively expensive.

Raj Rattan, Dental Director at Dental Protection, said: 'These figures released by the GDC show just how important it is to have a good defence team if you are the subject of a GDC investigation.

'Dental Protection regularly supports dentists before the GDC and we know how disturbing it can be. The investigation process can be lengthy and very distressing for dentists who fear that their reputation and professional livelihood can be at stake. This is the reason why Dental Protection supports dentists throughout all stages of a GDC investigation including the hearing by providing the best possible legal support from our team which includes experienced dento-legal consultants, expert lawyers, and other professionals who are committed to achieving the best possible outcome for our members and providing the highest service standards.' ◆



# Charity warning over telephone scam

The Oral Health Foundation is issuing advice for people calling its Dental Helpline service following an online telephone scam that tricks victims into being charged premium rates.

The scam features a series of bogus telephone numbers that forward people to the Dental Helpline. While connected, fraudsters are then able to hit callers with highly-inflated charges. These additional and illicit charges have been collected by criminals and not passed onto the charity.

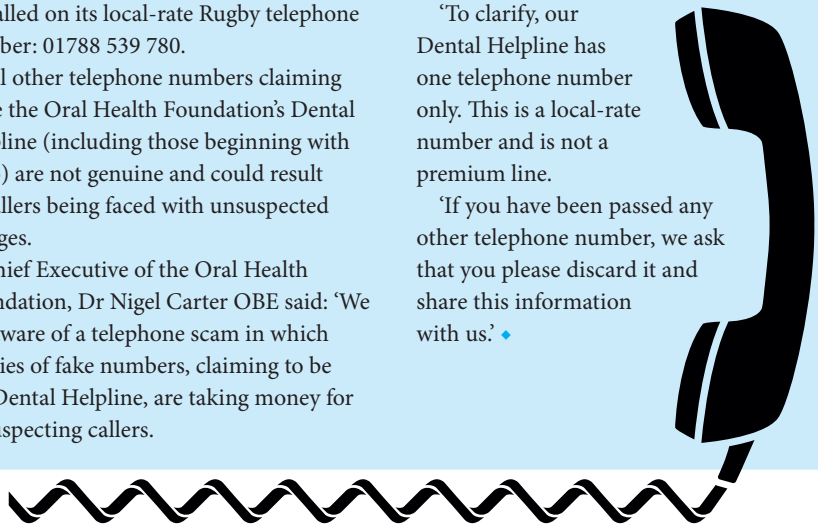
The Oral Health Foundation would like to make clear that its Dental Helpline can only be called on its local-rate Rugby telephone number: 01788 539 780.

All other telephone numbers claiming to be the Oral Health Foundation's Dental Helpline (including those beginning with 0845) are not genuine and could result in callers being faced with unsuspected charges.

Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE said: 'We are aware of a telephone scam in which a series of fake numbers, claiming to be the Dental Helpline, are taking money for unsuspecting callers.

'To clarify, our Dental Helpline has one telephone number only. This is a local-rate number and is not a premium line.

'If you have been passed any other telephone number, we ask that you please discard it and share this information with us.' ◆



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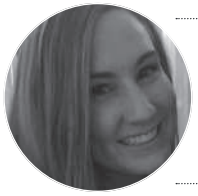
THE DENTAL INNOVATION SYMPOSIUM 2019

# What it means to me

A year on from the *BDJ*'s very first Facebook Live session to celebrate International Women's Day, much has changed. The #metoo movement has provided a powerful reminder of the responsibilities we all have to doing the right thing. The recent Gillette ad serves a similar purpose. To mark this year's International Women's Day, Hannah Walsh told *BDJ In Practice* what being a woman in dentistry means to her.



Hannah Walsh
Specialty trainee in paediatric dentistry, Manchester University NHS Foundation Trust

The first thing I did when I sat down to write this article was to Google 'women in dentistry and medicine'. I was faced with three common themes; history and the founding women of the modern female dentist, the tales of gender inequality and finally the collective empowerment of women to improve healthcare. And they got me thinking.

When I first qualified, I worked with a female dentist who was close to retirement. She told me that in her year at dental school she was one of only four women. How times have changed. In my qualifying year in 2011, I was part of a 60% female cohort. Slowly but surely over the past 50 years we've seen women now make up 50% of the overall workforce. The profession demographic has changed, and with it the front-line workforce of dental care.

I read online accounts of female medics who feel they have had to work twice as hard as their male counterparts simply to gain their respect and to get ahead in their careers. You only have to follow a bunch of vocal female dentists on Twitter to read countless stories of them being called a nurse on regular occasions. I myself remember being newly qualified, giving local adjacent to an upper right eight, picking up the forceps and then the gentleman stopping me. 'Hang on', he said. 'Are you going to take my tooth out?'

'Of course! Is everything alright?', I said gingerly, only six months out of dental school and still fresh-faced. Yet his response has stuck with me.

'I thought it was only the male dentists who took teeth out', he replied.

I was horrified. I felt incredibly undermined. Thankfully, the extraction was straight forward and the man was quickly on his way. I could spend the rest of this article reeling off similar examples, however recently I've begun to wonder that maybe the reason why female dentists are mistaken for nurses on such a regular basis is a product of our modern NHS. Let me explain. How frequently when you want to see your GP do you see a nurse practitioner? Likewise a dental therapist or hygienist. Our dental teams are filled with predominantly females and I can't help but think that the general public are genuinely confused who we are and why we are there.

I work as a speciality trainee in paediatric dentistry. The two departments I work in are female-led, and from colleagues I know that this isn't something confined to my two departments – the changing needs of the patient across NHS services mean many teams are now predominantly female.

Throughout my career I have held posts in maxillofacial and restorative, and their teams have been significantly more male-orientated. I was even a dentist in a category B male prison for a while. As a woman in dentistry, I'm delighted to think that never once have I felt held back in my career because of a different chromosome. I have never once questioned myself that had I been male would my career progression be anything other than what it is now. I have never questioned – either directly or indirectly – whether I can or cannot achieve something just because I'm female. I have been supported by both male and female colleagues equally and I am very grateful for that.

I'm also a realist, and I know my experiences are not shared universally across the NHS and within dentistry. Yes, my experiences of the NHS have been none other than positive with regards to gender equality – I take great pride in wearing my NHS badge – but I know there is still a long way to go before equality is a given.

I feel honoured to be surrounded by so many influential women who are inspirational to me. Especially so in the field of paediatric dentistry, where I feel a surge in a 'together we are stronger' attitude, fighting for a common goal – improvement in children's oral health. There is a 'can do' attitude empowerment in fighting for change. This is something both through my involvement with BSPD and the BDA I am very proud to be female and be a part of. And, as the demographic of the workforce continues to change, it is something I think I will continue to see as the years roll by. ◆

# Pushed to breaking point

By David Westgarth,
Editor, *BDJ In Practice*

Let me put a suggestion to you: 'I'm fine' is the most dangerous phrase in the English language.

My reasoning follows. For unsuspecting men, it is the phrase their seething partner conveys to them, rather than revealing their true feelings. For the Englishman, it can translate to 'my whole life has collapsed'. And for the person attempting to cope with their mental health, it can be the straight-bat answer that placates concerned friends or family while you're going through difficult times.

I know this because I did it. And you don't see it at the time. Nor do you do it intentionally. It's a coping mechanism, and one that with hindsight is a very dangerous one to employ.

I was fortunate. Two four-legged furry friends, a penchant for shopping and an insanely hot summer made all the difference for me. My coping mechanisms got me a tan, a new suit and fluff all over said new suit. For many others attempting to cope – and struggling with – the burden of mental health, the answer to their problems may lie in a more liquid solution.

The most recent figures from the Office for National Statistics revealed in Great Britain an estimated 29 million adults drank alcohol in the week prior to being interviewed for the Opinions and Lifestyle Survey.[1] The same survey – which looked at self-reported habits – showed men were more likely to drink alcohol than women, the highest consumption was found amongst those aged 45 to 64, those in a 'managerial and professional' occupation were the biggest drinkers and those earning £40,000 or more drank in the week before.

Men, aged 45-64, earning £40,000 or more in the managerial and professional sectors. You could be forgiven for thinking I have just described a significant proportion of practice owners in the UK.

## The profession

There can be little doubt that dentistry has many characteristics that make it prone to high levels of stress. A system of payment that relates directly to workload parallels the traditional 'piecework' payments of production lines which were always associated with high levels of stress. In addition, dental treatment requires high levels of concentration and physical demands that place a stress on the individual.

Research conducted by the British Dental Association[2] found that 85.6% of respondents reported having drunk alcohol in the last 12 months. The research went on to say that although not directly comparable, as frequency of alcohol consumption was measured in a different way, it appears that dentists drink more than the average in Great Britain.

But here presents a roadblock. Self-reported levels of alcohol consumption and self-reported levels of stress are often under-reported, and



when it comes to being a medical professional, seeking help remains a stigma. Would it harm their career? Are they too proud? Do they see it as a weakness? All of this leads into fear in the profession of being stigmatised, which, if not addressed early, can lead down a very dark path.

High levels of perceived stigma in the profession is a problem. And what makes it worse is that it goes beyond perceived. Research suggests dentists fear that their career would be damaged, or they would be stigmatised by their colleagues or patients, if they found out they experienced mental ill-health.[2] What is apparent is that some dentists may feel that they cannot be open about their mental health, so as to not appear weak or even as a failure in their own eyes. As stigma can act as a barrier to seeking support, it is paramount that this is addressed.

And if it isn't addressed?

It has been long recognised that medicine is one of the most stressful occupations and psychological morbidity in practising doctors has been estimated at 25%.[3] BDA research went on to discover that 17.6% of all respondents had seriously thought about suicide and nearly 10% of the sample said that they had thought about suicide in the last 12 months, representing 57.7% of those who said yes to suicide at any time in their life.[2] Although most people who have thoughts about suicide do not go on to die by suicide the fact that so many practising dentists are thinking about it should be deeply troubling to every individual involved in dentistry.

Breakthrough Expert Christopher Paul Jones spoke to *BDJ In Practice* about why seeking help and addressing the problem – regardless of profession – is crucial.

'I have met many intelligent, successful clients, who have an issue with turning to alcohol or other substances as a way to cope with stress or anxiety', he said.

'I would first of all like to highlight that this problem is not something to be embarrassed about. You are certainly not alone in this, but it is one that needs to be addressed. In a world that is full of social pressures, and we are struggling to create a happy work and life balance, particularly dentists, given the situation they find themselves in, it's no wonder that stress, anxiety, depression and even suicidal thoughts and feelings, have been steadily on the increase, as BDA research suggests.

'If you have recently found yourself in a stressed or competitive working environment, and are becoming less able to cope with things, it might be time to consider if you have a problem. The world of dentistry is one

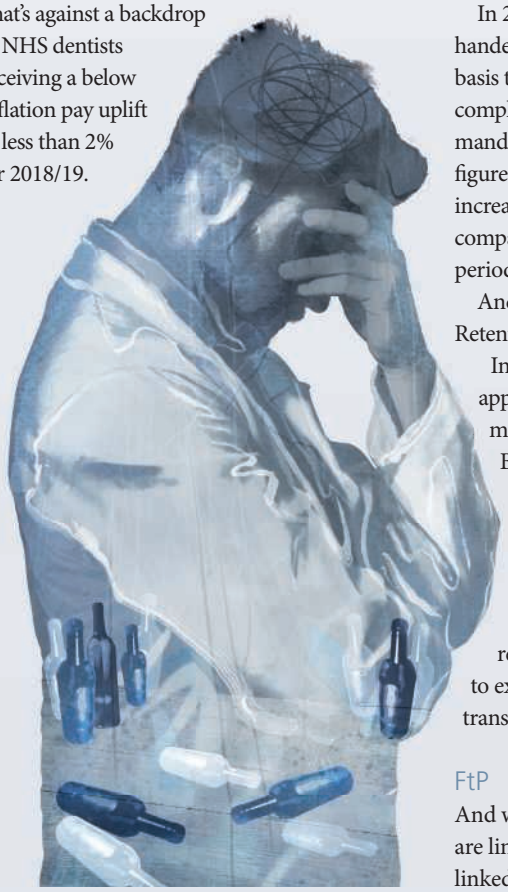
that is highly competitive, extremely stressful and draining on the mind – any profession requiring you to focus intensely and be the expert in your field does that to people. Therefore, finding yourself unable to handle things (and this can be dependent on severity), is nothing to be embarrassed about.'

## Sources

Not for one minute does this conclude that older, male dentists are a few steps away from a drinking problem and suicide, yet with any responsibility comes pressure, and we're all aware of the pressure NHS dentistry is under.

Every individual has a unique response to stress. There are thousands of potential triggers, and in 2018 research conducted by Forth suggested money and work were the two leading sources of stress amongst adults in the UK[4] – two areas that happen to be the biggest cause of stress in the profession. In fact, those with high job stress, psychological distress and burnout were statistically more like to think about suicide in the last 12 months.[2]

Take money to start with. Data from NHS Digital has shown that NHS dentists in England and Wales have experienced a 35% pay squeeze over the last decade. This unprecedented drop has seen real incomes for practice-owning dentists fall by as much as £47,000, and their associates by over £23,000 over the last decade. That's against a backdrop of NHS dentists receiving a below inflation pay uplift of less than 2% for 2018/19.



That's income, and it's the same story when it comes to expenditure.

An investigation by the National Association of Specialist Dental Accountants and Lawyers (NASDAL) in 2016 revealed the cost of compliance to the average sole practitioner practice has increased by more than 1086% in the last decade – an even greater increase than in 2014 when NASDAL last ran such an investigation (and a figure of 845%).

The investigation found that the advent of the Care Quality Commission (CQC), HTM 01-05 and a 'culture of compliance' had increased dentists' costs massively.

Back in the mid-2000s, the essential requirements for setting up in practice were a one-off registration fee to the General Dental Council and an annual retention fee and registration with the Information Commissioner's Office. The scene is now very different.

> 'Data from NHS Digital has shown that NHS dentists in England and Wales have experienced a 35% pay squeeze over the last decade. '

In 2016 it was estimated that it cost a single-handed practitioner £15,150 on an annual basis to meet the requirements of CQC and compliance alone. Combined with the various mandatory registration fees and indemnity, the figure reaches £21,875, an overall percentage increase in the cost of compliance of 1086%, compared to general inflation over the same period of 35%.

And yes, that does include the Annual Retention Fee.

In December the GDC published its approach to setting the ARF in the future, a move that drew stinging criticism from the BDA, who deemed it 'unacceptable' that the regulator plans to stop consulting on the level of the ARF and instead only consult on a high-level plan every three years. While the GDC has improved its performance in several areas of its regulatory activity, the BDA continued to express concerns about its approach to transparency and accountability.

## FtP

And why wouldn't they be? Money and work are linked to stress. Work and stress are linked to the regulator – whether they like it or not – and the move will only work to fan the flames of discontent amongst registrants fearful of a body seemingly intent on justifying their ridiculously high ARF on the increase in Fitness to Practise cases they have (or, as it turns out, have not had) to deal with. Viscous circle comes to mind.

And speaking of Fitness to Practise, there is little doubt that, as an investigation can take years to conclude, dental professionals' mental and physical health might suffer as a result. In fact, in November 2015, a consultation response from Dental Protection regarding Voluntary Removal from the Register, Fitness to Practise and the immense stress this caused stated 'Unfortunately in these situations suicide is a very real risk'.[5]

The admission from one of the largest indemnifiers in the field of dentistry that a Fitness to Practise case could potentially lead to suicide cannot and should not be taken lightly, and to their credit, it appears that is the case. In the time since that report was published, A Freedom of Information request was submitted to the GDC seeking to discover their approach to registrants who may be vulnerable or distressed while under a Fitness to Practise investigation.[6] Their response read:

*Q. Details of any process for establishing the psychological vulnerability of registrants who find themselves subject to investigation*

We have worked closely with the Samaritans to establish a checklist that supports staff in recognising when someone is in distress and helps staff to recognise when they need to escalate their concerns. When staff feel that someone is in distress, they are expected to use their communication training (referenced above) to support the registrant (or indeed any Fitness to Practise service user). This could include signposting to an organisation that can assist – details of which are accessible on our website.

We may also treat the handling of someone's case differently, such as not writing to them on a Friday or ensuring we call ahead of post or email, so they have someone to talk to. In serious cases where there is a concern for someone's life or they could be at risk of hurting themselves or others, staff are trained to call the police and request that they contact the individual. We will keep a record of all the support we offer to the registrant on our case management system, so we can see if their health and wellbeing is deteriorating and take appropriate action to encourage them to seek support.

*Q. Details of what action is taken should a registrant suffer mental illness following an investigation, including those who commit suicide as a result of investigations.*

We take the welfare of registrants subject to fitness to practise processes extremely seriously. Although no specific action is taken should a registrant suffer from mental illness following an investigation we hope the measures outlined above will assist in alleviating distress as much as possible. Some registrants may still find the situation difficult to cope with. Where a registrant commits suicide as a result of investigations we will review the case management database to determine if there was anything that we could have done differently, including ensuring that the above referenced procedures were followed. Our Executive Management Team are alerted as well as our Communications Team and any involvement from external agencies is complied with promptly and as fully as we are able to. The suicide of a registrant during or after FTP proceedings is an extremely sad and serious event and is treated with the utmost importance.

That certainly does not mean to say any dental professional under investigation turns to alcohol – everyone has their own coping mechanisms. Yet the link between alcohol, stress and the workplace cannot be ignored. And while signposting is a valuable method of providing support, it remains to be seen whether this perceived 'proud' profession would follow that path.

## Morale

Inevitably, when conditions are poor, the workforce suffers. Morale and motivation among NHS dentists is now at an all-time low in all UK nations, with lower levels of morale linked to higher NHS commitments. The data show a continued fall in the NHS workforce, with numbers at their lowest levels since 2010.

Needless to say, this has had – and will continue to have – consequences for the workforce. Nearly two-thirds of principal dentists and over half of all associate dentists across the UK often think of leaving dentistry. How can the workforce survive such low morale? And how can NHS dentistry survive?

During the last decade there has been a notable drop in the amount of time dentists spend on clinical work across the UK. Principal dentists have also seen a drop in the time they spend on NHS/Health Service work over the same period. The reality is simple; the more time dentists spend on NHS/Health Service work, the lower their levels of motivation.

The most common contributory factors to low morale? Increasing expenses and/or declining income, the risk of litigation and the cost of indemnity fees. Regulations are also cited as a major cause of low morale amongst principal dentists. You begin to see why three in every four dentists drink at least once a week.[2]

## Support

Today's fast-paced society offers little in the way of social support. While a drink after work or with dinner can be pleasurable and safe and is commonplace, people with excessive or chronic stress often drink to excess. High levels of stress may influence drinking frequency and quantity. This relationship between stress and drinking is even stronger when alternative coping mechanisms, social and professional supports are lacking.

With the contract, regulation and the regulator at the heart of the issue, practitioners are left with a choice – leave the profession, or find a way to cope that doesn't impinge on your ability to do the job. Whichever way you slice it, it's hard to provide professional support for things that have taken and will continue to take significant amounts of time to change.

> 'Today's fast-paced society offers little in the way of social support. While a drink after work or with dinner can be pleasurable and safe and is commonplace, people with excessive or chronic stress often drink to excess.'

To that end, the BDA has welcomed Health Education England's recommendations for sweeping action on stress across health professions, and renewed its call for parity in provision between NHS dentists and GPs on occupational health.

The NHS Staff and Learners' Mental Wellbeing Commission report builds on studies conducted by the BDA and other health associations on the cost of burnout and mental health to staff and the wider health service.

Recommendations include the creation of an NHS Workforce Guardian for primary care settings, tackling problems from the very outset of education, and rapid referral pathways for both students and staff to either a GP or an occupational health clinician – dubbed 'an NHS for the NHS'.

## Leaving the profession[7]

In England and Wales

- 62.7% of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 57.2% in 2015/16
- 56.1% of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 47.6% in 2015/16

In Scotland

- 69.3% of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 57.1% in 2015/16
- 57.1% of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 45.9% in 2015/16

In Northern Ireland

- 64.0% of principal dentists said they often thought about leaving general dental practice in 2017/18 compared to 59.2% in 2015/16
- 52.1% of associate dentists said they often thought about leaving general dental practice in 2017/18 compared to 51.1% in 2015/16

The BDA has called for funded access to the Practitioner Health Programme for NHS dentists across England on the same basis offered at present to GPs. The service provides a range of support and therapies for practitioners experiencing difficulties, and is currently only directly accessible for GDPs in London.

For many – including those providing, as well as receiving support – it is refreshing to see officials waking up to the weight of evidence on stress and burnout in this profession. No NHS dentist – or dental student for that matter – should suffer for the work they do for the NHS, simply because they work for the NHS.

For those dentists in desperate need of support, access to services currently offered to medical colleagues simply makes sense. We know the drivers fuelling this epidemic of stress and burnout – from regulation to the NHS treadmill – but what about those who feel they cannot seek help from within their own system?

Christopher offered some therapeutic mindset tips on how to handle the stress and anxiety that may be behind such addictions.

'The first piece of advice that I would give is that you come to a place of acceptance' he said.

'You look at yourself in the mirror, and just like in a 12-step programme, you say out loud to yourself who you are and what your problem is. Only when you acknowledge that there is a problem do you give yourself the permission and power required to deal with it.

'Next, it's vital that you understand the negative ways that it is affecting your life – and your career – but that you also look openly and honestly at how this is benefiting you. You might ask why, and that's because we hold on to negative behaviours and patterns as a way of protecting ourselves, albeit subconsciously, and there will always be something to gain from it. So, be brutally honest and think about the way that your behaviours are benefitting you, because it is those benefits that will then present themselves as challenges, and show up as resistance for you.

'Then ask yourself if there is another way that you could get those needs met – something that would be less destructive and unhealthy for you. It's important that you meet those needs, otherwise you will find yourself turning to alcohol and establishing a pattern for repeat behaviours.

'While I appreciate alcohol misuse and rational thinking does not go hand-in-hand, at some point you will need to think about why you are turning to alcohol. Most of us will turn to these things as a way to self-medicate and cope with pressures as a release. Make a plan of action. Think about how you can reduce the time spent doing things, or being around people, that are not good for you. Where possible, eradicate the 'triggers' from your life.'

Clearly, part of the problem associated with this theory is you cannot eradicate ambulance-chasing patients (legally, anyway). You cannot change the current contract and with it the target-driven system. No practitioner can magically create a money tree to improve the financial health of the practice. So, is there an obvious solution?

## At the heart

The reality of the situation is that those things cannot be remedied by individuals. Negotiations with the DDRB have produced some results – albeit practitioners had been waiting four months since the Government made their announcement on what uplift they could expect. It was a move that prompted the BDA and British Medical Association to issue a joint call for fundamental reform of the Review Body.

Negotiations continue with the Department of Health regarding contract reform. In January, Henrik Overgaard-Nielsen, wrote about his wishes for 2019 and what needs to happen to make the outcome right for dentists and patient alike. Are these triggers that could eventually be removed?

'It's more common than you think to find that happy work life balance', Christopher added. 'It's so easy and accessible to turn to self-medication as a way to handle things. It is a sad reflection of how those at the top have left dentistry to fester, and the results are exactly the same as if you left a problem with alcohol for too long. The parallels are uncanny, yet they affect thousands of people.

'If you find yourself unable to cope and are perhaps having depressive thoughts, and maybe even feeling suicidal, do go and seek professional support.'

It goes without saying that impaired dentists are unable to deliver the best dental care to their patients. A stressed practitioner is not one fully focused on the job at hand. That isn't an accusation, but simply a matter of fact – very few people can operate under stress without it reflecting in their work. And that's why colleagues who become aware of and are sure of another colleague's increasing dependency have a role to play. Besides the professional and ethical responsibility to intervene in a constructive manner, such interventions can involve discussing the issue with the addicted dentist, offering help if possible. The value of a supportive friend cannot be overlooked. Because all too-often the tendency is to say I'm fine, when, if you scratch under the surface, the truth is very different.

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## Contacts

Samaritans provides confidential support to anyone experiencing difficulties or in emotional distress

- → www.samaritans.org
- → 116 123 (UK)

Dentists' Health Support Programme provides free advice and support on alcohol, drugs and other health issues

- → www.dentistshealthsupporttrust.org
- → dentistsprogramme@gmail.com
- → 020 7224 4671

The BDA Benevolent Fund can offer financial assistance in times of need (e.g. cannot work due to illness)

- → www.bdabenevolentfund.org.uk
- → generalmanager@dentistshelp.org
- → 020 7486 4994

The BDA wants to find out what the causes of stress are, so that we can find solutions to support dentists and to help foster positive working environments. To find out what the BDA is doing for you visit

- → www.bda.org/stress
- → Access the BDA's CPD module on stress at https://cpd.bda.org/course/index.php?categoryid=26

With thanks to Christopher Paul Jones, who can be contacted at www.christopherpauljones.com

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## Jane Lawson
**Therapist**

Jane never dreamed she would run her own practice, but she succeeded last year. As the practice began to grow so did the pain in her neck and shoulders. She tried a few massages that eased it temporarily, so never expected the GP to diagnose an impingement that would last months, stopping her working. A number of visits to the physio and regularly doing her exercises and Jane is happy to be back in practice with her patients. She has popped out at lunchtime today for some window shopping, pleased she can lift her arm let alone be back at work.

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# Dial-a-dentist?

**Emily Kelly** on whether telephones could bring a new dimension to enabling patient access

Emily Kelly
Foundation Dentist, Bank House Dental Practice

A recent report from the Royal College of Physicians (RCP) on the future of hospital outpatient departments stated that alternatives to face-to-face appointments should be offered in order to cope with the modern demands on the NHS. Back in November 2018, outpatient appointments were described by Dr Toby Hillman from the RCP as being 'an 18th century system' due to its failure to take advantage of modern technology in providing appointments for patients; but couldn't the same be said about general dental practice?

The way dental practices have been run has not changed since the idea of a high street dentist first came about. Patients make a face-to-face appointment, attend for an examination or treatment, and then leave the premises with the opportunity to make another face-to-face appointment if necessary. Is there something else we can do to modernise the way we see and treat patients, or are face-to-face appointments all we can offer?

For years, general medical practice has recognised that capitalising on technology can lead to a better patient experience. Using

the humble telephone for consultations as an alternative to face-to-face appointments is now common place in most surgeries. This makes dentistry look outdated in comparison and reluctant to change our approach of reaching patients. So, should dentistry be taking advantage of the phones we are all glued to throughout the day to modernise our appointment philosophies?

## Benefits to patients

Telephone consultations in the medical field have been proven to have high patient satisfaction[1], mostly attributed to the convenience and time-saving ability of a telephone call over a trip to their general medical practitioner (GMP). If telephone consultations were made available as an option to dental patients as part of their oral health care, the inconvenience of having to arrange time off work, childcare and transport to attend could be reduced.

Not only is the idea of being able to receive care from the comfort of your own home or workplace appealing, it has the potential to be a vital access route for those who struggle to attend appointments. Patients living in rural areas, those with severe dental anxiety, and those with health or social circumstances that mean visiting the dentist would be difficult could simply speak to a member of the team from the comfort of their own home. Considering it is often these patients that have the highest treatment need, any way of improving their access to oral healthcare is worth considering.

Often, medical practices are able to provide patients with a telephone consultation sooner than they are able to provide a face-to-face appointment. Likewise, it is possible that the introduction of telephone appointments at dental practices could reduce waiting times for patients, which can only be a good thing!

## Why it can work for your team

Telephone appointments are more efficient to provide than face-to-face appointments, as there is potential to be able to reach more patients per hour. GMPs often use telephone appointments as a way of filling 'dead surgery time'; whenever they are without a patient in the room, they can do a few of their allocated telephone appointments for that day. In an age where dentists, hygienists and therapists alike are expected to maximise their working day by treating as many patients as possible, utilising telephone appointments might be an attractive concept.

Furthermore, telephone appointments are cheaper to provide than face-to-face appointments. Where for a face-to-face appointment a team of two is required, only one person is required to complete a consultation on the phone. Therefore, one half of the team can be released to complete other jobs required around the practice, thereby improving employee efficiency, or even work less hours, reducing wage costs.

Improving patients' access to dental care also has the potential to reduce the pressures on emergency dentists and A&E departments. If patients are able to contact a dentist quickly and easily via a telephone appointment and discuss any symptoms they have, a DCP could be able to advise the appropriate management, which could prevent a costly visit to other NHS services.

## Drawbacks for patients

Despite the potential benefits of telephone consultations in the world of dentistry, they would not be without their drawbacks. Although the majority of patients will find them convenient, some patients have reported that they struggle to plan their day around a telephone appointment if, for example, they are given a long time period in which to expect a call.[2] Therefore, if patients would prefer a set appointment time, perhaps a face-to-face appointment is more appropriate.

Patients may also feel unable to discuss their issue over the phone, whether that be for fear of someone else overhearing their conversation, or worrying they won't be able to get their point across without talking in person. Some patients may also simply not like the idea of a telephone appointment, and may feel less important than if they were to receive a traditional appointment. Offering a face-to-face consultation as an alternative may well be required.

## Drawbacks for the profession

There will be those who do not feel comfortable carrying out consultations without talking to the patient in person. The non-verbal communication that plays such a large role in face-to-face appointments will be completely lacking over the telephone. Dr Ged Faulks, a newly-retired GMP with over 30 years of experience, found this to be a frustrating drawback of telephone consultations, and likens the experience to 'having no arms or eyes'. Without being able to see a patient, special attention needs be paid to subtle verbal cues such as pace, pitch, pauses and tone of voice to pick up on how the patient is feeling and reacting to what is being said. This is a very specific communication skill, so special training and courses may be needed in order to provide successful telephone consultations. This is recognised in the medical field, and GMPs in training are now required to prove they've had sufficient telephone-based education and experience prior to qualifying.

Although telephone consultations have the potential to improve access to oral health care for many, they may be inappropriate or impractical for some population groups. Those such as non-English speakers who require an interpreter, some elderly patients, patients with hearing difficulties, socially disadvantaged groups who do not have access to a telephone, or those who simply choose to live life without a telephone (there are probably some out there!). Talking to new patients over the phone may also be challenging. This is something that Dr Lyttle, a GMP with more than 20 years' experience providing telephone consultations, tries to avoid. He says that 'for a patient I haven't met before, I would veer towards having an initial face-to-face appointment before offering a telephone appointment, as it's very difficult to communicate with unknown patients over the phone. This is easy to identify with, as without an established set of clinical notes and dental charts a new patient, it could be hard to get the complete picture of the patient's reason for calling, hence a telephone appointment may on be appropriate for familiar patients.

Telephone appointments open a whole new can of dento-legal worms. Over the phone, it can be trickier to ensure you are talking to the correct patient, to gain consent, to maintain confidentiality, to explain things and to record what was discussed. To help GMPs with this, indemnity providers offer CPD on risk-limitation, which is something that would be sensible for dentists to undertake as well.

Similarly, the potential to misinterpret and misdiagnose over the phone is higher than a face-to-face appointment. When communicating via the telephone, you rely entirely on the information provided by the patient, which is shaped by their perception of the problem, and may be very misleading. It would be important to have a low threshold in place for organising a face-to-face appointment to reduce the associated risks. If there was any doubt as to a diagnosis or the required management, a traditional appointment should be made.

Due to this, it has been proposed that telephone consultations may just delay an inevitable face-to-face visit[3], reducing the time-efficiency benefits previously mentioned. This is something that Dr Lyttle sometimes finds in his practice: 'If you offer a five-minute telephone appointment, then you end up giving them a further 10 minute face-to-face appointment, you're not saving yourself any time.

One of the reasons telephone consultations work well in general medical practice is that the patient does not need to pay for the service at the time they receive it. However, NHS medicine is very different to NHS dentistry, and deciding how to charge patients for a telephone service could be problematic. Under the current NHS banding system it has no clear place, and for it to be included in any of the bands would need to be recognised by the NHS as a viable service to provide. If telephone consultations were provided on a private basis, with each dental practice charging what they deem appropriate, how would this fee be collected? Taking payment details over the phone is possible, but not all patients will be comfortable or able to do this, and it may take some time to complete.

Finally, if you haven't thought of this drawback already, you're missing the obvious; the vast majority of dental appointments require an examination, special investigation or treatment of some sort. No matter how hard you might try, there is no way that this can be carried out remotely. So, how much of a role could telephone consultations actually play in general dental practice?

## Scope for telephone consultations

Admittedly, if telephone consultations became common place in dental practices, the proportion of these appointments in comparison to face-to-face appointments is likely to be small, due to the obvious drawback mentioned above. However, in light of the benefits they bring, there is potential for telephone consultations to work well in the following areas:

### 1. History-taking for triaging

'A lot of the time in medical practice the telephone is used first as a triaging tool, to sift patients who need a face-to-face appointment the most', Dr Lyttle says. This could also be applicable in dental practice. A significant proportion of any diagnosis in dental practice can be made through thorough history-taking, but there is nothing stopping this history being taken over the phone by any appropriately trained team member. This information could then be used to allocate who needs a face-to-face appointment, and who out of these patients will need to be seen urgently and who could be given a slot later on in the week. This has the added bonus of cutting down surgery time as the history will already have been taken.

### 2. History-taking for booking the correct appointment length

Similarly, history-taking prior to booking a face-to-face appointment will ensure an appointment of the correct length of time is made, thereby reducing 'dead surgery time' and running late. For example, if a patient calls complaining of toothache, taking a thorough pain history would indicate if the patient is likely to need a short appointment in the case of reversible pulpitis, dentine hypersensitivity or a high restoration; or perhaps a longer appointment in the case of irreversible pulpitis.

> 'A lot of the time in medical practice the telephone is used first as a triaging tool, to sift patients who need a face-to-face appointment the most'

### 3. Anxious patients

Being able to talk to a dentist from the comfort of their own home may be extremely reassuring to an anxious patient. In particular, if a patient has the opportunity to chat to their DCP, for example, before entering the dental environment, and ask any questions they might have, it may alleviate some of their anxiety before they attend for a face-to-face appointment. It will also give that DCP an opportunity to explain what the patient should expect during their visit, and ask how they can improve the patient's experience when they attend.

### 4. Preventative treatment and health promotion

Commonly, telephone appointments are used in the medical field to check how patients are coping with lifestyle changes they have been encouraged to make during a face-to-face appointment, such as smoking cessation. Similarly, the dental team has added responsibility when it comes to providing oral health advice on diet, oral hygiene instruction and fluoride use guidance. Making use of the telephone to deliver or follow-up advice given in a face-to-face appointment could have a great impact in disease prevention for patients. Increasing the frequency of the delivery of these messages to patients, will undoubtedly have more of a positive impact on patients' lifestyle choices than if they are only told once or twice a year.

### 5. Reviews

Simple reviews after a face-to-face appointment may not require an examination, and a telephone appointment would save both patient and practitioner time. For example, a patient who recently received a diagnosis of and advice for myofacial pain could be called to check if advice is being followed correctly and whether symptoms have improved, with more advice being provided if necessary. Similarly, for some oral lesions with a very clear diagnosis, such as a mucocele, the patient could be taught how to check and monitor the lesion themselves. Then, the patient can be telephoned and asked to assess if the lesion had improved, worsened or remains unchanged, with additional treatment arranged as necessary. However, it is important to note that this approach is clearly inappropriate for some conditions, such as those with the differential diagnosis of oral cancer where a review in person is essential.

It is clear telephone appointments are not capable of completely replacing face-to-face appointments in the world of dentistry. And equally, face-to-face appointments should not be all that we can offer patients. Telephone appointments have the potential to be a great adjunct for dentists and dental care professionals to use alongside traditional appointments, and utilising the humble telephone to our advantage would help propel the profession into the 21st century. ◆

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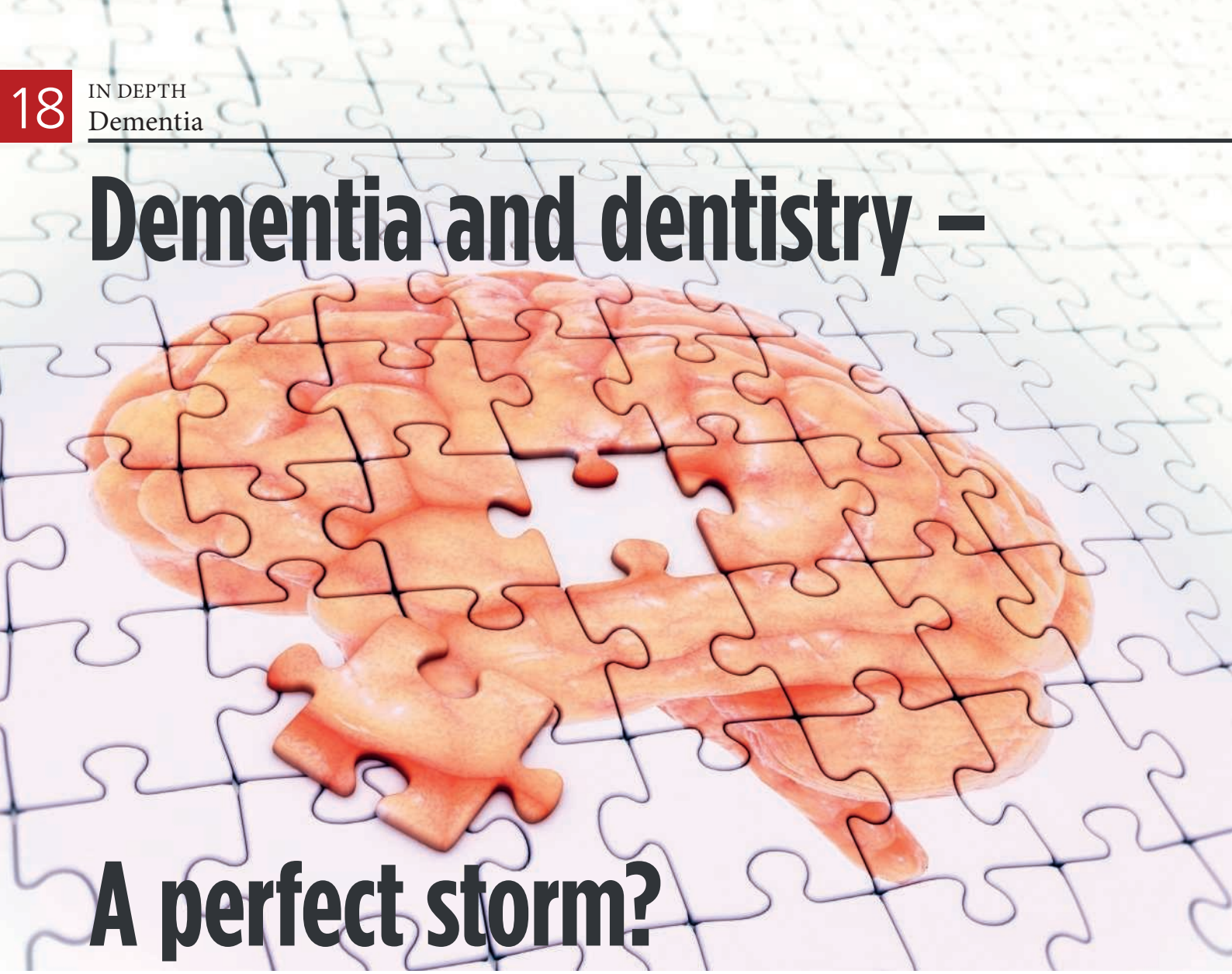
# Dementia and dentistry – A perfect storm?



Every practitioner, every practice, every area of dentistry – be it NHS, private, community or hospital – will encounter a challenging patient. As with most challenging patients, there's a sliding scale – it could be the one who didn't know they had to pay for the privilege or the one who didn't know they had an appointment that day. However, there is one patient not every practitioner will encounter but undoubtedly poses the biggest challenge; the one who doesn't know what you're trying to do.

By David Westgarth,
Editor, *BDJ In Practice*

Every projection available suggests dementia and Alzheimer's will rise – and sharply – by 2050. Add in co-morbidities and patients keeping their natural teeth for longer, and there's a storm brewing on the horizon.

'It's definitely heading that way', **Kerry Wafer**, Specialist Dental Nurse, Birmingham Community Healthcare NHS Foundation Trust, said.

'We know that oral health can be way down on the list of priorities; this can be understandable if you compare it in isolation to the trauma of recent diagnoses of dementia. You cannot view it in isolation - oral care for those living with dementia is incredibly time-sensitive; there will come a point when it is too late to consider beginning dental treatment because it becomes too difficult for the patient to manage.'

'We know that poor oral health and poor general health are intrinsically linked,' added **Laura Hyland**, Specialist in Special Care Dentistry for Birmingham Community Healthcare NHS Foundation Trust. 'Including dementia in the conversation about that link is essential. It's not uncommon for basic oral hygiene tasks to drop off the radar so it's vital that we work with our colleagues in the care home sector to promote good oral care interventions – if not the patient can be left in huge discomfort without the ability to communicate the problem.

'The NHS Long Term Plan ensured vulnerable patients have a suitable oral needs assessment. The onus now falls on the education and training of staff who have regular touchpoints with people living with dementia.

'Care homes often have frequent turnover of staff, and locums covering shifts, which can mean their basic understanding of oral healthcare isn't there. That needs to change, given the projected increase of the disease.'

## A platform for improvement

The challenges posed by care homes is nothing new. Besides dementia and Alzheimer's, it's often suggested oral

healthcare for the elderly lacks in a number of areas. Initiatives such as Mouth Care Matters aims to provide resources for all people who provide personal care to patients, be that in an acute, care home or community setting. Yet Laura believes even a concerted effort is still falling short of patient needs.

'Engagement and education is key here,' added Laura. 'We have to ensure new care home staff get the information they need at induction. They will see poor oral health throughout their patient interaction, and they need to know how to respond and in what manner. There are initiatives such as Mouth Care Matters that can support the training within care home and this is something that we would both support. Oral care is all too often, something new to the carers.'

'I think it boils down to two elements,' Kerry suggested. 'Acceptable and necessary – is it acceptable to leave a patient's mouth when you're caring for them? It is necessary to make sure they have adequate provisions so their oral health needs are met.

'They may seem fairly basic, but they are the fundamental principles on which training is built. If, for example, Mouth Care Matters empowers staff to become an 'oral health champion', then that can only be as good thing.

'That individual can be responsible for talking to patients and their family. Do they need a modified toothbrush? Do they need assistance to brush their teeth? What products do they need? These are questions that, if documented, can potentially overcome any degree of staff turnover.'

## Capacity and consent

Montgomery is a name no healthcare practitioner can escape. It changed the dynamic of every conversation with patients. But how does it work if the patient is showing signs their capacity to make a sound decision is becoming compromised?

'This is one of the biggest challenges with dementia,' Laura said. 'You must always assume a patient has capacity until it is proven otherwise. And that is why a mental capacity assessment on each patient is crucial. In the early to middle stages of dementia, it can be very challenging. You have to make a judgement about when to involve the family, based on when the patient no longer has the capacity to consent.'

Kerry added: 'It underpins everything we do. If, for example, we assessed a patient and decided not treating them was in their best interests, we would always encourage the family and care team to be involved in the decision-making process, after all they know the patient well and their insight is invaluable.

'You have to assess the benefit of treating the patient against the risks involved in doing so. Perhaps getting them in an ambulance from their care home, into hospital to have a procedure under sedation simply isn't worth the risk. The stress of treatment can sometimes be so great that it leaves you with little other choice.'

But what about the shadow of the regulator? They have been known to be keen on Fitness to Practise cases.

'You have to know and be confident in when to treat, when to defer and when to refer,' Laura said. 'Managing expectations can come into it too – would you suggest dentures for someone who cannot tolerate the impression stage let alone the longevity of wearing dentures?'

'For an experienced practitioner, this might be easier to handle than if you were new to the role. I always remind our team that you can seek a second opinion if you're unsure. A new set of eyes can shed different light on the situation. Clinical judgement is important, and understandably that's easier with experience.'

'It boils down to training too,' Kerry added. 'Each patient is different; it is essential that we can develop special care dentists and dental nurses to prepare the workforce for the challenges that lie ahead; and there will be challenges; you could be the newest member of the team but still be fully able and have the confidence to make clear decisions about a patient's best interest.'

## Prepared?

Kerry's point about the nature of the workforce is interesting. The majority of graduates head into general dental practice. As of February 2019, there are 297 special care dentists in the UK.[1] To put that into context, the same report showed there are 40,943 dentists.

Who is going to care for this growing cohort of patients? Is the workforce adequate? And can GDPs take the strain off special care?

'We know people don't go to the GP for a check-up. They only go if they're unwell', Laura said. 'Yet regular check-ups at the dentist means they could be the first healthcare professional to notice signs of cognitive decline. Is the patient struggling for memory recall? Do they see signs that oral health is being ignored? These are all early indicators, and dental teams could theoretically be in a position to do something about it.'

However, according to Kerry, it's never quite as simple.

'It's a difficult subject to raise with someone', she said. 'There are multiple barriers, beyond it being an awkward conversation. Do dentists know where to signpost patients if they see signs of cognitive decline? Is there a referral pathway for them? Do they share the information with their GP? All of these things are barriers.

'In reality, the GP is at the centre of the jigsaw puzzle. They can signpost accordingly. They might be a family doctor who can also see the decline, given touchpoints are few and far between. It isn't something that should be addressed at crisis or breaking point – the earlier the intervention, the better for the patient.'

With an increasing number of patients presenting with failed implants, complex crown and bridgework and amalgam fillings, just how difficult is it going to be to treat patients living with dementia?

'It will be a challenge for the future', Laura said. 'Yet there is plenty of groundwork being done to prepare. Referral pathways are in place for dementia-friendly dentists. A shift to treating patients holistically will only serve to help. There is a national agenda around cognitive diseases, a lot of money being invested in research and a lot of work being done to support patients living with these diseases.

'If dentistry can build on the integration from the Long Term Plan, it will benefit the patients and the complexities we will see. It will give us the opportunity to fully ensure oral health does not fall through the cracks.' ◆

1. General Dental Council. Registration report – February 2019. Available online at: www.gdc-uk.org/api/files/Registration%20report%20-%20February%202019.pdf (Accessed February 2019).

This is an excellent free training resource DVD, created by 100lives campaign, designed with care home staff in mind to help teach the basic oral care skills

http://www.1000livesplus.wales.nhs.uk/looking-after-the-mouth

https://www.gov.uk/government/publications/living-well-with-dementia-a-national-dementia-strategy

https://www.gov.scot/publications/scotlands-national-dementia-strategy-2017-2020/

http://www.mouthcarematters.hee.nhs.uk/

To book a place at the Dementia Friendly Dentistry event taking place at the BDA please contact the events office on 020 7563 4590, events@bda.org or visit www.bda.org/training

# A partnership made in heaven?



By David Westgarth,
Editor, *BDJ In Practice*

It's always good to have options. Be it a visit to a Chinese buffet, choosing a car or navigating through a career, you'd rather have too many options than too few.

So, for new graduates, the myriad of choice available to them once they've finished university and are embarking on FD training must feel like a bit of a puzzle. Factor in the corporate market, with each clamouring over the other to highlight why they're the pathway for you, and maybe there is such a thing as too much choice.

Step forward Dental Partners. With 37 practices, and growing, across the country and a burgeoning reputation for being tangibly different, perhaps the new kid on the block really is what it says it is. I spoke to CEO **Neil Lloyd**, Operations Director **Caron Best** and National Clinical Director **Ravi Rattan** to find out exactly how and why Dental Partners might just be right.

Left to right: Caron Best, Neil Lloyd and Ravi Rattan

*The biggest question on everyone's lips is Brexit. How is the uncertainty affecting you?*

**NL** I think there is a certain amount of foresight that has almost been built into future staffing patterns and projections. If you look at 2015/16 there was a bit of an exodus of people, yet 16/17 plateaued and it's quite stable now – 16% of all dentists in the UK are trained in the EU.

The EU dentists that are here, have been for some time, have families here, have children at school are unlikely to face issues post-29 March this year. What we do not know and cannot predict is the number of dentists coming to the UK for one or two years to

experience dentistry here – bearing in mind UK dentistry is held as a gold standard in many, many areas – because they simply are not coming. That will have an impact.

*What do you see as the biggest issue?*

**NL** If we have a no Brexit deal, there will be an issue surrounding the mutual recognition of qualifications. As yet, there is no guidance from the regulator on this crucial area. Could all of our non-EU dentists lose their right to practise in the UK? We – and the entire profession – need guidance on what happens next.

Besides the recruitment factor, a lot of what I see is down to pure economics. For dentists coming in from Europe, the Pound's value against the Euro means 'where am I going to be able to send the most money home from' no longer applies to the UK – France and Germany are significantly more profitable for those with that outlook.

*How does that economic uncertainty affect what you're trying to achieve?*

**NL** The entire profession has issues with recruitment and retention, and in my view, it's simply going to carry on exacerbating those areas. That's why our 'best place to work' strategy is so central to the success of what we're doing and what we'd like to achieve. You really have to step up a notch and look after all of your staff, from reception staff to nurses, hygienists and practice managers – for me it's essential to the long-term success of what we want to do.

> 'Through a model of engagement, we make sure everyone has a say in the development of their practice and the company. We believe that is the right model in the current climate to get the most from our members of staff.'

Through a model of engagement, we make sure everyone has a say in the development of their practice and the company. We believe that is the right model in the current climate to get the most from our members of staff. Central to that is empowerment of clinical freedom. There are too many negative things I hear about associates working for corporates – it isn't just corporates either. We make sure we don't tell people what to do – our staff are the highly-skilled ones, they know their patients better than we do. We simply empower our dentists to make decisions about their treatment plans; once you're behind the surgery door, it's your space.

**CB** We're not trying to be a corporate, in the traditional sense of the word. The very nature of our name suggests we're about being partners, and that's how we approach our business. Our clinicians are self-employed. We value their clinical skill and don't restrict their clinical freedom – we feel we should be supporting and developing them. We have invested in a clinical support network if individuals do need to seek advice, but the bottom line is we never tell people what materials to use, what instruments to use and how best to deliver clinical care to their patients.

*Neil you mentioned everyone has a say in the practice. Is there a case of too many cooks?*

**NL** To date that hasn't been our experience. Each clinical lead will coalesce the opinions of each practice and go from there. Yes – we do have some strong opinions and some stronger voices than others, but you get that in any place of work. A recent staff survey highlighted they felt they could raise criticisms and suggestions to management, which I'm particularly proud of.

**CB** A good example is one of our practices that has a team of 50, is open 365 days a year and operates four different contracts. If we had one voice in there given the complexity of each contract, that isn't going to work. I'd go back to a word Neil used – empowerment. We have empowered that team to sit down and talk about issues they face, find solutions and take ownership of that situation. It would be very difficult and frankly inappropriate for us to go over their heads and do that.

The team engagement surveys play a crucial role in enabling that model. We

believe that acting on the feedback from the surveys grows the engagement they have with us. It's a way to build trust – if their voices are heard, then naturally they will be far more likely to engage in future discussions.

**NL** I know the practice. We have someone who has emerged from the clinical side and someone very much from the commercial side. It's important for individuals to recognise their own strengths and weaknesses. In this case the dovetail has worked very well and been extremely useful for us. People stepping up and taking clinical leadership of situations is a great segway for those who have aspirations of owning or running their own practice in the future.

*Are there enough leaders in the profession?*

**RR** That's a difficult one to answer. We like to think the development of the clinical tiers we have – which is done very much in partnership with the teams across the business – creates leaders rather than managers. There's a formal training programme for those who show leadership and for those our clinical leads think has the potential to be a leader.

*What kind of profile of clinician do you see – well-rounded practitioners or highly-skilled clinicians with room for improvement?*

**RR** The reality is in any group you will get a mixture. New graduates are very academic but we often talk about their need for more work on the softer skills. This group needs a certain type of management to get them through their early years, and it's something we're looking to develop in the future to support that side of it.

Of course, you also have those at the different end of the spectrum who have been practising for 30 years and are very set in their ways. Again, they need a different type of support. Any strong management team has to recognise the variants in their staff and lead accordingly.

*With so many options out there for the new graduates you mention, haven't they heard it all before about corporates being different?*

**RR** I think a look at the fundamental structure of the business highlights how different we really are. Operations and clinical are aligned so, staff will receive multi-directorate support, which from my understanding is quite unique.

The strong clinical leadership, autonomy and freedom we encourage is something we hear about through the staff survey, which is obviously particularly pleasing for us to hear. Anyone joining the group is going to have access to a huge range of experienced clinicians, which will only aid their clinical and professional development.

In this climate, people are making employment decisions based on certainty and uncertainty. As Neil suggested, no-one really knows what will happen after 29 March, so they're staying put. We have established a very solid set of foundations that we are building on, and the certainty that offers I would hope is a reassuring thing for new graduates to recognise.

> 'Every practitioner, be it in our group or otherwise, has a duty to their patient, to the GDC and to fulfil their contract, being realistic with UDA targets ensures the pressure isn't on to do that.'

**NL** The other thing is the sheer variety of career pathways. To recruit and retain the best you have to provide diversity in their careers. In terms of the profile of practices we look to buy – we look to acquire large practices – that gives us the platform and the opportunity to provide the variety needed to retain them for longer.

*How have you managed to develop the clinical freedom within the confines of the universally discredited contract?*

**NL** Each practitioner knows what their patient's needs are. In terms of the clinical and governance support we provide, we ensure they practice ethically and professionally. If they need training on how to claim, for example, we provide that. We have the systems to monitor where some areas could be improved upon, but that's commonplace for a successful practice – they are encouraged to use their judgement.

**CB** Part of that is realistic expectations. We don't encourage them to take on board 8000 UDAs because we recognise the need to give options to their patients. Every practitioner, be it in our group or otherwise, has a duty to their patient, to the GDC and to fulfil their contract, being realistic with UDA targets ensures the pressure isn't on to do that.

*What systems do you in place to alleviate pressure?*

**NL** In the short space of time we have been operational, we have changed our strategy on UDAs. We now look for fewer than 6,500 UDAs per surgery in order to be able to deliver on everything we promise practitioners about clinical autonomy. If a practice doesn't have that, it needs to have expansion capabilities for us to be able to bring the pressure down quickly. If a practitioner wishes to go private we need to be in a place to facilitate that.

**CB** To keep the best staff you need to let them work as they want. We're aware a growing number of people want to work flexibly and part time!

**RR** I don't think clinical freedom is or should be linked to contractual agreements. I think it's more about best practice.

*It shouldn't, but that goes against the grain of what the majority say about the current contract.*

**RR** That's why we haven't taken the target-driven route, but that of best and accepted practice.

**CB** We also look to accommodate the practitioner's wishes – if they want a career break, if they want to work part-time. They're all taken into account. We firmly believe we're different, and it isn't difficult to see why. ◆

Find out more about Dental Partners at www.dentalpartners.co.uk, call 0121 655 1200, or email contact@dentalpartners.co.uk.

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# Medical devices in practice

## By Lynn Woods

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

Dentists and their staff will be familiar by now with the requirements of the Medical Devices Regulations 2002 but it is useful to summarise current guidance to ensure continuing compliance.

### What is a medical device

Firstly, we will look at what is a medical device. In general, medical devices must have a 'medical purpose' and would include products used for the diagnosis or treatment of disease, or monitoring of patients. This includes dental instruments, associated equipment and materials, and would also include medical emergency equipment including defibrillators.

Other examples include:

- Examination gloves
- Syringes and needles
- Mouthguards intended for a specific medical purpose including retainers following orthodontic treatment or for use in the treatment of bruxism
- Anaesthetic machines
- Pulse oximeters.

### What is not a medical device

Secondly, it is useful to know what is not normally considered to be a medical device because it is not specifically intended for a medical purpose:

Examples include:

- Toothbrushes, dental sticks, dental floss, tooth whitening/bleaching products (including bleaching trays)
- Mouthguards used as PPE such as those intended for sports purposes.

### Custom-made devices

Custom-made devices are usually one-off devices made specifically for an individual patient on the basis of a written prescription. Dental appliances are custom-made devices and include:

- Appliances mainly constructed outside of the mouth on a model such as man-made temporary crowns, crowns, bridges and removable orthodontic appliances, and TMJ splints such as Michigan and Tanner
- CAD/CAM – although the dentist takes a digital image and it is fitted whilst the patient is there – the machine makes the filling inlay/onlay, crown, bridge etc extra-orally and it is intended to last long term
- A denture constructed mainly outside of the mouth for someone who has lost a tooth, including if only intended to last a week while a better alternative is made.

### In-house manufacturing

Dentists who manufacture dental appliances for their patients in their own laboratories are required to register with the MHRA as a custom-made device manufacturer and to meet the relevant requirements. A Statement of Manufacture must be drawn up and provided to the patient with the dental appliance.

### Using a dental laboratory outside of the UK

The GDC advise that if you decide to use a dental laboratory or agent which sources dental appliances outside of the UK, your choice not to use a UK-registered dental technician puts a particular responsibility on you. You will be held professionally accountable for the safety and quality of the appliance because you have chosen not to use or issue the prescription to a registered dental technician who would otherwise be accountable. You take on the dental technician's responsibilities for the appliance and the GDC will hold you accountable for your decision.

### Reprocessing of reusable dental instruments

Dental instruments, associated equipment and materials should be decontaminated in line with the device or material manufacturer's instructions. With regard to dental instruments, the overall aim is to achieve a reprocessed dental instrument that is fully compliant with the 'essential requirements' of the Medical Devices Regulations. This implies that the instrument is:

- Clean and sterilised at the end of the decontamination process; and
- Maintained in a clinically satisfactory condition up to the point of use.

Dental instruments do not have to be 'sterile' at the point and time of use but do need to have been cleaned, sterilised and stored hygienically (a somewhat different approach from that in invasive surgical procedures).

### Single-use devices

The re-use of a single-use device has implications under the Medical Devices Regulations. Anyone who reprocesses or re-uses a device CE-marked for use on a single occasion bears the responsibilities normally carried by the manufacturer for the safety and effectiveness of the instrument. If in doubt about whether a device is re-usable, check with the manufacturer beforehand. Where a single-use device is reused, action may be taken by the relevant authority and the GDC.

### Reporting a problem with a medical device

A problem with a medical device can lead to an 'adverse incident'. The MHRA defines this as 'an event which produces, or has the potential to produce, unwanted effects involving the safety of patients, users or other people'.

If there is an incident with a medical device you should record the following:

- Manufacturer and model of the device involved (and any other details you can find)
- Details of the incident (how it happened and any effects on the people involved)
- Device settings
- Details of any error messages
- Date and time of the incident.

The MHRA will then investigate and take action to protect other patients and users. You should also tell the manufacturer about it. ◆

To report an incident to the MHRA visit www.gov.uk/report-problem-medicine-medical-device

# Decontamination equipment use

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.

All decontamination equipment should be validated, tested, maintained and serviced as recommended by the manufacturer. In the absence of manufacturer's instructions, you should follow the schedules in HTM 01-05.

Regardless of the type of decontamination equipment you have, the time between using instruments and cleaning them, should be as short as possible. Where a delay cannot be avoided, the used instruments should be immersed in water or an enzymatic cleaner.

Ensure that you check your instrument's manufacturer instructions as they may have specific requirements about how they are cleaned and what machines they can be cleaned in.

Unless you are a new practice, you do not need to use a washer disinfector for cleaning your instruments. Instruments can be cleaned manually and/or using an ultrasonic bath. Washer-disinfectors do, however, offer the best option for a validated process and remove the need for manual cleaning, which can increase the chances of team members getting a sharps injury. New practices are subject to best practice guidelines from the beginning. All established practices must have a documented plan for working towards best practice, which would include the use of a washer disinfector. You should include evidence of consideration to how you would accommodate your washer and ideally obtain quotes from an engineer.

Washer-disinfectors – points to consider

- Installation must comply with the water fittings regulations
- Do not overload instrument carriers or overlap instruments
- Open instrument hinges and joints fully (this goes for all other cleaning and sterilising methods too)
- Log all cycle parameters and carry out tests as per manufacturer's instructions.

Ultrasonic cleaners – points to consider

- Prior to cleaning, briefly immerse used instruments in cold water (with detergent) to remove visible soiling
- Change the water/fluid at the end of the clinical session and more frequently if it becomes heavily contaminated
- If your bath does not have a lid that locks, place a laminated sign up to say that the lid is not to be removed whilst cleaning in progress
- Leave the bath clean, dry and empty at the end of the day
- Carry out tests according to manufacturer's instructions.

## Written scheme of examination

It is a legal requirement that where an autoclave or air-receiver (with a capacity of more than 250 Bar-litres) is used, a 'competent' person must draw up a Written Scheme of Examination.

A Written Scheme of Examination includes (but is not limited to) details about; those parts of the system which are to be examined, the nature of the examination required, the critical parts of the system which, if modified or repaired, should be examined by a competent person before the system is used again and the periodic examination of the vessel (usually 14 months for autoclaves and 24-48 months for air receivers).

A 'competent person' has practical and theoretical knowledge and experience of the type of machinery or plant to be examined, can detect defects or weaknesses and assess their importance in relation to the strength or function of the vessel.

The Written Scheme must be regularly reviewed, and records kept showing that examinations have been carried out in line with the recommendations.

## Pressure vessel inspection and insurance

Examination for safety reasons is not the same as servicing and performance testing, which should be carried out in accordance with the manufacturer's instructions. Hazards associated with using autoclaves include door displacement if not properly secured, violent opening of the door due to residual pressure at the end of a cycle and scalding and explosion of sealed glass containers containing liquids.

It is also a requirement to have pressure vessel insurance. This does not have to be a separate policy and it may already be included in your practice insurance. You should check the details of your practice insurance for this. If it is not covered, then you will need to obtain a separate insurance policy.

Autoclaves – points to consider

- Where instruments require wrapping and sterilising in a vacuum autoclave, they must be dried first using a disposable non-linting cloth
- A record of every single sterilisation cycle should be made. This record should demonstrate that the autoclave is working within validated parameters such as time, temperature and pressure
- You should seek advice from the manufacturer on whether the daily tests can be undertaken while instruments are being processed
- Avoid overloading
- Fill water reservoirs daily using fresh distilled or reverse osmosis (RO) water
- At the end of the day, drain, clean and dry the chamber and ensure the door is left open
- Its not mandatory to have a vacuum autoclave but you should check the manufacturers' instructions for your instruments as some may require one (e.g. some implant kits).

All decontamination records should be kept for at least 2 years. It is good practice to keep your validation and servicing documentation for the life of the machine. ◆

For further information, have a look at the BDAs advice page on Infection Control: https://www.bda.org/dentists/advice/ba/Documents/Infection%20control.pdf

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

# What you need to know about hepatitis B

By Harriet Purdie

Hepatitis B is an infection of the liver, caused by a virus that can spread through blood and body fluids.

A vaccine that offers protection against hepatitis B is available for people at high risk of the infection or complications from it. Those who have direct contact with patients' blood or blood-stained body fluids (including saliva) should be vaccinated against hepatitis B. This includes contact with blood-contaminated sharp instruments.

The vast majority of people infected with hepatitis B in adulthood are able to fight off the virus and fully recover within one to three months. Most will then be immune to the infection for life.

Babies and children with hepatitis B are more likely to develop a chronic infection. Chronic hepatitis B affects around:

- 90% of babies with hepatitis B
- 20% of older children with hepatitis B
- 5% of adults with hepatitis B.

Although treatment can help, there is a risk that people with chronic hepatitis B could eventually develop life-threatening problems such as scarring of the liver (cirrhosis) or liver cancer.

## Vaccination

The Green Book includes information on hepatitis B immunisation.

For pre-exposure prophylaxis in most adult and childhood risk groups, an accelerated schedule should be used, with the vaccine given at zero, one and two months.

In those at risk of occupational exposure, particularly healthcare and laboratory workers, antibody titres should be checked one to four months after the completion of a primary course of vaccine. The results will inform decisions about post-exposure prophylaxis following a known or suspected exposure to the virus.

Antibody responses to hepatitis B vaccine vary widely between individuals, however it is preferable to achieve anti-HBs levels above 100mIU/ml.

## Hepatitis B infected clinicians

Chronic hepatitis B infection is defined as persistence of HBsAg in the serum for six months or longer. Among those who are HBsAg positive, those in whom hepatitis B e-antigen (HBeAg) is also detected in the serum are the most infectious. Those who are HBsAg positive and HBeAg negative (usually anti-HBe positive) are infectious but generally of lower infectivity.

Dental clinicians who are e-antigen positive carriers of hepatitis B infection must not perform Exposure Prone Procedures (EPPs). Those who are e-antigen negative should undergo additional testing to identify their viral loads. If the viral load exceeds 103 genome equivalents per ml, the clinician must not perform EPPs. Below this, working practices are not restricted but the clinician should be retested at 12-monthly intervals, as viral loads may fluctuate over time. Further advice can be obtained from your local occupational health department

## Non/low responders

Around 10 to 15% of adults fail to respond to three doses of vaccine or respond poorly. Poor responses are mostly associated with obesity, smoking and those who are over 40 years of age.

Non-responders (anti-HBs levels below 10mIU/ml) must be tested for markers of current or past infection; a repeat course of the vaccine may be required. They should be briefed on the personal risk of working in dentistry and the importance of following the practice inoculation injury protocol to allow timely post-exposure prophylaxis.

Occupational health will provide guidance on any other precautions that may have to be put in place. The BDA has a template risk assessment for non-responders.

## Nurses working in practice before immunity has been confirmed

If full immunisation has not been confirmed, then there are several areas to consider before allowing nurses to work chairside. It is a matter for the practice and the nurse to consider the risk that they might contract Hepatitis B in the course of their duties, how that risk might be controlled and whether the parties involved are willing to accept that risk. At the very least they should have had their 1st injection.

Practices should:

- Discuss with your nurse the risks of infection from BBVs, in particular that hepatitis B is the most infectious agent
- Consider the effectiveness of the other controls in place, and consider whether any additional controls should be implemented to allow them to work safely
- Ensure they are made aware of the importance of standard infection control procedures and, in particular, procedures for the prevention of sharps injuries
- Ensure your nurse is aware of the practice protocol for managing sharps injuries.

In order to minimise the risk of a sharp's injury, they should not handle sharps including dismantling needles, removing burs from handpieces or performing manual cleaning.

We suggest that practices discuss the matter with their employer's liability insurance provider. Practices may find they do not have cover for injury to staff if they do not adhere to the terms of their employer's liability insurance.

## Boosters

The Joint Committee on Vaccination and Immunisation (JCVI) have now advised that immunocompetent healthcare and laboratory workers who have received a primary course of hepatitis B vaccine and are known responders no longer require a single booster dose 5 years later.

## Following an inoculation injury

Practices should have a protocol for dealing with inoculation injuries. This should include first aid measures and relevant contacts for further advice and/or treatment.

Following a significant exposure all staff will require a risk assessment and may require a booster dose of hepatitis B vaccine or further action at that time. The risk assessment should take account of the type of exposure, the patient risk and the previous vaccination history. The recommendations in table 18.7 in the green book should then be followed.

# Accidents and ill-health at the practice

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

Accidents and ill-health do happen, but hopefully not often and not if preventable! Forward thinking is the key to minimising the risk of injury to a person and/or damage to premises or equipment. This feature will look at ill health and accidents that have happened and ways to help prevent them happening again, as well as the recording and reporting process. Below we look at three examples of situations which have occurred.

## 1. Dental nurse – latex allergy

On returning to the practice after a long holiday a dental nurse noticed symptoms – wheezing – suggestive of occupational asthma. Her symptoms improved at home in the evenings and at weekends. She reported this to the practice manager who was able to arrange referral to an occupational health provider where it was confirmed she had an allergy to latex. Her latex gloves caused a rash over her hands and lower arms and led to her developing asthma.

She now wears vinyl gloves and her practice colleagues avoid using powdered latex gloves. She has been able to continue in her role without any further problems.

In this situation HSE did not need to investigate as the practice took action as soon as the dental nurse reported the problem.

## 2. Practice manager – fall down stairs

After speaking with a dentist on the first floor a practice manager tripped on the stair carpet whilst returning to the ground floor. The stair nosing had worn, the practice owner was aware of this and had placed tape there – this had also come away.

The practice manager suffered a broken ankle and dislocated foot. He spent 10 days in hospital and required ankle surgery. He was unable to walk for several months and was still in pain and using a stick almost a year later. He has so far been unable to return to work.

Prosecution under the Workplace (Health, Safety and Welfare) Regulations 1992 resulted in a significant fine and the practice was also ordered to pay the prosecuting authority's legal costs. In this situation, HSE did investigate as the problem had been noted in a health and safety risk assessment of the practice some 15 months prior to the accident.

## 3. Don't forget about the cleaner – use of wrong cleaning product

A practice employed a new cleaner and shortly afterwards staff noticed that various floor areas of the practice seemed slippery. The practice manager was puzzled so contacted the floor cleaner product supplier for advice but the supplier was also at a loss. As soon as she was able, the practice manager spoke with the cleaner and discovered the cleaner was using washing-up liquid to clean the floors as she hadn't been informed where the floor cleaning products were stored.

Thankfully nobody slipped, but this highlights the importance of involving all staff in how the practice works and what is kept where. Prompt investigation by the practice manager prevented a foreseeable accident.

## After an accident or near-miss

If there has been an accident at the practice, or a near-miss that could have resulted in an accident, you should:

- → Record all the details in the accident book as soon as possible
- → Report it if it is reportable
- → Consider what you can do to prevent recurrence, in particular:
  - What happened
  - How or why it happened
  - What has been learned
  - What change can you make or action can you take to prevent it happening again.

## The usefulness of the accident book

Employers and employees can use an accident book to record details of work-related injuries for which state benefits could be payable.

The accident book is also a valuable document that practices can use to record accident information as part of their management of health and safety. It can be used to record details of injuries from accidents at work that employers must report under the Reporting of Injuries, Diseases and Dangerous Occurrences Regulations (RIDDOR).

## Recording and reporting under RIDDOR

If a worker sustains an occupational injury resulting from an accident, their injury should be reported if they are incapacitated for more than seven days. There is no longer a requirement to report occupational injuries that result in more than three days of incapacitation, but you must still keep a record of such injuries.

Only 'responsible persons' including employers, the self-employed and people in control of work premises should submit reports under RIDDOR.

Employers must report certain work-related injuries, cases of disease, and near misses involving employees wherever they are working.

## What about members of the public?

Work-related accidents involving members of the public or people who are not at work must be reported if a person is taken from the scene of the accident to hospital for treatment to their injury. There is no requirement to establish what hospital treatment was actually provided, and no need to report incidents where people are taken to hospital purely as a precaution when no injury is apparent.

## Occupational diseases

Employers and self-employed people must report diagnoses of certain occupational diseases, where these are likely to have been caused or made worse by their work: These diseases include (but are not limited to):

- → Occupational dermatitis
- → Occupational asthma
- → Any disease attributed to an occupational exposure to a biological agent. ◆

To see what is reportable under RIDDOR visit www.hse.gov.uk/riddor/reportable-incidents.htm

## Black Is best

Since it was founded in 1972, Curaprox has strived to create products that benefit both professionals and patients alike.

Its latest creation, the Hydrosonic Black Is White toothbrush, is one such solution.

Thanks to its hydrodynamic effect, this innovative toothbrush can help patients clean hard to reach, critical areas.

When set to 'intensive mode' the Hydrosonic Black Is White system is capable of up to 32,000 strokes per minute, and is an ideal setting for preventing decay and reducing plaque.

In 'soft mode', which operates at 42,000 strokes per minute, the smart solution is great for cleaning sensitive teeth and gingiva.

But that's not all – to ensure that patients get the full experience, the Curaprox creation also offers the 'massage mode', which stimulates blood circulation in the gingiva.

Available to purchase as a package with two additional extra-soft brush heads, a charging station, cable and dock, a power plug, travel case and Black Is White activated carbon whitening toothpaste, the complete Black Is White box set is a perfect oral healthcare kit for any patient.

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


## Colour me intrigued

It's easy to make a mistake or forget something, particular in the midst of a busy and stressful day. However, when it comes to dental waste segregation even a single errant sharp could result in a bloodborne pathogen being accidentally transferred.

Understanding that the best solutions are often the simplest, Initial Medical designed Colour Coded Characters to help professionals remember how waste should be sorted and where it should be disposed of.

Initial Medical is an expert in healthcare waste management, providing a complete collection, disposal and recycling service for hazardous and non-hazardous waste and offensive waste produced by businesses and organisations within the UK.

The safe management of healthcare waste is vital to ensure your activities are not a risk to human health. Initial Medical's healthcare waste services ensure that all of your waste is stringently handled in compliance with legislation and in accordance with Safe Management of Healthcare Waste best practice guidelines, providing you with the peace of mind that you are adhering to current legislation.

These explanatory illustrations help ensure that your staff have an at a glance reminder that is simple and easy to remember for the future.

For further information visit www.initial.co.uk/medical or call 0870 850 4045.

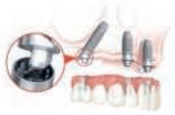
## Key to the All-on-4 treatment concept

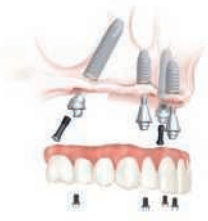
Designed to rehabilitate both fully and partially edentulous arches, the Multi-unit Abutment from Nobel Biocare is a key to success with the All-on-4 treatment concept.

The wide shoulder facilitates prosthetic positioning, while straight and angled variants are available in nine different collar heights to meet the needs of every patient. The product also comes with a unique pre-mounted holder for simple abutment seating and it ensures incredible precision of fit of all NobelProcera fixed and removable prostheses.

All this ensures the very best results when used in combination with the All-on-4 treatment concept – another original innovation from Nobel Biocare.

To find out more about the Multi-unit Abutment and the latest Multi-unit Abutment Plus, contact the team at Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com/all-on-4.





## Sit comfortably

Ensure you sit comfortably with a solution that is designed to accommodate you and your patients. Clark Dental offers practitioners the A-dec 500 dental unit, which features a flexible, ultra-thin backrest that enables you to maintain a healthy posture, preventing pain and discomfort.

The sophisticated A-dec 500 can be customised with various different delivery systems designed to suit your professional workflow. These provide internal integration of all your instruments and ancillaries, so you can operate ergonomically.

Patients are also able to benefit from true comfort as the A-dec 500's pressure-mapped cushioning provides balanced support throughout treatment.

For more information, call Clark Dental on 01268 733 146, email info@clarkdental.co.uk or visit www.clarkdental.co.uk.

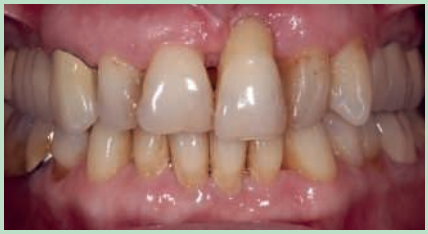
## Say cheerio to perio

Assessing the true extent of periodontitis can be difficult. So why not use PROPACS from PRO Diagnostics UK?

A secure cloud-based storage system, PROPACS can also be used to assess and monitor periodontitis. You simply send radiographs to their team of specialist radiologists and they will create a PerioGuide report.

This report uses an easy to understand colour coded system to assess the severity of periodontitis and also give information such as the amount of bone loss at each tooth site – everything you need to accurately classify the severity periodontitis and treat it accordingly.

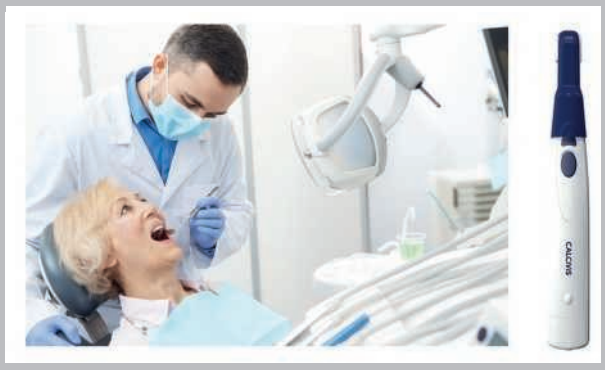
Find out why so many people are choosing PROPACS by contacting the team on www.prodiagnostics.co.uk or email sales@prodiagnostics.co.uk.



## Seeing behind the smile

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

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




For an early detection system that helps patients to better understand their oral health, contact CALCIVIS by visiting www.CALCIVIS.com or call 0131 658 5152.

## Optimal aesthetics assured

Many implantologists are faced with the challenge of traditional titanium implant systems becoming visible through the gingiva. TBR provides an innovative solution to this issue with the sophisticated Z1 implant, which enables clinicians to ensure optimal aesthetic and functional outcomes.

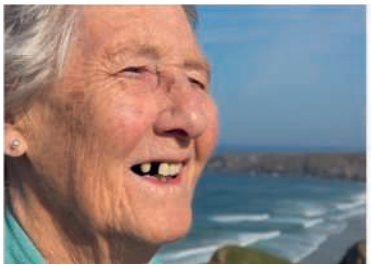
As the world's only tissue-level implant that seamlessly combines a titanium body with a zirconia collar, the Z1 offers exceptional osseointegrative properties. It also encourages the soft tissue to heal around the implant in a way that mimics natural gingival growth, thereby enhancing the overall visual result.

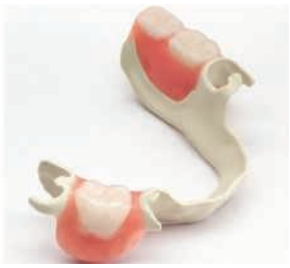
For more information on the Z1 implant, visit tbr.dental, email support@denkauk.com or call 0800 707 6212.

## A new, cutting edge option for older patients

Solvay Dental 360 has developed a new generation polymer called Ultaire AKP specifically for the fabrication of metal-free removable partial dentures. This material is an ideal alternative – it is strong and offers stable retention, but it is also lightweight and biocompatible.

As the manufacturers of Ultaire® AKP, Solvay Dental 360® can also arrange a professional Lunch and Learn session at your dental practice to show you and your team the benefits of digitally designed, polymer-based RPD frameworks.





To find out more about metal-free removal partial dentures with improved fit and superior aesthetics, visit www.solvaydental360.com.

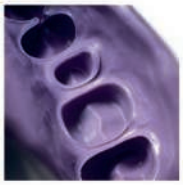
## The speedier solution

Want to be able to take impressions fast and with no fuss?

Try new Impregum Super Quick polyether impression material from 3M Oral Care.

Needing only 45 seconds of working time, the material sets in just two minutes, helping you to streamline your workflows and improve patient comfort thanks to its fresh minty taste. Impregum Super Quick polyether impression material is also scannable with the current generations of scanners and compatible with a CAD/CAM workflow, helping to take your impressions to the next level.

Find out more about Impregum Super Quick polyether impression material and request your demo by calling 0800 626 578 or by visiting www.3M.co.uk/Dental.

## Innovation for all

A practice that can offer high quality care to the entire family, in one location, will always be sought after.

A family practice should look good and use the best in modern equipment to deliver a world-class service.

Castellini dental units combine tradition and technology to give practitioners and patients a superior experience. Adults and children alike can be treated in comfort and with efficiency – your practice will be elevated to a new level.

Castellini is dedicated to progress and innovation, while respecting the values that every successful family practice has been built on.

For further information visit www.rpadental.net or call the London and Manchester Sales and Service Centres on 08000 933 975.


## Unrivalled online reputation solution

Systems For Dentists (SFD) is the longest UK established quality software provider for dental practice management. Since 1987, dental practices have looked to Systems For Dentists as the independent source for planning, running and management of their dental business.

The online reputation management tool called Kudos is provided in partnership with Working Feedback and the integration makes patient feedback a seamless, automated process for practices using Systems For Dentists' practice management software.

The new tool helps dental businesses to gain a clearer understanding of the patient journey; which they can use to improve upon what they do, increase additional treatment uptake, turbo-charge their online reputation and deliver exceptional customer service that sets the practice apart from its competitors.

The Kudos tool attracts new patients too by sharing review ratings with Google, NHS and key social media platforms such as Facebook, so that consumers can feel even more confident when they choose a dental practice that comes highly recommended.

Working Feedback is the UK's leading solution for patient reviews and as well as its strategic partnership with Practice Plan, NHS Choices and CQC; it works with hundreds of independent dental practices in helping them grow their business through patient feedback.

For further information visit www.sfd.co/kudos.

# Dentist to Dentist

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

## North West

### DENTAL SPECIALISTS

www.dentalspecialistsmm.com

Dental Specialists Melton Mowbray – Specialist Private Dental Centre

20 Park Rd,

Melton Mowbray,

LE13 1TT, UK

**Dr Adetoun Soyombo** Specialist in Periodontics

**Dr Richard Craxford** Special Interest in Prosthetics

**Dr Ayodele Soyombo** Specialist in Orthodontics

**Dr Carol Subadan** Specialist in Periodontics

**On Specialist List:** Yes

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

### ST GEORGE'S DENTAL PRACTICE

www.stgeorgesdentalpractice.co.uk

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

## South East

### MOUNT VERNON DENTAL SPECIALISTS

www.mvdentalspecialists.co.uk

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

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

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

### HAPPY KIDS DENTAL

happykidsdental.co.uk

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

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

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

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

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

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

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

### MOOR PARK SPECIALIST DENTAL CENTRE

www.moorparkdental.com

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

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

**Dr Lydia Hopkins BDS MSc Ahea**
Specialist in Periodontics

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

**Dr Norman Gluckman BDS Rand**
Specialist in Endodontics

**Dr Neeta Patel BDS FDS RCS**
Specialist in Oral Surgery

**Dr Sheetal Patel BDS MFDS RCS MSC Morth**
Specialist in Orthodontics

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

**Dr Ayesha Patel BDS MFDS RCS(Edin) PG Cert Dental Ed MPaed Dent RCS (Glas)**
Specialist in Paediatric Dentistry

## TOOTHBEARY RICHMOND
www.toothbeary.co.uk

10 Anniversary

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

## AYUB ENDODONTICS
www.ayub-endo.com

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

## J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

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

## DENTAL SPECIALISTS
www.dentalspecialistssa.com

Dental Specialists St Albans – Specialist Private Dental Centre
96 Victoria St,
St Albans AL1 3TG, UK

| | |
|---|---|
| **Dr Adetoun Soyombo** | Specialist in Periodontics |
| **Dr Carol Subadan** | Specialist in Periodontics |
| **Dr Juanita Levenstein** | Special Interest in Orthodontics |
| **Dr Neil Kramer** | Specialist in Endodontics |
| **Dr Ayodele Soyombo** | Specialist in Orthodontics |

**On Specialist List:** Yes
**Services**:
Periodontics, Dental Implant, Orthodontics, Sleep Disorder, Endodontics

# Midlands

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

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

## DENTAL SPECIALISTS
www.dentalspecialistsmk.com

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

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

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

# In Practice CPD

**Q1:** What is the ideal anti-HB level post-vaccination?

**A** 25mIU/ml
**B** 50mIU/ml
**C** 75mIU/ml
**D** 100mIU/ml

**Q2:** Which of these items is classified as a medical device?

**A** Tooth whitening product
**B** Mouthguards
**C** Dental floss
**D** Defibrillator

**Q3:** For how long should decontamination records be kept?

**A** 12 months
**B** 24 months
**C** 36 months
**D** 48 months

**Q4:** When should you report an occupational injury?

**A** If the person is incapacitated for more than four days
**B** If the person is incapacitated for more than seven days
**C** If the person is incapacitated for more than 10 days
**D** If the person is incapacitated for more than 13 days

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

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

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

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

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

## Need help?

To access *BDJ In Practice* CPD online:

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

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

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

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

For support use: cpd.hub@bda.org

BDA

British Dental Association

**Patrick Rochford**

19 December 2018 ·

Help! I am selling my practice and I don't want to get caught out.

**Jill Lockley**

19 December 2018 ·

A confrontational employee is making life miserable – what can I do?

**Iraj Almasi**

19 December 2018 ·

I'm not happy with my pay – what could I do about it?

**Nikita Patel**

19 December 2018 ·

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