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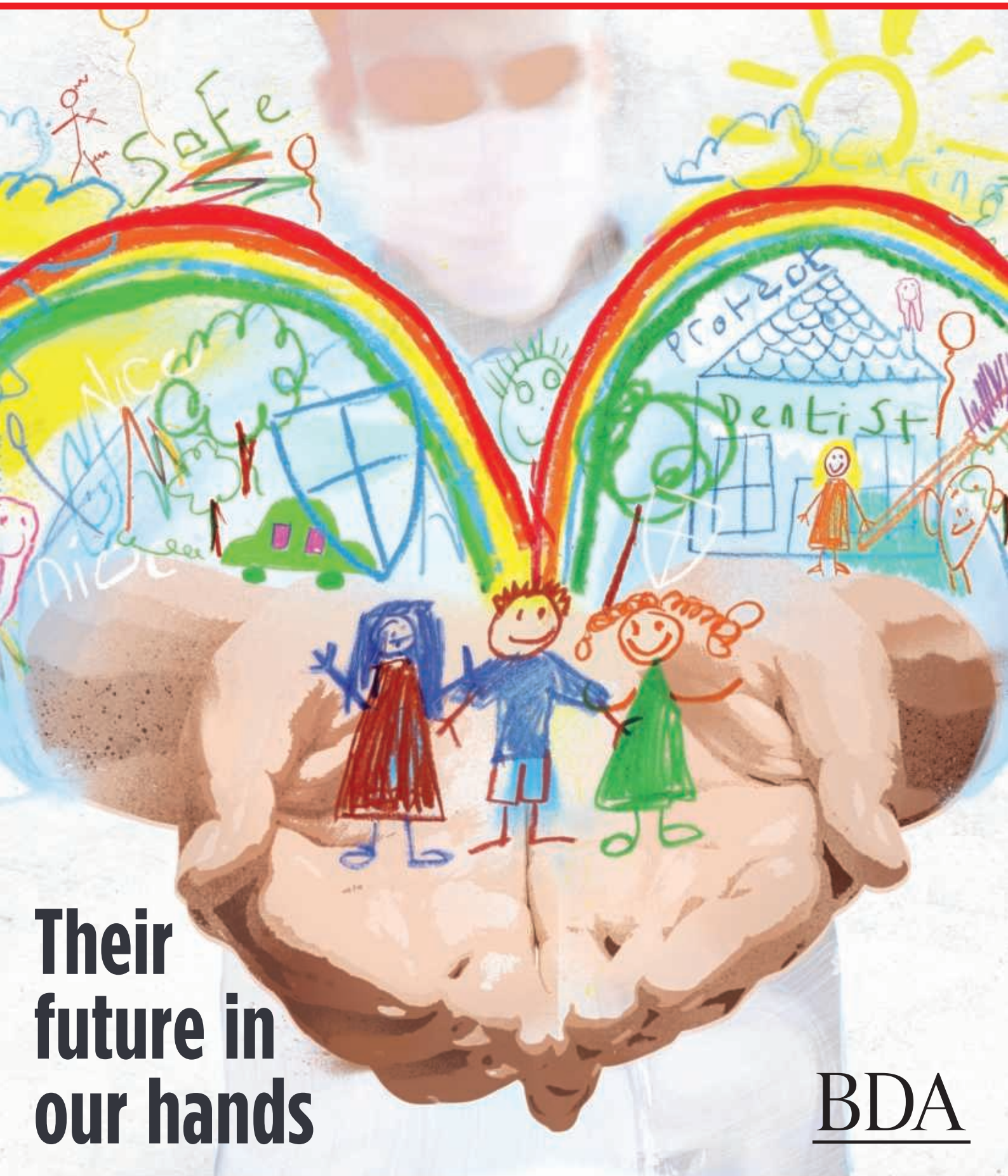
October 2016



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Cover illustration Danny Allison

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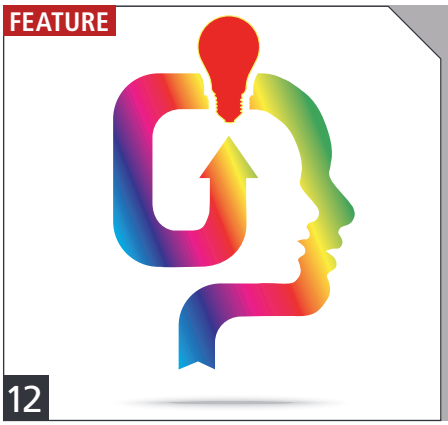
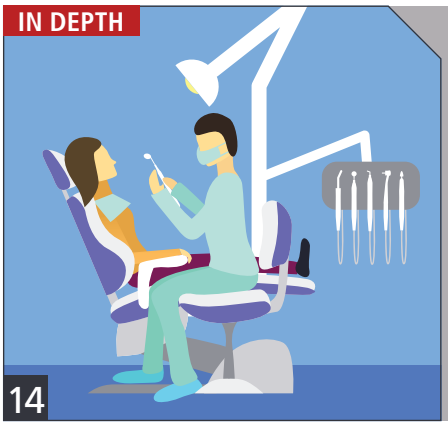
To contact the **Advertisement Office:** Tel: 020 7843 4729. To contact the **Editorial Office:** 64 Wimpole Street, London W1G 8YS. Tel: 020 7935 0875. Fax: 020 7487 5232. E-mail: bdjinpractice@bda.org. Web: www.bda.org/bdjinpracticeonline. Published for the **British Dental Association** by: Springer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

Acceptance of an advertisement by *BDJ In Practice* does not necessarily imply endorsement by the British Dental Association. ISSN 2057-3308.





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COLUMN

NHS charges: A tax on Health

Henrik Overgaard-Nielsen, Chair, GDPC

NHS dentists know all about doing more with less. So we have set out to shine a light on the finances that underpin the service, and one increasing large part – the patient charge. NHS charges are almost as old as the service itself. They arrived in 1951 to stem the flow of post-war patients lining up to try dentistry free at the point of use. It was a move that prompted one Aneurin Bevan to resign from government in protest.

The original motive behind the charge was to suppress demand. But in 2016 that logic has changed.

Today this tax on health has become a substitute for real investment from government. Patients are paying more into a largely static NHS dental budget, while ministers pay less.

> 'Today this tax on health has become a substitute for real investment from government. Patients are paying more into a largely static NHS dental budget, while ministers pay less.'

Charges went up 5% last April, and will go up by another 5% next April. And our latest analysis shows charge income is now on course to exceed the government's own 'contribution' into the service within a generation.

These increases do not go to dentists. They certainly aren't earmarked for improvements in patient care. They are nothing more than an emblem of a sustained strategy of government underinvestment.

Of course charges remain effective at making the patients who need us most think twice about dental care. The last Adult Dental Health Survey showed just over a quarter of adults say that the type of treatment they opted for has been affected by the costs. Almost one-fifth said that they had delayed dental treatment for the same reason.

And now we've got the press talking about the 600,000 patients with dental problems who are now heading to their GPs every year – for treatment our overstretched medical colleagues are not trained or equipped to provide.

This debate matters. Charges are feeding the false economy of underfunding. It's the same failed philosophy that would rather see millions spent extracting teeth from children in hospitals under general anaesthetic, than provide a cost effective focus on prevention.

£170 million in direct government investment has been taken out of England's annual budget since 2010. While other UK nations become less dependent on charge income, England is becoming ever more reliant on patients to plug the funding gap.

Underfunded and undervalued, NHS dentistry remains the Cinderella service. And that approach comes with consequences. Quality care costs money, and in dentistry it's not just how much you put in, but where that money comes from that matters.

We need patients and practitioners to join the debate on NHS funding. ◆

www.bda.org/patientcharges

Oral health a missing piece in programme for government

Dentists have expressed concern that oral health has not received any coverage in the Welsh Government's new Taking Wales Forward document, raising questions over the future of the innovative oral health programme *Designed to Smile*. Since 2008 the Welsh Government has funded *Designed to Smile*, the Wales National Oral Health Improvement Programme.

The supervised brushing and fluoride varnish programmes have already helped young children establish good habits, and according to a Cardiff University study have contributed to dental decay rates among children falling by 25% between 2007/08 and 2014/15.

The Child Dental Health Survey published in 2015 showed that 63% of Welsh 15-year-olds have decay, compared with 44% across the border. The BDA, which has welcomed leadership from the Welsh government on the issue, is now seeking reassurances over the future of the programme. The BDA believes the core programme will need to run for at least 10 to 12 years to really see the benefits come through for the next generation of teenagers – and has previously called for expansion of the programme to children under three.

Katrina Clarke, Chair of the BDA's Welsh General Dental Practice Committee said: 'Dentists have welcomed leadership from the Welsh government on tackling our nation's deep oral health inequalities in recent years. We are both saddened and disappointed to see this pioneering oral health scheme has not made the cut for the new programme for government.

'When it comes to combating tooth decay Wales is setting an example that puts ministers in England to shame. The *Designed to Smile* programme works - our children are already reaping the benefits, and we believe it offers firm foundations this government should build on. We cannot understand why even a passing reference failed to make it into this document. ◆

Dentistry not yet felt impact

In response to the news that more than half of SMEs (56%) say they have felt no impact on levels of business from the UK's decision to leave the EU, It seems that the UK dental sector has not yet experienced any massive fall-out one way or another following the UK's decision to leave the European Union on 23 June. That's according to the National Association of Specialist Dental Accountants and Lawyers (NASDAL).

Alan Suggett, media officer of NASDAL and a partner in UNW LLP, identified six key ways in which Brexit could affect UK dentistry. They were:

- Recession. Those private practices who depend on elective treatments for a significant part of their income could notice a drop in demand and even 'regular' care is likely to see a reduction as patients put the check-up off for yet another six months, year or longer
- Status of EU dental professionals. EU 'immigrants' currently make up around 5% of the total NHS workforce[1]
- NHS Incorporation. A major hurdle thrown up by LATs against the incorporation of NHS practices is that it falls foul of EU tendering law
- New contract. Stalling on a new contract is likely to get worse
- Sale of practice. Uncertainty around the new contract certainly hasn't affected the current market and the further down the track the decision goes, the more that potential buyers may be prepared to invest?
- Reduction in Lending. Will we see money leave the UK economy and move to those options perceived to be safer?

Alan continued: 'We are undoubtedly in a period of great uncertainty. It can be argued that a new contract already seems somewhat further away and that some elective treatments may be being reconsidered. EU citizens in the UK may well be feeling uneasy and it seems likely that there will be controls placed on future immigrants. Although there has been a downgrading of the UK's credit rating to AA by Standard & Poor's, the current mood music from many of the major lenders is that it is 'business as usual'. The practice sales market is still incredibly buoyant and shows no sign of slowing up.'

Russell Abrahams, Senior Partner at Abrahams Dresden has been speaking to many of his dental clients about Brexit. He added: 'At present the message that I am getting is that there have been no Brexit specific issues but that less confident patients may delay treatments. In turn, this may have a significant (but delayed) impact on private dental revenues, as was the case in 2009-12.'

1. https://fullfact.org/immigration/immigration-and-nhs-staff/

'Ill-judged and inappropriate' – response to CDO

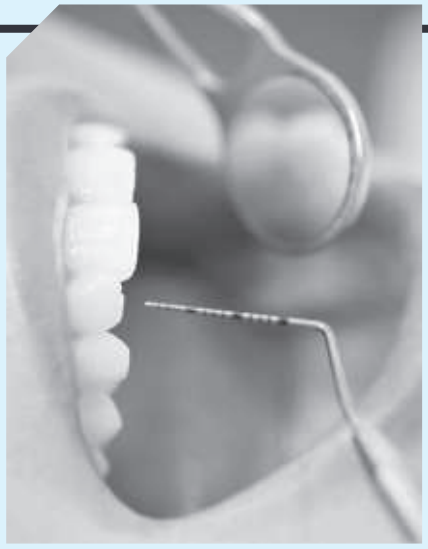
The BDA has responded to comments on patient recall from England's Chief Dental Officer (CDO), Sara Hurley at the NHS England Expo event in Manchester.

BDA chair Mick Armstrong said: 'The CDO for England's comparison of dental professionals with car mechanics was ill-judged and inappropriate.

'Certainly recall intervals will differ depending on a patient's individual oral health, but the CDO needs to be very careful in future with her choice of words, so as not to give the impression that patients cannot trust the advice of their dental professionals.

'Oral health is improving with the considerable efforts of dentists' continual and regular reinforcement of vital oral health measures and messages. Colleagues continue to provide an excellent, committed service, despite a 25% real terms cut in NHS fees over the last decade – which means a huge drop in the money available to them for reinvestment in their practices.

'We are already the most efficient, most trusted and compliant of health care sectors, and we do not expect to see a CDO pointing an accusing finger at dentists for honest endeavours.'



35% collapse in earnings undermining NHS dentistry

An historic collapse in dentists' earnings across the UK is jeopardising needed investment in NHS dentistry, says the BDA.

BDA analysis of new official figures on earnings and expense levels in NHS dental practice show both self-employed associate dentists and practice owners in England and Wales have seen taxable income fall by 35% in real terms over the last decade. The story is replicated across the UK nations, with real terms falls in Scotland and Northern Ireland of well over a quarter since 2009.

Unlike their medical colleagues NHS dentists do not receive any capital investment from central government. These profits therefore serve to fund all improvements in equipment, training and facilities for NHS practices.

The BDA has recently pointed to chronic underinvestment in NHS dentistry, and the inflated charges that have helped drive 600,000 patients with dental problems to GPs every year.

The dentists' professional body has renewed its call for fair funding.

Henrik Overgaard-Nielsen, the BDA's Chair of General Dental Practice said: 'This 35% fall in NHS dentists' real incomes over the last decade is without parallel in the public sector.

'Governments across the UK are squeezing NHS dentistry until the pips squeak. Every penny of investment this service receives comes from dentists' own pockets, and this collapse in real incomes has a real impact on our ability to deliver the improvements in facilities, equipment, and training our patients deserve.

'These savage cuts have long ceased to be a question of 'pay restraint' or 'efficiency savings'. A wilful singling out of an entire sector of dedicated health professionals is irresponsible, unsustainable, and carries consequences for millions of NHS patients.

'The government has taken £170 million of direct funding out of NHS dentistry in England since 2010, and there are no pledges of capital investment to sweeten this pill. Our patients deserve better than a strategy that rests on them putting in more, while ministers pay less.'

David McColl, Vice Chair of the Scottish Dental Practice Committee, said: 'The Scottish government has ensured we remain the lowest paid dental practitioners in the whole of the UK. Beset on all sides by red tape, underinvestment and a crisis of morale, something has to give. Ministers need to know there are no further efficiencies that can be extracted from the service without compromising patient care.'

Peter Crooks, Chair of the Northern Ireland Dental Practice Committee, said: 'A strategy of sustained cuts is compromising the service in Northern Ireland. Effective care for a population with the worst oral health in the UK costs money, and we are being denied the resources required to do what we're trained for.'

Katrina Clarke, Chair of the Welsh General Dental Practice Committee, said: 'NHS dentistry in Wales is being stretched to breaking point, and we are starting to face a recruitment crisis. We want to give our patients the best, but we cannot continue doing more with less.'

BOOK REVIEW

A brilliant mind

Brilliant strategy for business
Chris Dalton
Pearson Education, 2016
ISBN: 978-1-292-10784-4
£14.99

'Strategy is finding out *why* your business is here, what it stands for, who it is for and *what* it aims to achieve next'. Thus avers author Chris Dalton, an Associate Professor of Management Learning at Henley Business School with a PhD in Management Learning and Leadership and crucially, Dalton understands how a strategist thinks, or at least how one *should* think.

The book is arranged in three broad sections; part one deals with getting to grips with strategy, the second part looks at strategy from a business level perspective and the final part considers strategic thinking in a changing world. As to definitions of strategy for business, four common assumptions comprise strategy being necessary and important, future or goal-oriented, a connection from the present to the past and that it is dynamic.

The practical side of strategic planning is covered in Chapter 6 *Strategy day to day*. This chapter acknowledges that it's not just the CEO of an organisation who can plan strategies. Those who actually implement the strategies also play a vital role in devising the company's direction of travel. Conversely, those who impose impractical strategies can cause major problems, and Dalton here quotes management consultant Peter Drucker saying: 'So much of what we call management consists in making it difficult for people to work.'

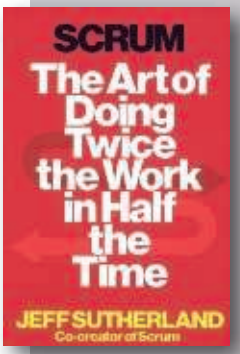
Dalton is at pains to reference the importance of knowledge management as a medium for an organisation's capacity for learning, perhaps by using tools such as key performance indicators and benchmarking. But as Sir Ken Robinson says: 'Knowledge isn't about what you know, it's about what you don't know, and being prepared to say 'I'll find out''.

One unusual example of a consummate strategist, albeit an ironic one – since he was still alive at the time this book was written – is David Bowie who, the author points out, demonstrated the hallmarks of 'systems thinking', careful product positioning and clever promotion. There could perhaps be no better example of a deliberate strategic plan than Bowie's swansong album Blackstar, the lyrics of which poignantly foretold his demise and which was released two days before his death.

BOOK REVIEW

Doubling up

Scrum – the art of doing twice the work in half the time
Jeff Sutherland
Random House Business Books, 2014
ISBN: 978-1-847-94110-7
£9.99



Jeff Sutherland, the inventor of the Scrum mode of work makes a point early on in his book that the reason projects fail is because of the traditional and antiquated 'waterfall' (ie, top down) methodologies they employ. He even goes as far as to suggest that these methods were responsible for the FBI's failure to prevent 9/11. The term Scrum takes its name, unsurprisingly, from rugby, where the team work together to move the ball down the field. Another vital characteristic of Scrum is to keep on top of the work in progress in what Sutherland calls an 'inspect and adapt' cycle.

But it's when Sutherland describes the epitome of the team that his ideas start to crystallize into a meaningful shape. Crucially, these descriptors fall into three main headings. Transcendent is the notion that the team has a sense of purpose, a self-realised goal that transcends the ordinary and believes that what it is embarking on is not ordinary, but rather a great and significant goal. This ideal is not unlike the collective spirit of the teams who cracked the Enigma machine code at Bletchley Park helping the allies to win the Second World War.

The next element of the scrum team is that they are autonomous, self-organising and self-managing and have the power to make their own decisions, decide how to do their jobs and are able to make the decisions stick. Obviously, this implies that the team now has a vested interested in making it work. Finally, the team will be cross-functional, possessing all the skills required to make it work and these skills will feed and reinforce each other.

Fraudulent dentist pleads guilty to ABH and receives five and a half years imprisonment

A fraudster who received almost £50,000 for carrying out dental work illegally and causing actual bodily harm by his substandard treatments has been sentenced to five and a half years imprisonment following a joint prosecution between Humberside Police and the General Dental Council (GDC).

Ronnie Barogiannis fraudulently obtained employment at the Smiles Dental Practice in Cottingham, East Yorkshire by impersonating a properly registered dentist and stealing his identity. During the course of his employment over a year at the practice he was paid £48,844.39 and the dental treatments he provided to several patients were so poor that he left them with permanent damage to their teeth and gums.

In 2013, Mr Barogiannis illegally worked as a dentist at a dental practice in Scotland and, during that time, he recruited the dentist whose details he subsequently stole. Following a joint prosecution by the GDC and the local prosecution service in Scotland on 28 August 2013, he left this employment and moved to England, where he almost immediately took up working illegally again using the identity of his former colleague.

Following his guilty plea to one count of fraud on 27 May 2016, Ronnie Barogiannis pleaded guilty to a further four counts of assault occasioning actual bodily harm at Hull Crown Court on 28 July 2016. On 16 September he was sentenced for both fraudulently obtaining almost £50,000 and causing serious and permanent damage to several patients.

©Chris Ryan/Getty Images Plus

Promise of breakthrough on AMR welcomed

The BDA has welcomed news that 193 countries will sign a landmark declaration to rid the world of drug-resistant superbugs.

Dentists' leaders have paid tribute to the work of Chief Medical Officer, Professor Dame Sally Davies, who spearheaded international work on antimicrobial resistance (AMR), and has raised the issue at G20 level.

Dentistry accounts for up to 10 per cent of all antibiotics prescribed in the UK. The BDA has taken a lead on addressing AMR in dentistry, issuing a consensus report in May 2015, and has engaged directly with Professor Davies, who has been briefed on the barriers to reducing prescriptions rates presented by current contractual arrangements.

The BDA has recently pointed to studies showing the 600,000 patients with dental problems are driven to GPs by costs. Studies in the British Journal of General Practice indicate 57.1% of those patients are offered antibiotics as a stop gap, further contributing to the problem of AMR.

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Protecting children, the future

Former UN Secretary-General Kofi Annan once said *'There is no trust more sacred than the one the world holds with children. There is no duty more important than ensuring that their rights are respected, that their welfare is protected, that their lives are free from fear and want and that they can grow up in peace.'*

In the late 90s and at the turn of the century, the Victoria Climbié case that shocked the nation was the diametric opposition to this statement. Between 14 July, 1999 and 25 February 2000, Victoria suffered 132 separate injuries. On every occasion, the state let Victoria down. A report into the incident by Lord Laming found that health, police and social services missed 12 opportunities to save her. It was a case that proved to be the turning point for child protection and welfare.

Fast forward to 2016, and healthcare providers have safeguarding at the very heart of their care. Dentistry, like our allied healthcare colleagues, has significantly advanced in that time. So too have general levels of oral health, although there is something to be said for the fact that a greater degree of inequality exists between top to bottom.

Perhaps the exception to that rule is the number of teeth being extracted from children. The figure currently stands at more than 40,000 per annum. The Oral Health Foundation have previously labelled the number of children requiring extraction as 'parental neglect in three areas, all of which are basic oral hygiene principles'.[1]

BSPD describes dental neglect as '...the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development.'[2] Yes, there are cases of neglect but there are also longstanding cultural, socioeconomic and educational barriers to overcome. Parents and carers need the causes of dental decay explained to them in a way they can understand, it cannot be assumed that they know. There is a woeful lack of support and the general public has still to be convinced that baby teeth matter. Is it any surprise we have a problem of this scale? Please, let us not make the job harder by alienating families before we have even got them through the surgery door.

Prior to 2006, the only nationwide guidance that existed was a generic flowchart emanating from the Department of Health which briefly outlined what to do if you suspected a child was being abused. Consultant in Paediatric Dentistry, Jenny Harris was a specialist paediatric dentist working in a community clinic in Rotherham, and realised dentistry had a big role to play in the safeguarding of children.

> 'We didn't want to refer children to social services unless we were absolutely sure we had the diagnosis right. So generally we crossed our fingers.'

'Not everyone in dentistry was receiving child protection training at the time', Jenny explained. 'But in our community dental service we had a session arranged for us. It was becoming clear the guidance and expectations outside of dentistry were greater than what we were doing in our own profession. We were getting left behind. It seemed to be accepted practice not to do anything if we had concerns about children. We didn't want to refer children to social services unless we were absolutely sure we had the diagnosis right. So generally we crossed our fingers and hoped nothing was wrong, thinking there would be another explanation.

'However, we began to see things from a different perspective. It wasn't about assigning blame, it was usually about giving families the right support. Often they were doing their best in challenging circumstances yet if we let them continue on the same path they would not receive advice and support that would help them to improve their oral health. That change in attitude and outlook was a key part of modernising the profession's input into safeguarding.'

In her own words, Jenny 'simply set out to write something that answered my own questions, produced in a format that every member of our own team would find useful', and so Child Protection and the Dental Team (CPDT) was born.

'It was important to involve every member of the dental team in this. It was clear this wasn't just an issue for specialist paediatric dentists as the majority of children in the UK are treated by general dental practitioners. The children at risk aren't just going to be seen in dental hospitals. We work together in teams – the receptionist may spot something while the child is waiting to be seen. The nurse may pick up on something while the dentist is concentrating on treating the child. Or the dentist may see something that doesn't add up. If you bring together all of those viewpoints and discuss the issue, instantly there's a more complete picture to help you decide if it needs onward referral.'

'In recent years government policy has been to delegate and empower local health decision-makers. So there will inevitably be regional and local variations in referral pathways, and over time these have grown. CPDT was designed to give every team the same basic framework on which to base their judgement and actions. That has helped keep CPDT as future-proofed as possible. It was initially funded for England only, but Scotland, Wales and Northern Ireland chose to use it too.

Even so, Jenny believes guidance documents alone are not enough. She has previously called for someone in every region who is identified as being responsible for safeguarding children.

'What is different about dental neglect, from other forms of abuse and neglect, is that dentistry plays an important part in both recognising AND managing the problem. At the outset I realised that what dental teams were already doing, and accepted as simply good preventive dentistry, was part of the solution to dental neglect. I described the Preventive Dental Team (Single Agency) Response in local guidance, which was taken up in CPDT, then expanded in the British Society of Paediatric Dentistry (BSPD)'s subsequent policy document on dental neglect in children.

> 'If you have a concern, don't ignore it. Pick up the phone and have an informal conversation about the child. This might be with your local paediatric consultant who has more experience.'

Dental teams can offer support, resources, practical advice and create an environment where oral health becomes a priority. If this proves insufficient then we can involve other health and social care professionals, the Preventive Multiagency Response, and if the situation is too complex or deteriorating we must make a child protection referral.'

Where does dentistry stack up against other healthcare areas?

'I've been really pleased at the profession's response to the guidance. Many of my colleagues in Paediatric Dentistry have embraced it wholeheartedly. The dental schools started teaching it and the new generation of graduates understand their responsibilities better and expect child protection to be part of their job in a way that previously was not the case. Meanwhile the British Society of Paediatric Dentistry has been a staunch supporter of building strategic links with other organisations, such as the NSPCC, that have children's welfare at their heart.'

Warning bells

It is not every day that dentists see patients with signs of child abuse and, generally, dentists are not in a position to assess all the factors involved. But where you have concerns about a child who may have been abused, prompt action is important.

Claire Bennett, Practice Management Consultant from the BDA said: 'It is important to listen to and observe the child. If possible, you may wish to talk to the child without their legal guardian present. Always make and retain records of what is discussed and from those observations and your records, consider whether you suspect maltreatment. This is where Jenny's earlier point regarding the role of the entire dental team becomes key.

'Where you are concerned about a child and want to report the case, your first point of contact should be your local Social Services Department. If appropriate, explain your concerns to the child and parent/carer, inform them of your intention to refer and seek their consent to do so. Being open and honest from the start results in better outcomes for the child.

'There are a number of circumstances where discussing your concerns with the legal guardian may actually be counterproductive. If you feel the discussion might put the child at greater risk, would impede a police investigation or social work enquiry, or if you suspect sexual abuse by a family member, or organised or multiple abuse, then discuss your concerns with colleagues. If they have noticed the same things or feel the same way, informal advice is available from your local Social Services Department. If you suspect fabricated or induced illness or the child's legal guardians are being violent or abusive, again this course of action is one the BDA strongly recommends.'

Claire Stevens, Consultant in Paediatric Dentistry and Vice President of BSPD, believes the key to deciding whether to start the process lies with the nous of the dental team.

'As dental professions we are very, very good at identifying something that just does not feel right. If you get that niggly feeling, then discuss it within the team. You might be the first health professional that the child has come into contact with, so don't treat it as if someone else is managing it.

'Engaging in that discussion with parents or carers can sound like a difficult thing to do but it is important to share your concerns, even if you are not absolutely sure. Look at the child's attendance history as well as how they present to you – have there been missed appointments too?

'If you have a concern, don't ignore it. Pick up the phone and have an informal conversation about the child. This might be with your local paediatric consultant who has more experience. Speak to their GP and say 'this child has high levels of caries, are they on your radar?', and quite often you will find the answer is that there is already a named social worker. If this is the case, it's your role to feed in a factual summary

to the care co-ordinator that you have that child under your care, this is the problem, this is what I'm going to do about it and I'll keep you informed throughout.

'In my personal experience I have found that a lot of the time general dental practitioners don't feel comfortable initiating that conversation with parents or carers. It may be the first time they have had to have that type of conversation with a parent. If they don't fully understand the process that comes next and the potential response from the parent or carer, then it is important to seek input from someone who can help. There are things you can put in your referral letter than indicates potential signs of neglect. For instance, a high caries rate is an acceptable basis on which to start the proceedings.

'The way in which safeguarding children has evolved means these types of conversations don't have to be covert. They're now very frank discussions. You can say – and unfortunately I have had to use this phrase on too many occasions – that you have concerns that the child's oral health needs are not being met. You can ask whether they have the adequate support they need in order to make their oral health a priority.

'If this comes from someone who is caring and knows how to progress the support for the child, it is often a very positive step. In my career only once have I had a negative comment from a parent. A lot of the time Social Services are already involved. I've even had parents thank me. There's a complete lack of understanding about the impact good oral hygiene can have on a child. It's not our job to judge – it's our job to give them the information to prevent it from happening in the future.'

When to act

As Claire points out, as a profession we are not used to highlighting cases of neglect. So when should a dentist intervene?

'If I had a child that came into my surgery covered in bruises, I'd look at a number of things and quietly appraise them in my head. I once had a case where the child had multiple dental traumas and the story just did not add up. It goes back to that niggly feeling. If it doesn't make sense, the same procedure applies. You have to be able to sleep at night knowing you've done the right thing with the child's best interests at heart.

'Bruises on the legs are different to those behind the ear. If the pattern doesn't fit the story, then be aware. It's part of the jigsaw. It's not 'see bruises do X, Y, Z immediately. There's more to it.'

According to Jenny, it comes down to one thing; judgement. 'Individual cases require careful clinical judgement, she added. 'Assessing dental neglect is complex, so to a point you can understand the reluctance. Just because a child has severe dental disease doesn't mean they're neglected, but is doesn't mean they're not neglected either. I find NICE's 'When to suspect maltreatment CG89' document really useful I use the quick reference guide which is designed to educate and be a reference point for any healthcare professional. It is very useful for defining when to consider and when to suspect neglect, for working out how concerned you should be.'

But where does dental neglect become neglecting a child's welfare?

> 'The dentist might be the treatment co-ordinator, but the pieces of the puzzle are often filled in by the rest of the dental team.'

'The concern is whether the child has obvious dental disease that impacts on their life and isn't being taken for treatment. A sustained pattern of repeated general anaesthetics for tooth extraction because of dental decay would likely be considered neglect. A child not eating because of painful teeth or losing sleep because of untreated dental infections are other examples. '

'When we were putting the document together one of the key points we wanted to make in the guidance is it is not your responsibility as an individual to diagnose child maltreatment. That's for an experienced body of child protection professionals. If you have concerns then we encourage you to raise them and leave other more experienced people to take it further.'

Claire's view comes back to an integrated healthcare approach. 'This would be where the dental team comes in. My receptionist once saw a parent yelling profanities at a child and then clipping them round the ear. She told me it made her uncomfortable, and my dental nurse witnessed something similar during a previous visit. It's about connecting as a team. The dentist might be the treatment co-ordinator, but the pieces of the puzzle are often filled in by the rest of the dental team. Information sharing is how this will work. If we share information – even in the informal way I've highlighted – we will make the right decision.'

Example of a preventative single agency response to dental neglect: a team approach (applied to a 4-year-old child with caries who only attends when in pain)

Guide for action	Action required	Suggested team member/s responsible
Raise concerns with parents	Explain clinical findings, the possible impact on the child, and why you are concerned	Dentist
Explain what changes are required	Explain treatment needed and expectation of attendance	Dentist
	Give advice on changes needed in diet, fluoride use and oral hygiene	Therapist, hygienist or dental nurse as appropriate
Offer support	Consider giving free fluoride toothpaste and brush	Dental nurse
	Offer the parent or carer a choice of appointment time	Dental receptionist
	Listen for indications of a breakdown in communication, or parental worries about the planned treatment, and offer to discuss again or to arrange a second opinion if this is the case	All team members
Keep accurate records	Keep accurate clinical records	Dentist and/or other team members
	Keep accurate administrative records of appointments and attendance	Dental receptionist
Continue to liaise with parents/carers	Keep up open communication with the parents and repeat advice, so that they know what is expected of them	All team members
Monitor progress	Arrange a recall appointment	Dentist
If concern that child is suffering harm involve other agencies or proceed to make a child protection referral	Consult other professionals who have contact with the child (e.g. health visitor, nursery nurse) and see if your concerns are shared	Dentist
	Take further action without delay if indicated	Dentist

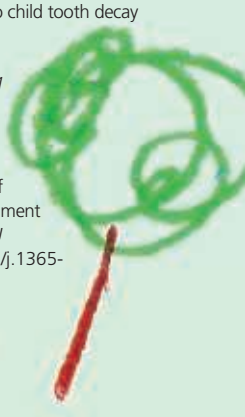
Reproduced from CPDT with permission of Harris *et al*, 2006.

Since the introduction of CPDT there have been great improvements in suspecting, monitoring and safeguarding children. The document is now second nature for many practitioners. Claire believes it encourages the notion of 'flattening the hierarchy' – everyone has a role to play in safeguarding, so speak up. While there is always room for improvement – better integration with school nurses and health visitors and how practitioners monitor patients not brought to appointments, dentistry remains a key component in ensuring children get the right start in life. Jenny believes we have got better at recognising signs of child maltreatment and at referring, but she also thinks it adds an extra workload for clinicians and that hasn't yet been recognised.

Much like the profession it serves, CPDT will have to move with the times. As Jenny points out, locally-organised training is now more readily available, but is still not always sufficiently relevant to dentistry. Child protection in dentistry is still an emerging field and will benefit from advances that add to the evidence-base. As Kofi Annan said, it is our responsibility to ensure the welfare of children is protected. Their future is in our hands. ◆

1. News release: Charity responds to child tooth decay hospital admissions. 14 July 2014. Available online at: *www.dentalhealth.org/news/details/801* (Accessed October 2016).

2. Harris J C, Balmer R C, Sidebotham P D. British Society of Paediatric Dentistry: a policy document on dental neglect in children. *Int J Paediatr Dent* 2009: doi:10.1111/j.1365-263X.2009.00996.x.

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The art of flexible thinking

Bob Hughes,
CEO of the Forton Group

In his regular series, Bob Hughes talks about the art – and necessity – of flexible thinking

I'm often asked the question 'are good leaders born or made?' Most people can lead well, especially when they receive the right training and development needed to get to that point. The way that one person leads will be radically different from the way another person leads.

We all build on the strengths we've got and lead from a combination of those strengths. Add to this our internal value set, and our choice of leadership style, which depends upon the context in which we find ourselves.

The formula for leadership success is simple: develop your leadership competencies; choose the right leadership style, and apply both to the situation in which you find yourself.

A few years ago I was working with a US computer company. We bought one of their brand-new machines and, just before Christmas, something went wrong with the operating system. The company flew two teams into the UK and set them off in competition with each other to solve the problem. The team that solved the problem quickest were offered the option to bring their families out and spend Christmas at the company's expense in the UK. Not surprisingly, a solution emerged, probably quicker than it otherwise would have done. The two teams very quickly worked through a number of different solutions until they picked the correct one – time pressure helped them quickly evaluate and discard options.

Quite often, when faced with a problem, especially an intractable one, we sit around scratching our heads until, eventually, someone comes up with an idea. The risk is, we all leap on it and try and implement it. The problem is that, whilst it may be the first solution, it isn't necessarily the best.

The 'flexible thinking' behaviour is about looking at the problem from as many different angles as possible, then coming up with a range of equally plausible solutions and assessing them against each other. Only after this process does implementation happen.

> 'Be careful before rejecting any ideas. It can be useful to look back at ideas that have been rejected in the past and see, with hindsight, whether any of them might actually benefit the organisation.'

There are many techniques for brainstorming ideas and looking from different perspectives. Edward De Bono' 'six hats' concept is one of the most famous; and there are other, equally successful, ways you might approach this.

Start by thinking about the different stakeholders in your project and imagining what they would say. Get creative, what would an alien think about this? What would a child think? What would an engineer think?

The secret is to free up your brain from the traditional thinking channel that you have been in.

Another way of looking at this behaviour is to have a 'Plan B'.

Turkish Airlines, one of the fastest growing airlines in the world, started to use psychometrics when recruiting for cabin staff, around 10 years ago. They analysed the factors they believed would be most important in the personality characteristics of those staff.

One of the key elements was flexible thinking: both the belief that there could be an alternative and the ability to craft those alternatives.

Having a 'Plan B' in the event of an aeroplane crisis is critical and one that we could all agree on!

When motor engineers were set the challenge of accelerating a 1½ ton vehicle from 0 to 60 mph in less than five seconds, they were stuck. It could be done, but the challenges to the internal combustion engine were huge.

When the same problem was given to hydraulics engineers, they created a process of capturing and storing energy in hydraulic fluids as a vehicle decelerated, and using the hydraulics to accelerate when needed. As an idea, it was unlikely to ever be commercially

viable, but it shows how a radically different approach might come up with an idea, on which you can build.

It helps if you can get a group of people together to co-create this range of ideas. Your role is not to defend your particular idea, but to see the positives in all the ideas. Keep an open mind.

A useful phrase here, when somebody comes up with an idea that you cannot instantly see as being valid, is to say 'What I like about that idea is…' because by the time you finish saying those words, there will be a nugget of something in their idea which you can latch onto and build upon.

Be careful before rejecting any ideas. It can be useful to look back at ideas that have been rejected in the past and see, with hindsight, whether any of them might actually benefit the organisation.

When you do have a number of different viable alternatives, be disciplined and rigorous in the way that you assess them. Involve other people in the debate. Make sure you do a proper option appraisal. Create a process if necessary, looking at all the factors that would impact on the decision and weight them if necessary.

Map out the implications and impact of each solution on the organisation. Look at what contingency plans you might need to put in to manage any risks that emerge.

Try to be as logical, objective and analytical as possible. It's amazing how often we make a decision on some gut instinct, an emotional attachment to an idea, or a predetermined stance. We then selectively use the facts and logic in a way that justifies our decision that was arrived at in a subjective way.

> 'In our lives, the scale of the decisions we make may be different, but getting the right solution in order to create the right outcome can have a huge impact on the people who are reliant upon us.'

Think about the friendly arguments you've had in the past with friends, perhaps about your favourite sports team, your political party or favourite film star. However valid your argument, I imagine you didn't shift their view. So, watch out for your own bias coming in during the appraisal of the options.

As you are analysing and evaluating various solutions, be open to the possibility that the solution you eventually choose may be an amalgam of more than one.

Another possible outcome is that the idea that is rejected might have a completely different application. By involving a wide range of people with different perspectives, you are more likely to spot those and put them to use elsewhere.

An employee of 3M sang in a choir as a hobby. One evening, he was shuffling through the book, picking which song was next. He had used scraps of paper as bookmarks and they kept falling out. He then remembered a conversation with a colleague at work, who was complaining that his attempts to create a new adhesive were going badly – the glue wasn't sufficiently sticky to be useful. He instantly saw a different application and the Post It note was invented.

And, like the software teams I opened this section with, get creative about the rewards and acknowledgements you give. When people see that the behaviour you are looking for is creating multiple solutions, assessing them, in order to create a viable option, then people will start to behave in this way.

Competitiveness and tribalism can be harnessed for good, though you need to be wary that they don't lead to entrenched thinking; or people defending their positions without heed to the bigger picture.

When you become familiar with, and adept at, creating solutions and analysing them, encourage this behaviour in others. Where there are opportunities to create teams to look at problems, make them as diverse as possible. Bring different skill sets, different perspectives, people of different ages and from different backgrounds. The broader the thinking involved in solving the problem, the more variety of solutions you are likely to create, which enhances the prospect of getting the best one.

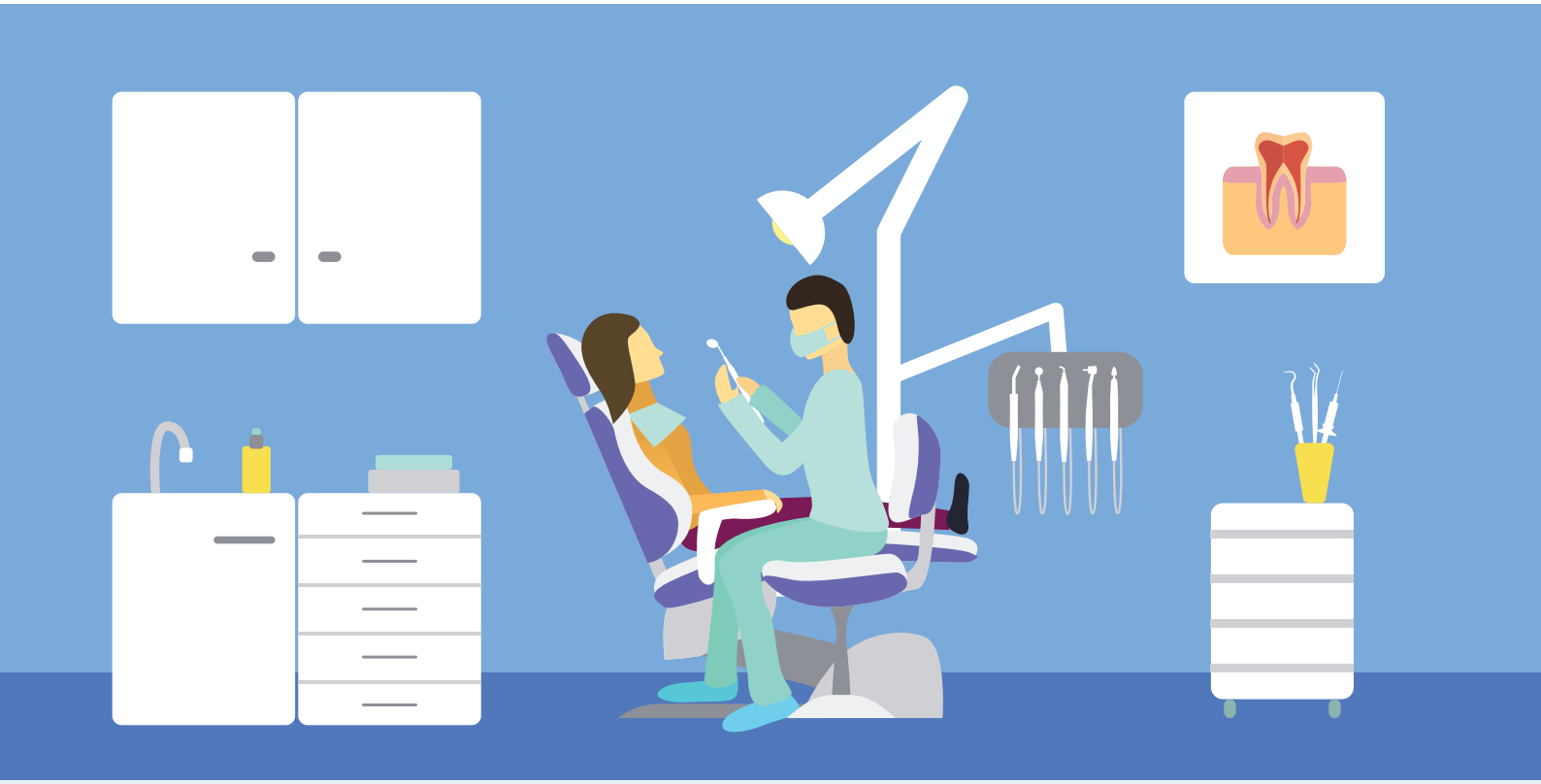
There is a theory that it's more important to get the timing of the decision right than it is to get the decision right. Timing is believed to be a quality of strong leaders. There's certainly a place for speedy decisiveness in leadership, but it is overrated.

When Barack Obama was elected President of the United States, he was under pressure to start a bombing campaign. He said he wanted to reflect on the situation, and might take time before coming to a decision. He was criticised for being 'weak'. I argue that's exactly the kind of decision that you need to think long and hard about and I applaud him for saying that and avoiding such actions.

In our lives, the scale of the decisions we make may be different, but getting the right solution in order to create the right outcome can have a huge impact on the people who are reliant upon us.

Next time we'll start with the 'Involving Cluster' and explore the behaviour of 'Empathy'. ◆

If you'd like to contact Bob Hughes about any of the points in this article, contact him at bob.hughes@thefortongroup.com.



Finding the right solution

Dentists spend at least five years of their life training to be extremely but specifically skilled. They become experts in the art of dental care, but what happens when they progress through their career and want to open or run a practice of their own? Where do they get their business acumen from? **Andy Sloan**, General Manager, Business Solutions, talks to *BDJ In Practice* about one crucial area of business – marketing.

'Marketing is of growing importance for today's dental practices' Andy said. 'What we find is increased competition both on the high street and from corporates, a more orally health-aware and discerning public who are demanding communication in a variety of ways including via digital means allied with a need for practices to attract new patients and engage more proactively with existing ones – particularly in the face of increased pressure on NHS finances – means that practices need to enhance their profile and differentiate their offering from others as the fight for new patients intensifies.'

For some practice owners or managers, the time needed to dedicate to marketing simply does not exist. As Andy says, the increased pressure on NHS finances means that quite often priorities become skewed. Practice marketing can, in some instances, simply not be enough of a priority.

In order to ensure your practice attracts and retains patients, Andy believes there are three golden rules behind a successful marketing campaign.

'The first thing I would say is to identify your goals. Most dentists make the mistake of lunging headfirst into marketing activity, but the best plans are those which aim to achieve specific targets. Personal and professional goals are vital if marketing is to deliver the results a practice principal is looking for – whether this is increased revenue, working on more challenging cases or more time to spend on the golf course – everyone's goals are different and marketing a practice effectively can help achieve these things if they are identified from the outset.

'The second is planning. Nothing was ever achieved without a well thought out plan. You wouldn't dive into treatment without planning what you're going to do beforehand, and marketing is no different. This should include targeting the right patients, at the right time, with the right message. By having a robust planning process dentists can think through the marketing journey and create messages which resonate with patients in the most effective way.

'The final thing is measurement. Measuring the results of a particular activity enables tweaking with the campaign to achieve better results next time round. Defining what constitutes success is down to the individual practice but the most common criteria would be in terms of enquiries, appointments booked, treatment uptake and revenue. For example software such as SoE's EXACT V12 enables practices to measure return on investment in financial terms through its Marketing Manager module. Failure to adequately measure success means that dentists largely base future decisions on gut feeling rather than on factual evidence.'

Andy's point regarding planning is one all dentists should be able to resonate with. If you are a practice that adopts skill mix, an integrated approach is another aspect of marketing mirroring general dentistry.

But why is it so important for marketing? 'Integration is a fundamental cornerstone of successful marketing', Andy said. 'There are now numerous channels by which practices can engage with potential and existing patients and making sure that communication utilises all the most appropriate channels ensures the best results.

'In the same way dentists need to make sure that marketing and promotions are integrated with other aspects of the practice and take into consideration things like chairtime capacity, treatment blend, reception team capabilities etc. There is nothing worse than having a successful campaign but one which overwhelms the practice in terms of the ability to deal with enquiries or one where patients have to wait several weeks for an appointment. Ensuring that not only communications are integrated but also that the practices logistics are integrated with the promotion ensures that demand generated from a campaign can be met.'

That's not to say some dentists don't get marketing. In September's *BDJ In Practice*, Nicki Rowland and Shiraz Khan highlighted what they believe are the key facets of marketing from two completely different angles. But not everyone is as competent.

'One of the most common mistakes relates to the point above and is that dentists tend to organise their marketing on a very *ad hoc* basis. This means they look at their appointment book and decide that they should promote hygiene for example as a one- off, rather than creating a plan designed to meet specific goals', Andy explained.

'From my experience dentists are also reluctant to set budgets for marketing. Marketing spend in UK practices is exceptionally low (around £500 per annum on average)[2] and therefore the returns are similarly low. Rather than regarding marketing as 'spend' dentists should be encouraged to view this as investment and expect a reasonable return.

> 'Most dentists make the mistake of lunging headfirst into marketing activity, but the best plans are those which aim to achieve specific targets.'

'Practices also need help in terms of compliance. These days thanks to digital communication dental practices, like many other services are 'rated' according to their service levels – this is happening whether they like it or not. Practices need to manage this aspect of their public profile and ensure their patient communication ticks all the right boxes for CQC and GDC compliance.

'Practices struggle with executing campaigns – often consultants are used by practices who give them lots of advice and ideas. Business Solutions has a network of industry leading partners able to deliver the marketing collateral necessary to create campaign and analyse results.'

So what are the options for those who need some guidance?

Third party consultants tend to help practices by ensuring that marketing remains a top priority. By setting goals and agreeing the tasks which need to be completed, external consultants can be the driving force behind successful marketing campaigns.

Andy added: 'I know that Business Solutions consultants are also able to analyse the individual practices data which gives firm evidence of where the practice is and where the best opportunities lie. This Practice Analysis is a great start to any marketing activity and uses data taken direct from the practice's management system. This gives a great benchmark against which to assess the results of any activity.

'Having a third party sounding board is helpful for any business, but particularly those, like dental practices where the owner also works in the business. In this scenario it is sometimes difficult for dentists to prioritise anything other than treating patients and they can become entrenched in detail which stops them from seeing the bigger picture. An independent objective view is very helpful in these situations.'

According to Andy, the practices which get the best results are those in which the principal is 'driving the marketing forward and which has 'buy-in' from the whole team'. This involves the principal keeping the team informed about why and how they are executing various campaigns so that everyone understands the messages and crucially the part they play in making the campaign a success.

Rather like dentistry, marketing is a fast-flowing, ever-changing sphere. Traditional marketing methods such as letters, posters and flyers still have their use, but more and more practices are embracing digital ways. Emails, social media and even text reminders play a vital part in speaking to the right patients in the right way. The clamour to be one step ahead of the competition is now two or three. With the right support, you might just end up adding marketing expertise to your list of skills. ◆

Expert members can get advice from www.bda.org/marketingadvice.

How to get the best out of placing a job ad

Finding the right person for your practice starts with placing the right advert in the right place. A well-constructed job advert acts like a magnet to help you attract better candidates. The job advert you place can promote your reputation to attract able recruits and by demonstrating your professionalism may discourage weaker candidates from applying.

Of course you will want the best candidate for the job – who doesn't – but according to Neeta Udhian, BDA Practice Management Consultant, you shouldn't rush into it.

'Sit down and take some time to figure out what your idea of the best candidate looks like. Any job advert is an opportunity to paint a picture of your ideal candidate. Before you write it, draft out the job description and person specification. The more information you give, the more likely the right candidate will find you. Getting it right the first time has huge benefits too. Time, wages and unnecessary staff turnover are all areas the right job advert will take care of'.

The recently re-launched BDJ Jobs website enables recruiters to do this. With more than 7,000 new applications since the re-launch, improved SEO means recruiters can reach out to their target audience more effectively. So how does it work? Classified Advertising Manager, BDJ Portfolio James Richards, discussed the new additions.

'We have introduced a number of features we believe will benefit recruiters and job-seekers. The biggest change is the benefit to BDA members. If you wish to place an ad, you can get 15% off, which is up to £100. As an additional benefit listings for dental nurses and practice support staff are free. Job seekers can also now apply to your vacancies with ease from their phones.'

In order to get the best response from your job advert, here are James' and Neeta's eight key points to bear in mind.

Use a clear job title

'Think about this in really simplistic terms', James explained. 'The fewer words the better. Try to make it something that people would search for. Part time dental hygienist, for example, would be a good listing. It's clear and unambiguous'.

Include a detailed job description

Neeta said: 'The job description should confirm the title of the vacancy, its purpose and objectives and the main tasks and responsibilities of the job holder. The person specification identifies the qualifications, level of experience and skills required for the post. These are vital for evaluating candidates when it comes to shortlisting and interviewing.

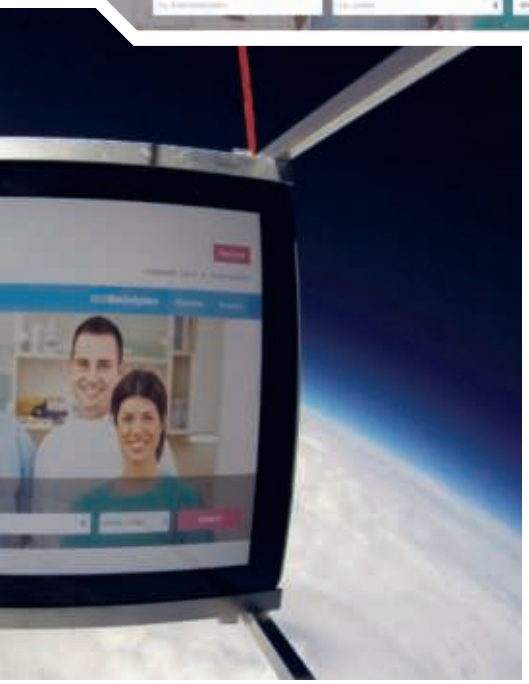
'BDJ Jobs will now allow you to include as much information as you want, so go into detail. That way you can be specific with the job description. This gives you the opportunity to list the job satisfaction that can be gained from the role, team camaraderie, opportunities for training or career progression and any other benefits such as treatment for staff or gym membership. Describe the practice environment, you might state that your practice is friendly, family run, busy, a diverse team or fast-paced. The more information the better.

'Importantly, tell the applicant what action you want them to take. Once the right candidate has found your advert and decided that you are offering what they are looking for, they need to know how to get in touch. Include an email or postal address and be specific about your requirements. State whether you want the applicant to send in a CV and covering letter or fill in your standard

application form. Give a prominent deadline by which they should respond. It may be helpful to provide a telephone number so prospective applicants can call and discuss the role with you before submitting their application. This will provide you with an opportunity to tell the candidate more about the practice and what you can offer as an employer.'

Include location details

An often overlooked area. If you can include the nearest tube or train station in your advert, it is more likely to appeal to the right candidate. James explained: 'Job seekers can sign up to job alerts that will go straight into their inbox. Every listing is up for 30 days, which gives you a better chance of finding the right candidate.'



Include salary information

'It's a good idea to highlight the rate of pay', Neeta added. 'You may not wish to fix this until you make a job offer as you may want to make a higher offer in order to attract experienced candidates who may already be in employment, but it is important to give an indication in order to attract interest. Sometimes employers make the mistake of omitting crucial information such as salary details when placing adverts!'

Make your advert mobile friendly

BDJ Jobs is now fully compatible with mobile and tablet devices. With 50% of traffic coming from mobile, James believes this is a key element to the new design.

'The new site allows these job seekers to apply to your jobs with ease from their mobile devices. A recent study found that 30% of job searches are carried out during the daily commute to work and 12% of job seekers applied for jobs from the comfort of their bed.'

Develop your employer brand

I would consider outlining your achievements to potential applicants', Neeta suggested. 'If you have been established for a number of years or have a steady and loyal patient base, tell them about it! This shows the candidate that they will be joining a stable and well known practice. Mention it if you have just had a refurbishment, a modern newly refurbished practice with all the latest gadgets will be appealing to many candidates. Further qualifications that you hold or any awards that the practice has won. You get the idea.'

'Being able to fully customise your 'recruiter profile' gives you the chance to build your brand and include Neeta's points', James explained. 'A potential applicant can click on your profile to be met with a practice banner, video content, images and anything you think would benefit you. It adds a different dimension to the previous BDJ Jobs website. This gives applicants the chance to get a look and feel of what you're about. It could be the difference between their application landing on your desk or someone else's.'

Search relevance

It goes without saying that if you are looking for someone with experience of the dental industry, a good place to advertise is somewhere where you know individuals with dental experience or those wanting to work in the dental industry will be looking for your jobs. According to Neeta, niche jobs boards such as BDJ Jobs is perfect for these types of vacancies.

Discount codes for members

- Enhanced = BDJenhanced
- Promoted = BDJpromo
- Essential = BDJessential
- Nurses & Practice Support = BDJnurse.

The same applies to keywords throughout the advert. Here are some of Neeta's suggestions for a good ad:

- 'The practice has been established for more than 20 years'
- 'Work is a recently refitted surgery'
- 'Fully computerised'
- 'Award winning'
- 'Experienced team'
- 'Friendly team'
- 'Diverse team'
- 'Develop your career'
- 'Flexible working hours'
- 'Patient base of over 4,000 private patients'
- 'Large'/ 'small'/ 'busy'/ 'friendly'
- 'Minutes away from transport links'
- 'Three surgery practice'

Remember to be equal

Adverts cannot be discriminatory – the Equality Act 2010 legally protects people from discrimination in the workplace and in wider society. Therefore you must not set requirements for age, gender, race or national origins, sexual orientation, able bodied, marital status or religion in your advertisement. And do not use inappropriate language or wording that might be considered discriminatory, such as describing your ideal candidate as 'he' or 'she'. ◆

BDA Expert members can access a standard application form template at www.bda.org/ExpertSolutions

For further information see www.bda.org/advice for the BDA's advice document Recruiting staff.

Contact the BDJ Jobs team on 0207 843 4729 or email bdj@nature.com if you have any questions.

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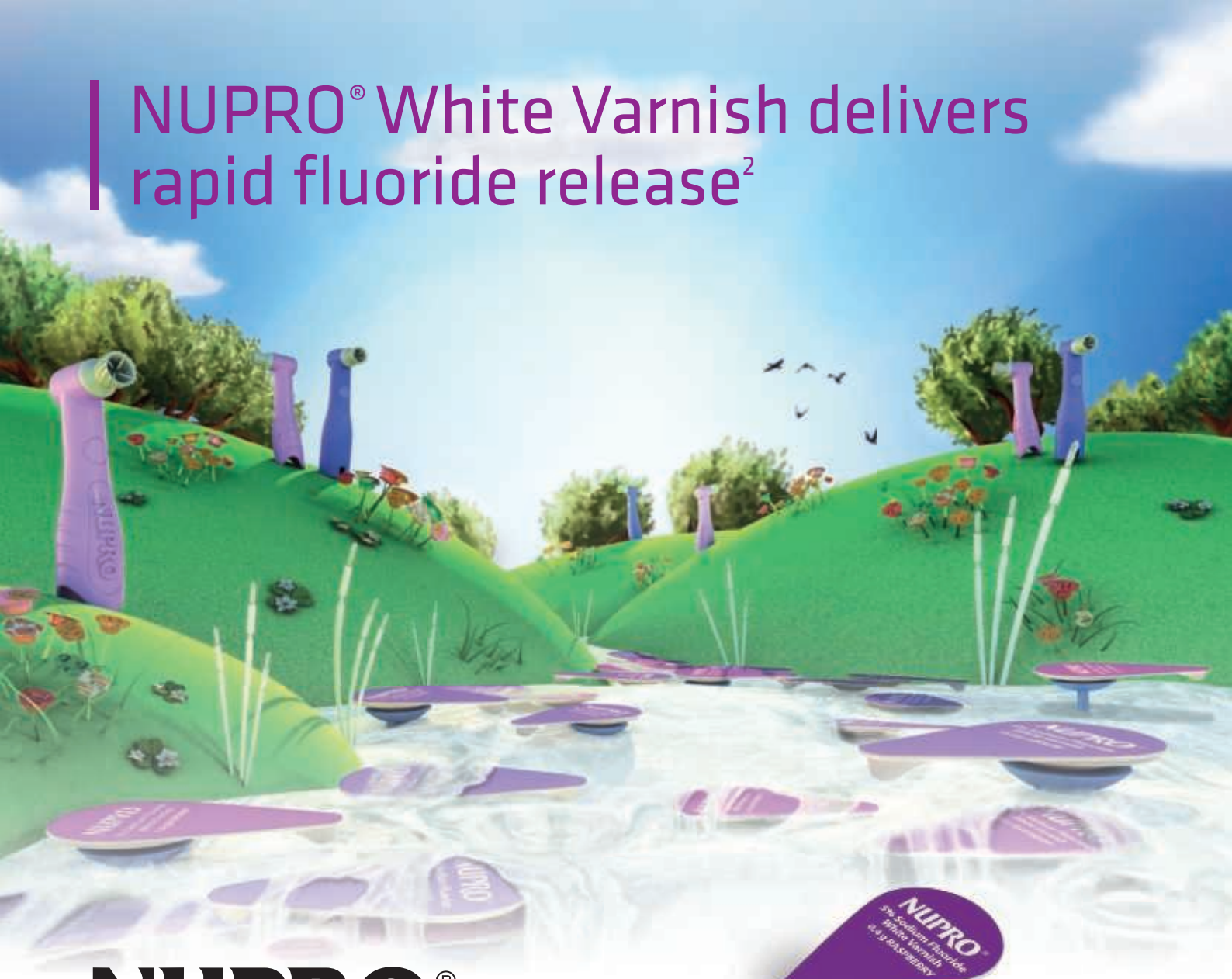

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References:
1. Data on file, Dentsply Professional.
2. Compared to competitive varnishes. Data on file.

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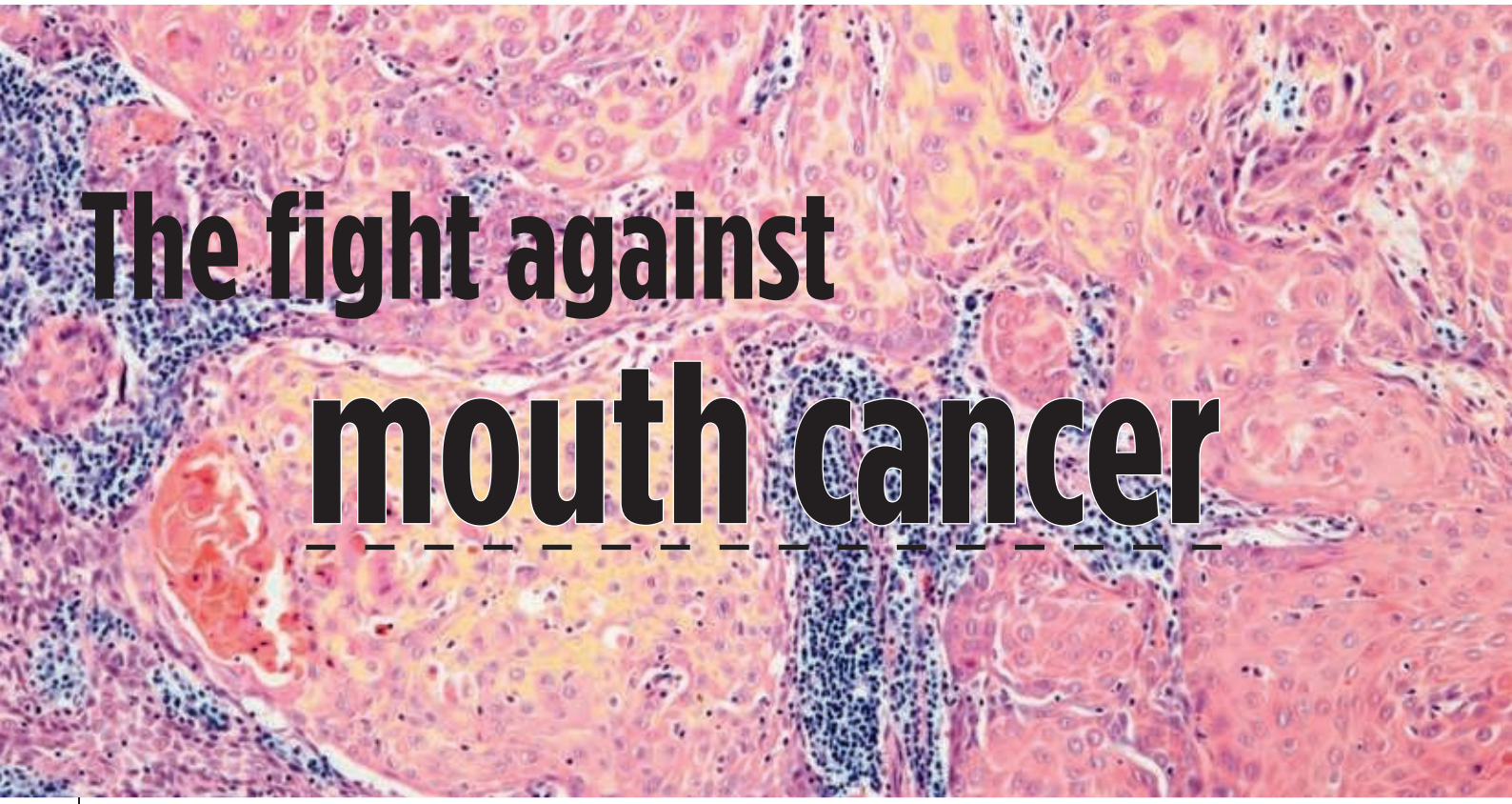

The fight against mouth cancer

Mike Lewis

Professor Lewis is Professor of Oral Medicine and Dean of the School of Dentistry at Cardiff University. He is a past President of the British Society for Oral Medicine and a past Dean of the Dental Faculty of the Royal College of Physicians & Surgeons of Glasgow.

Chet Trivedy

Dr Trivedy is Honorary Associate Clinical Professor at Warwick Medical School.

In 2013, there were 7,591 new cases of mouth cancer[1]. In 2014, 2,386 people lost their battle with the disease.

However startling those figures may – or may not – be, what they don't tell you is the 40% increase in a decade. Mouth cancer is one of the few variations of the disease on the rise, which makes our job ever-more important.

With Mouth Cancer Action Month around the corner, **David Westgarth** spoke to Professor Mike Lewis and Dr Chet Trivedy about the disease, our role and the future.

Given these statistics, why do you think we don't see more about the disease in the press?

CT The absence of high-profile cases doesn't help with awareness levels. Michael Douglas and John Diamond may be the exceptions to that rule of course, but I don't think people realise just how much of a killer it is.

There's also a lack of a joined up approach. There are very few – if any – campaigns on this outside of dentistry. Boundaries for Life is a charity I'm involved in that tries to highlight the disease on par with blood pressure, cholesterol and diabetes through health checks at large sporting events. Men are more susceptible to mouth cancer than women, which is why sports events are great for reaching the target demographic.

ML We see a lot more now than we did 20 years ago, so there has been some progress. I think an all-round improvement in awareness allied to the great work a number of charitable campaigns and causes like Chet's have made a substantial difference.

There is – and always will be – room for improvement. We did some work here at Cardiff University on the number of times it was mentioned in the national press. The general public's awareness of the disease lags behind testicular and breast cancer, for example. On a number of occasions when I have been heading back to the station from giving a lecture somewhere in the UK, the taxi driver often asks me what the topic of my talk was, more often than not they've never heard of mouth cancer and a barrage of questions follows!

What are we doing to try and get ahead of increasing incidence rates?

ML The problem is that mouth cancer is often symptom free. Patients do not notice

anything unless they're shown or told what to look for. Recurrent mouth ulcers would prompt them to seek help because they hurt. Mouth cancer is silent and deadly. We need to get people looking for the right signs and symptoms. We need to get them to act on anything they see that might be unusual.

CT Those kinds of things Mike are done through the large number of campaigns that take place. The GDC's move to make mouth cancer a core CPD topic was a big step in the right direction, but I feel we need to take that on to more medical spheres. The notion of inter-professional learning is huge. If mouth cancer detection is taught across pharmacists, nurses and GPS, who we know patients go to because they're free at point of access – then they're instantly in a better place to make a referral.

ML Chet is right. Gaps exist within the medical profession on this. A pharmacist must know to ask how long the ulcer has been present.

Chet mentioned Michael Douglas earlier. To what extent is HPV redefining the nature of the disease?

ML The sites we are discovering lesions is changing. HPV positive cancers are often located in the oropharynx.

CT It's changing the nature of how dental professionals tackle general health issues such as smoking, alcohol with the patients. Everyone knows that alcohol and tobacco can increase the risk of developing mouth cancer. Explaining that certain sexual practices could do the same is trickier. Dental professionals just aren't used to having those conversations. A patient may be comfortable – or at least be expected to talk to their GP about sexual history, but not with a dentist.

ML This is why it's absolutely vital the HPV vaccination for adolescent males is introduced sooner rather than later. There is little doubt in my mind that the campaign for the vaccination is strong. I was one of 100 people who co-signed HPV Action's petition for this, and also recently had a letter published in the *Times*. I've read that the Health Minister supports gender neutral vaccinations, so I'd hope for no further delay.

As a profession are we too pre-occupied with meeting targets and UDAs to spend enough time with patients to effectively give them all the information they need to lower their risk of mouth cancer?

CT It's my opinion that the dental profession works incredibly hard within the framework of the current contract. The majority of dentists are extremely vigilant on this, but the way in which renumeration is structures really tie their hands. The drive towards targets is not always patient-friendly. It's often routine dental work that is mentioned. What we need is a system that allows dental professionals to address common risk factors such as smoking and sugar consumption that are linked with diseases such as oral cancer, cardiovascular disease obesity and diabetes as well as dental diseases such as caries and periodontal disease.

> 'The GDC's move to make oral cancer a core CPD topic was a big step in the right direction, but I feel we need to take that on to more medical spheres.'

ML The pressures of delivering care in a target-based way drives them to offer care in a certain way. I've long proposed the need for a fee for detecting mouth cancer at an early stage. What's the alternative? Expensive, invasive surgery followed by complex restorative work that costs the NHS significantly. If a lesion is found when it's 2cm then we can work with that. Late presentation when the cancer is greater than 4cm and we're looking at a neck dissection and major reconstruction work. It's more cost effective all-round if we can implement a 'detection fee'.

What do you think the profession can do better?

ML Aside from a complete and thorough examination, we need to raise awareness with patients. We don't want to cause undue worry and start a cycle of false positive diagnoses, but we do need to bring more attention to it.

CT That's where campaigns like Mouth Cancer Action Month come in. If the profession throws its weight behind that, we will raise awareness across the profession, in waiting rooms and to the general public.

For me, the key to all of this is being open-minded. Why not look outside the profession? Boundaries for Life attracts a lot of attention because it's an opportunity for a free mouth check. Normally you have to pay for that, so improving access is definitely up there. It opens the door to inequalities too. Breast cancer and testicular cancer patients don't have to pay for a check up if they find something suspicious. Why is that not the case for mouth cancer patients?

ML Mouth cancer needs the same support – at the very least financially – as some more high-profile forms of the disease that perhaps don't claim as many lives.

CT That's absolutely correct. All it takes is a pair of gloves, a mirror and lights to perform a mouth cancer check.

Looking ahead to the campaign, what do you hope it achieves?

There is a lot of great work being done to highlight mouth cancer all year round. There may be a national month-long campaign, but mouth cancer doesn't take 11 months off.

Getting public, government and support from across the dental profession – and outside – would be fantastic. We have to look beyond the dental profession to tackle this. Mouth cancer sits between two very specialist healthcare areas, so we need support.

ML Given there are a multitude of different ways in which mouth cancer can manifest and patients present with, we need to get the message out there that although a noticed lump or ulcer is highly likely to be a benign nothing, it is essential to get it checked out anyway. I have had a few patients in Cardiff where we almost didn't go ahead with the biopsy. We are certainly glad we did since the dental team were surprised with what was found.

If we get this, then we have every chance of saving lives. I remember finishing a talk in West London earlier this year where a lady came up to me and said 'Mike, you saved my life. I heard your talk last year advising to get any abnormality looked at. I found something I wasn't sure about, got it checked out and it turned out to be a tumour. Without you I wouldn't be here'. It's stories like that which make me even more determined to find new ways in which to tackle the disease. ◆

Mouth Cancer Action Month takes place throughout November. To pledge your support your support to the campaign visit http://www.mouthcancer.org/support

Cancer Research UK. Oral cancer statistics. Available online at http://www.cancerresearchuk.org/health-professional/cancer-statistics/statistics-by-cancer-type/oral-cancer (Accessed September 2016).

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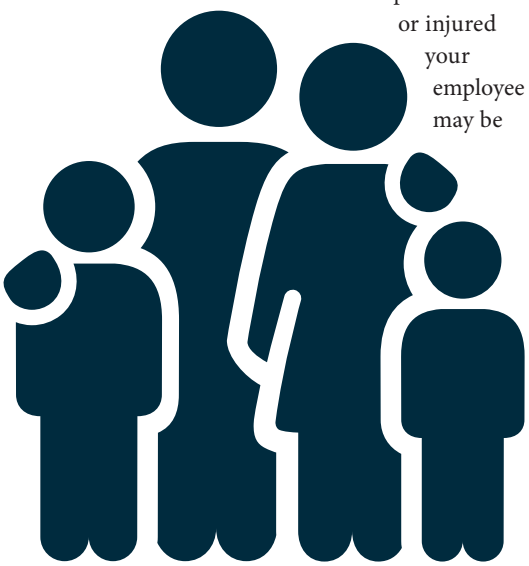
Time off for Family and Dependants

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

The right to take unpaid leave to deal with an unexpected event involving a dependant – a domestic emergency – applies to all employees. A dependant in these situations is the employee's spouse or partner, child or parent, or someone living with the employee as part of the family.

There is no qualifying period, this right applies from the moment employment starts and you cannot penalise an employee for taking the time off, provided their reasons are genuine. The amount of time off work, however, must be reasonable – it should be no more than is necessary to deal with the immediate problem and make any arrangements that are needed. There is no set amount of time allowed to deal with an unexpected event it will vary depending on what the event is, but for most cases a couple of days should be sufficient.

A domestic emergency can cover a number of situations from the illness or injury of a dependent to the death of a dependent.



When a dependent is ill or injured your employee may be needed to provide care or emotional support. If the dependent is a young child they may not be able to go to their regular childminder or nursery. However, other relatives, say a grandparent, may be able to help out. Also it is generally reasonable to say to the employee that their partner, if they have one, should share the responsibility (and, if need be, ask their employer for time off). Normally only one parent can expect to have the time off at once, but there would be exceptions, such as the child being very seriously ill, having an accident or undergoing a major operation.

It may not be personal illness or injury, domestic emergencies can concern a disruption or breakdown in normal arrangements. This might be a childminder being ill, dealing with an incident which occurs unexpectedly at school. What is an unforeseen event has been stretched by the case of Royal Bank of Scotland plc v Harrison[1], where the Employment Appeal Tribunal found that a mother who had two weeks' notice that her childminder would not be available. The mother could not make alternative arrangements for her children during the fortnight and so took time off to care for them. The court still found in her favour, that the time off was necessary and reasonable in the circumstances.

It is often known as compassionate leave when a family member dies and the employee needs to make funeral arrangements or attend the funeral. Strictly speaking the legal right to leave only applies if the deceased is a dependent. However, it would be unreasonable not to allow time off if another close relative, say a grandparent has died. In any case your employee may need to comfort a dependent in these circumstances. If they need to travel a long distance for a funeral or even abroad then discuss how long the journey will take, they should only have as long as is necessary and you may need to discuss other arrangements, such as annual leave, if they want to take extra time.

Generally, as long as the circumstances are appropriate and genuine, there is no limit to the number of times you can take time off for dependents. Though, if major disruption is caused by a particular employee taking large amounts of leave you would need to seek independent advice on how to handle the situation.

There is no legal obligation for you to pay for emergency or compassionate leave. It is at your discretion if you do provide paid leave but you must always show consistency if you do so. Good practice would be to make it clear in the employment contract or leave policies whether an emergency is paid or unpaid but that would also make it a contractual commitment.

Other situations that could be seen as domestic emergencies are not covered by this specific right. There is no automatic legal entitlement to leave for household problems such as fire, flood or burglary, but it would be unreasonable to penalise an employee in such situations. If there is an urgent issue that requires immediate attention then the employee should be able to ask for unpaid time off to take the immediate practical steps. As a rule of thumb the problem must have caused a major disruption to their living arrangements and the tasks that they want to do to deal with it should be ones that cannot wait. ◆

1. Royal Bank of Scotland plc v Harrison [UKEAT0093/008; [2009] IRLR 28].

Practice fire precautions

by Lynn Woods
a Health and Safety adviser 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.

Your practice's fire precautions should be appropriate for your individual practice. As you are no doubt aware, it is your duty as the practice owner or employer to ensure, as far as is reasonably practicable, the safety of staff, patients and visitors at the practice. For fire safety this means having in place a suitable and sufficient fire risk assessment, appropriate fire precautions and an emergency plan – all of your staff need to know what to do in the event of a fire.

In your risk assessment you need to identify fire hazards – potential sources of ignition, fuel, and oxygen; and consider anyone who may be especially at risk. Eradicate or reduce risks as far as is reasonably practicable and separate flammable/explosive materials from sources of ignition, both in use and whilst storing. Record your findings, especially any potential fire risks or issues affecting escape routes, this is compulsory if you employ five or more people.

Fire-detection and warning system

Your system can range from a shouted warning (in simple single-storey premises) to an electrical detection and warning system but it must be able to warn people in all circumstances. In larger practices where an alarm given from any single point is unlikely to be heard throughout, an electrical fire warning system incorporating sounders and manually operated call points (break-glass boxes) is likely to be required.

Firefighting equipment

In premises with a simple layout, having one or two portable extinguishers of the appropriate type, readily available for use, may be all that is necessary. In larger or more complex premises, a number of portable extinguishers may be required and sited in suitable locations, for example by the escape routes. As a rule of thumb you should have one extinguisher for every 200 square metres of floor space, with at least one on each floor. It may also be necessary to indicate the location of extinguishers by suitable signs. All staff should be familiar with the location and basic operating procedures for the equipment provided. But note people with no training should not be expected to attempt to extinguish a fire.

Emergency escape routes and lighting

People must be able to find their way to a place of safety by using escape routes that have sufficient lighting. Normally there should be at least two escape routes, with a travel distance to the outside of no more than 45 metres. Though the specific requirements for your premises will depend upon its size, lay-out and your risk assessment.

Where escape routes are internal and without windows or your premises are used during periods of darkness, including early darkness on winter days, some form of back-up lighting to your normal lighting should be provided on escape routes.

Your emergency plan

The purpose of an emergency plan is to ensure that all staff know what to do if there is a fire and that the practice can be safely evacuated.

Your emergency plan should be available for your employees and patients (if they request it) and the local fire and rescue service. In simple single-storey premises, the emergency plan may be no more than a fire action notice.

In larger or more complex premises, especially where the practice forms only one part of a larger building, the emergency plan will need to be more detailed and compiled after consultation with other occupiers of the building. This may mean a single emergency plan covering the whole building.

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Once the emergency plan has been drawn up and the appropriate training given, its effectiveness should be evaluated by a fire drill, which should be carried out at least annually.

Staff instruction and training

All staff should be given an explanation of the fire procedures as part of their induction and at least annually after that; make sure you include staff who work outside normal working hours, such as the cleaner. This should include showing staff the designated escape routes, the location and operation of the fire-warning system and any other fire-safety equipment provided, such as fire extinguishers, and how to care for and evacuate patients. Fire action notices can complement this information and, where used, should be posted in prominent locations.

If some people have been designated as fire wardens or given specific safety tasks (such as calling the fire and rescue service or checking that exit doors are available for use at the start of each shift) they should be provided with more comprehensive training and written instructions. ◆

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Just pop on-line to register and you're ready to go. Visit www.dentalsky.com.

Practical as well as functional

Oral-B's latest power toothbrush really does cover both the practical and functional aspects of tooth brushing.

In terms of functionality, performance is enhanced through the use of Precision Detection Technology. By combining motion sensor technology located in the brush, and video recognition using a smartphone's camera, all areas of the users mouth can be tracked so that they know exactly where they've brushed and where they've missed! Guidance on pressure applied and brushing duration is also reported.

On a practical note, the Oral-B Genius incorporates several features to facilitate its use. Firstly, the travel case charges both the brush and a USB device, with a single plug for any voltage to make traveling easier than ever.

Secondly, it's supplied with a practical smartphone holder so that your phone can be easily and securely placed on your bathroom mirror. Thirdly, it contains a lithium-ion battery, which has a much longer battery life, giving patients at least two weeks of brushing between charges. Lastly, it contains SmartRing, a personalised multicolour 360° lighting system, featuring 12 different coloured lights that allow patients to customise their brushes. If you share your brush, you can ensure that it can clearly be identified by your colour! If you don't, then you can just switch colours, maybe to match your bathroom or maybe to match your mood!

Visit www.oralb.com for further information.

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The recent sale of Wootton Dental Centre to the Rodericks Dental Group is just one example of their ability. According to Lily Head, MD of Lily Head Practice Sales, while it was essential to maximise the commercial value of the business, it was also a key requirement that the buyer was able to expedite the purchase process.

To take advantage of their expertise contact James Head via jh@lilyhead.co.uk.

Amazing adjuncts for patients with Parkinson's

In the UK, one in every 500 people suffers from Parkinson's disease.[1] In addition to the common symptoms of tremors, rigidity and slowness of movement, the condition can also cause a number of oral health problems including dry mouth, difficulty controlling dentures and increase in tooth decay.

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With an extra-small head, ultra-gentle CUREN filaments, three operating modes and easy-to grip handle, the Black Is White Hydrosonic toothbrush is an ideal adjunct for patients who suffer from Parkinson's.

Curaprox also offers a complete line of Xerostom dry mouth products, including mouthwash, toothpaste, spray, gum, pastilles and salivary substitute gel – an ideal solution for Parkinson's patients who suffer from dry mouth or xerostomia.

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1. Parkinson's UK. Accessed online April 2016 at http://www.parkinsons.org.uk.

The latest addition

Planmeca has announced the latest addition to its comprehensive product line – the Planmeca PlanMill 40 S milling unit for dental clinics, the most powerful unit for chairside milling the dental market has seen.

The Planmeca PlanMill 40 S milling unit has been designed for the chairside fabrication of metal-free dental restorations and appliances. It combines superior usability with accurate high-speed milling.

Planmeca PlanMill 40 S will introduce a level of quality, precision and performance that has not yet been seen in the industry.

With its state-of-the-art design, smart tool paths, expanded range of applications, automated tool changer for 10 tools, and intelligent maintenance features, Planmeca PlanMill 40 S is set to offer the most complete milling experience available today.

The new milling unit will also combine with the Planmeca PlanScan intraoral scanner and the Planmeca PlanCAD Easy design software in forming the Planmeca FIT chairside CAD/CAM system from now on.

For further information visit www.planmeca.com

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Kemdent are pleased to announce a new look to the ChairSafe Disinfectant Alcohol Free range, the ChairSafe range has been an effective companion to dental nurses and dental practices since 2010 fighting the battle to protect patients and staff alike.

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Visit www.kemdent.co.uk to take advantage of the special offers available. Contact Kemdent on 01793 770256 or e-mail sales@kemdent.co.uk.

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Align Technology, Inc., the worldwide market leader in clear aligner treatment, has announced that 4 million patients have now started treatment with Invisalign, the most technically advanced clear aligner system in the world.

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Visit www.aligntech.com for further information.

Nuview announces courses in December

In partnership with UCL Eastman Dental Institute, Nuview is pleased to announce two upcoming courses: 'Dental Microscope: Restorative Dentistry' on 2 December, and 'Dental Microscope: Endodontics' on 3 December.

The one-day courses will be presented by Dr. Greg Finn and Dr. Tony Druttman respectively at the UCL Eastman Dental Institute, and are both worth 6.5 hours of verifiable CPD.

Anticipated outcomes for participants include an understanding of how to set up and use the dental operating microscope and how it can be used in either restorative dentistry or endodontics.

The informative and educational training will consist of lectures, demonstrations and practical exercises, with a chance to get first-hand experience of using a high-performance Carl Zeiss microscope.

To book a place on one or both of the upcoming courses, contact Marjorie Kelly on 020 7905 1234 or email edi.cpd@ucl.ac.uk.

For more information please call Nuview on 01453 872266, email info@nuview-ltd.com, visit www.nuview.co or 'like' Nuview on Facebook.



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Cone beam CT scanning
Mr Paul Stone BDS (Hons) Lpool, FDS RCSEd, FDS RCPS (Glasg)
Interests: Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts.
On Specialist List: Yes, Oral surgery (60534)
Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants
On Specialist List: Yes, Prosthodontics (66211)
Dr Marilou Ciantar BChD (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel
Interests: Oral surgery, implant surgery, tissue regeneration, periodontology, conscious sedation
On Specialist List: Yes, Oral Surgery and Periodontics (84070)
Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA
Interests: Fixed and removable prosthodontics, endodontics and dental implants
On Specialist List: Yes, Restorative Dentistry and Endodontics (77605)
Mr Graeme Lillywhite BDS Edin, MFDS, MSc, MRD, FDS RCSEd
Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics (68916)
Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd
Interests: Endodontics
On Specialist List: Yes, Endodontics (79246)
Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR
Interests: Cone beam CT imaging
On Specialist List: Yes, Dental and Maxillofacial Radiology (70079)

266979

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Business skills CPD

Q1: Who has a responsibility to identify signs of child abuse or neglect?

A The dentist treating the patient

B The dental nurse assisting the treatment

C The receptionist who should inform the dentist prior to treatment

D The entire dental team

Q2: Where there is serious physical injury arising from suspected abuse you should first refer the child to:

A Social services

B A&E

C The police

D The person with parental or care responsibility for the child

Q3: Which of the following is a golden rule of marketing?

A Planning

B Identifying competitor's weaknesses

C Monitoring

D Evaluating KPIs

Q4: What is the maximum escape route distance?

A 15 metres

B 30 metres

C 45 metres

D 60 metres

Q5: Which of the below circumstances entitles you to legal compassionate leave?

A Burglary

B Flooding

C House fire

D None of the above

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