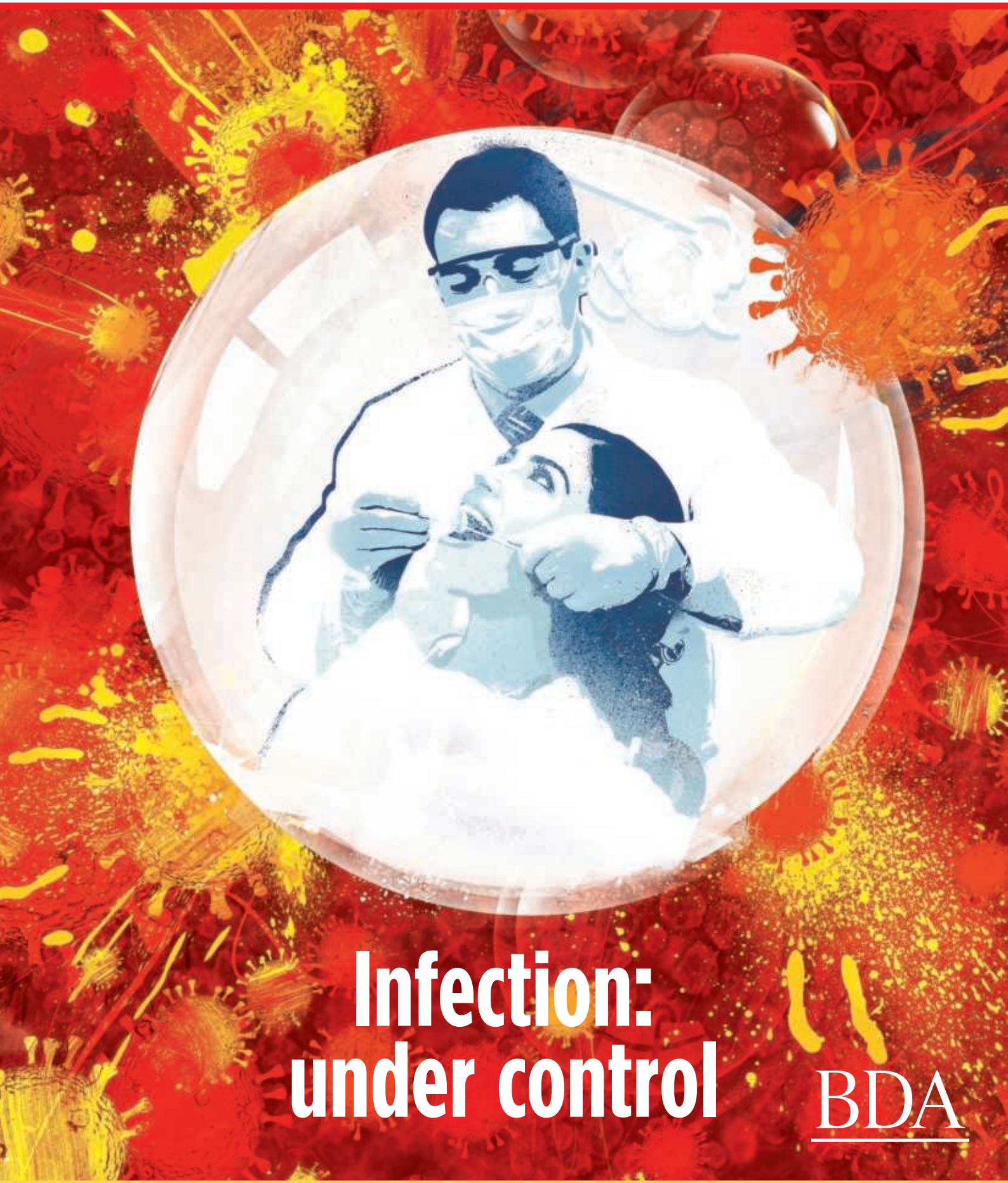
BDJ InPractice
September 2016



# Infection: under control

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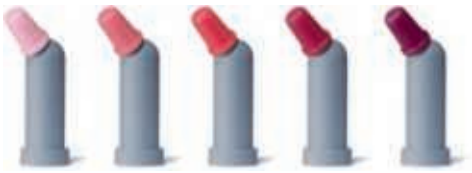

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# BDJ InPractice

## SEPTEMBER 2016



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COLUMN

# Read all about it...

## Rob Chaffe, BDA YDC member

It's been an interesting few weeks in the press for dentistry. Headlines such as 'The great dental rip-off' making front page news in *The Times,* and the case of Desmond D'Mello accused of 56 misconduct charges at the GDC making headlines. I wrote a blog on this last week, and since then teeth have been in the headlines again, with the government obesity plans outlined.

In the blog I tried to explained how *The Times* was right to raise awareness in the public about issues with the NHS contract, prevention and putting patient interests first. *The Daily Mail* have gone on to produce an article on dentists taking teeth out unnecessarily, which seems to be an extension of the *Times'* findings for Desmond D'Mello. However these articles were presented in a biased fashion to give patients the opinion they should doubt dental care provided by their dentists.

Following the government's watered down tactics to tackle obesity in the UK, as a profession we need to be putting pressure on the media, the government, and food manufacturers to raise awareness of the importance of good tooth brushing, interdental brushing, diet advice and regular dental check-ups. The BDA has already released its opinions on this, which in turn sparked debate in the *Daily Mail*, *ITV News, Radio 4* and *Radio 5 Live*.

The World Health Organisation describe dental caries as 'a worldwide epidemic'. When thinking about this it seems crazy that cigarette packets come with warnings of what smoking can cause, but in high sugar food stuffs this is not the case. But this is a worldwide epidemic, so why is more not done?

Newspapers need to get members of our profession to help produce articles to encourage people to have sugars and acidic foodstuffs at their meal times only and to reduce the frequency of exposure of sugar leading to tooth decay, and acid leading to dental erosion. We need to raise awareness of the guidelines on dental recall according to disease risk and dental radiography recall by the Royal College of Surgeons so that tooth decay can be screened and appropriate high strength fluoride varnishes, toothpastes and mouthwashes can be used for high risk patients. NHS patients need to be aware prescriptions for high strength fluoride products are available to them, and privately can often be purchased on the dentist's prescription.

> 'Action on Sugar called for warnings on soft drink billboards following San Francisco, USA requiring these warnings for fizzy drinks.'

In the United States adverts always contain the slogan of 'contact your dental professional for advice' – we need to get that out there in the UK rather than criticise the profession. *Action on Sugar* called for warnings on soft drink billboards following San Francisco requiring these warnings for fizzy drinks. It is sad that this is not thought to be as important to the government as this vibrant US city. It also seems a shame the lobbying for the 'sugar tax' by prominent people such as Jamie Oliver has been abandoned, which as a profession we feel is a great idea. Water should be the cheapest thing to buy out of our tap, not fizzy drinks from our shops.

Since a publication via the Associated Press in the United States there has been further headlines that dental floss is pointless. If anyone in the profession missed this press release it is good to know the advice to give patients who are questioning the use of floss, and again the press should ensure this view is explained following their brash headlines.

Patients at increased risk of dental diseases need to be made aware they are, and regularly attend to receive the preventative treatments they need. Polarising articles in the media passively discouraging patients to doubt their dentists and not get their teeth checked is counter-productive and leads to alienation rather than protecting patients. ◆

# DDU successfully defending more claims

Dentists are feeling the pressure from the current adversarial climate where complaints and claims are common, but the Dental Defence Union (DDU) revealed that it is defending more negligence claims successfully – with no compensation being paid in just under 60% of dental claims in 2015.

Following the newly released Medical Defence Union Annual Report for 2015, the parent company of the DDU, John Makin, Head of the DDU, said: 'The continued financial and other pressures on health services and their direct impact on clinicians who work within it, meant 2015 was another challenging year for our members. We recognise that dento-legal issues like complaints and claims contribute to this pressure and we saw a rise in members asking for our help with both in 2015.

'For the DDU's part, we are working hard to ensure members are not disadvantaged by the current climate. While claims have increased over recent years, so has the DDU's success rate in defending cases. In 2015, we only paid compensation in just over 40% of dental claims. ◆

# D'Mello removed from register

The GDC has announced that Desmond D'Mello has been removed from the register for serious infection control breaches.

In making the decision, the PCC found all but one of the 56 allegations proven against Mr D'Mello, following secret filming at the Daybrook Dental Practice in Nottingham.

Caroline Surgey, one of Mr D'Mello's colleagues, was also part of the hearing. She admitted to all 27 of the allegations.

Ms Surgey is now subject to conditional registration for a period of 12 months, with a review prior to the expiry of the order. ◆

# Reaction to childhood obesity strategy

The publication of the Government's plan to tackle childhood obesity has drawn widespread criticism after a number of measures were dropped. These included measures on advertising junk food to children and promotions such as two-for-one deals.

The industry levy on sugary drinks has been retained and the plan includes a voluntary target for the food and drink industry to cut 5% of the sugar in products popular with children over the next year. It says the ultimate target is a 20% sugar cut, with Public Health England monitoring voluntary progress over the next four years. If insufficient progress is made, the government will consider 'whether alternative levers need to be used'.

The Chair of the Health Select Committee, Dr Sarah Wollaston, the BMA, the Obesity Health Alliance, the Local Government Association, the Royal College of Paediatrics and Child Health, the Royal College of Physicians, and TV Chef Jamie Oliver were amongst those criticising the plan for not containing stronger measures.

BDA Chair Mick Armstrong slammed Ministers' 'relaxed attitude' to health inequalities and combating sugar. The BDA has pointed to official data, showing that children in Health Secretary Jeremy Hunt's constituency in Waverley have the lowest levels of obesity and tooth decay in England, and called for real action to tackle persistent health inequalities.

Five-year-olds in Blackburn and Darwen are nearly seven times more likely to experience decay, and year 6 pupils in Southwark are almost three times more likely to experience obesity than children in the Health Secretary's South West Surrey seat.

Tooth decay remains the number one cause of hospital admissions among children. Dentists have led calls for joined-up action on sugar, and advocated a package of measures including around taxation, effective public education and changes to advertising and marketing.

Mick said: 'It will take more than half-measures to deal with the sugar crisis. A sugar levy is one thing, but watering down action on junk food advertising and 2-for-1 deals sends entirely the wrong signal to business, parents and health professionals.

'The Health Secretary cannot afford to take a relaxed attitude to sugar. Children in his constituency might enjoy the lowest rates of obesity and tooth decay in England, but we think all children deserve the best start in life.

'We require a real strategy from government, one that is willing to address the huge, costly and preventable health inequalities Britain now faces. This isn't rocket science, but we need Ministers to take a lead.'

©Mustafa Arican/E+/Getty Images Plus

Speaking on the release of the strategy, Dr Nigel Carter OBE, CEO of the Oral Health Foundation spoke of the unnecessary harm it will cause to thousands of children in the UK as well as for generations to come.

Dr Carter said: 'This Childhood Obesity Strategy is a disaster. Despite the strategy being focussed on tackling obesity, the knock on effect it would have had on oral health was enormous and what we have seen today spells bad news for generations of our children.

'We are incredibly disappointed but sadly not surprised by this move. The government continue to ignore the children's oral health crisis we are experiencing in the UK and are putting the wellbeing of millions of people a risk by bowing to pressure from the food and drink industry.'

Claire Stevens, BSPD Spokesperson and Consultant in Paediatric Dentistry echoed Dr Carter's thoughts saying: 'Any Government policy which addresses sugar consumption has the potential to impact on oral health. We are very disappointed that this strategy does not go further to reduce sugar content in food. There is no hope that it will make a substantial difference to the number of children requiring general anaesthetics for multiple extractions.'

Anna Feuchtwang, Chief Executive of the National Children's Bureau added: 'Controlling how advertising and promotions are used to entice children and their families to choose unhealthy foods could have further supported public health initiatives. The Government's failure to stop aggressive marketing tactics used by the food and drink industry could undermine efforts to reduce childhood obesity.'

Henry Clover, Chief Dental Officer at Denplan, highlighted the apparent afterthought that is oral health. Henry said: 'Not only does the strategy omit the desired restriction on junk food advertising and multi-buy promotions, it was also hugely disappointing to see that childhood tooth decay was only referenced once in the entire report. Although the strategy focuses on obesity, the knock-on effects of implementing tougher sugar restrictions on manufacturers and retailers could only have been positive for our children's dental health too.'

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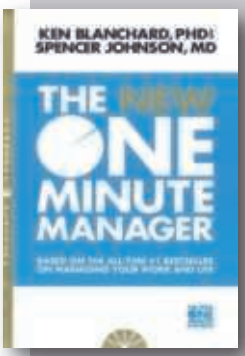
BOOK REVIEW

# All in 60 seconds

**The new one minute manager**
Ken Blanchard and Spencer Johnson
Thorsons, 2015
ISBN: 978-0-00-812804-3
£7.99




Books on leadership and management don't always have to follow the same formulaic conventions and this one most certainly doesn't. Its nearest comparator is the now famous work *Who moved my cheese?* which was written by one of the two authors of *The new one minute manager*, Spencer Johnson. Both books are told as parables using a fictional narrative. The storyline follows the quest by an anonymous young man in his search for a model manager with whom he can train and learn. In his journey the young man encounters managers who are 'tough' but disliked and friendly ones who are popular but fail to get results.

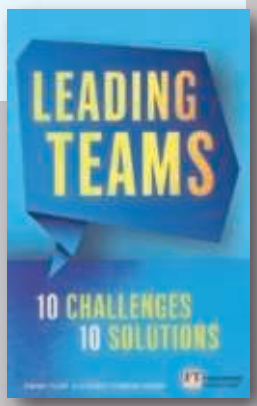
This allegorical tale focuses on the young man's dialogue with the new one minute manager (the OMM) and then with his reports and the information which they reveal about the OMM's modus operandi. The OMM, he discovers, facilitates work rather than dictates it, so his staff discuss with him what problems they perceive as being in need of solutions and how they will work on these goals. Crucially, these goals are enveloped within the 'one minute' time frame, so they are not complex but they are viable. Another aspect of the OMM is to deliver 'One minute praisings' so that rather than tell someone they've done something wrong the manager praises the staff member for doing something well, which makes staff feel confident and valued. ◆

For more about these books visit www.bda.org/booknews

BOOK REVIEW

# Being a leader

**Leading teams – 10 challenges: 10 solutions**
Many Flint and Elisabet Vinberg Hearn
Pearson Education, 2015
ISBN: 978-1-292-08308-7
£14.99




The authors of this highly readable paperback have over forty years of practical leadership experience between them. They've also worked with and advised a range of blue chip companies including *American Express* and *Virgin Atlantic*. So it's not surprising that within the first introductory paragraph they recommend that leaders take a proactive (as opposed to reactive) approach to leadership. Obviously, being a proactive rather than a passive leader is harder, takes more time and commitment but as the book demonstrates, clearly yields rewards. But their intention is not to offer some nebulous treatise on the philosophy of directing teams, but rather they seek to addresses specific challenges.

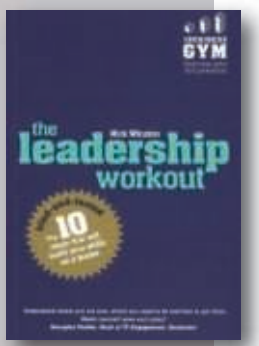
The presentation of the book is such that is lends itself both to quick reference on multifarious topics or can be read from beginning to end and at just under two hundred pages this is neither irksome nor time-consuming. The content is divided into ten chapters beginning with building trust, followed by overcoming conflicts, encouraging the sharing of relevant information, creating engagement, creating transparency and openness, long-term strategic thinking, how to get a team to deliver and managing change. The two final chapters focus on how to get a team to work together for the common good and how to get the team going in the same direction.

There are practical exercises and self-assessments and diagrams throughout. ◆

BOOK REVIEW

# Building a leader

**The leadership workout – the 10 tried-and-tested steps that will build your skills as a leader**
Nick Winston
Pearson Education Ltd, 2015
ISBN: 978-1-292-01771-6
£12.99




Experienced manager and consultant Nick Winston has credibility as an expert on leadership. Unusually his opening gambit addresses the issue of why new leaders fail. He identifies three main reasons for failure, in reverse order of importance: the newly promoted are not given the necessary training to undertake the new role. They try to do their old job rather than the new one. But the primary reason is their inability to say no.

This 200 page paperback can be read cover to cover, or Winston suggests, dipped into according to the reader's need, helpfully including a comprehensive subject index. But the author recommends a third way, using it within a learning group as part of a full learning programme. However, just dipping into it is arguably the most practical option.

The first part, entitled '10 steps to better leadership' comprises the bulk of the book and reveals some critical tips for a pain-reduced managerial career. For example, there's a chapter on how to build trust and a final one optimistically entitled 'Managing up (or how to say no without ruining your career)'. This deals with saying no by using a reasonable approach, rather than an outright refusal. But Winston also manages to refer over several pages to the notorious Milgram obedience experiment of the 1960s. Essentially this demonstrated that it is very hard to say no to an authority figure, but this inability is a sign not of weakness. ◆

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# Keeping things under control

There are two types of people in this world. There are those who brush their teeth twice a day, who wash their hands after they have been to the toilet, who clean up after a spillage at home.
And there are those who don't.

Of course this is a huge, sweeping generalisation, but you get the point. Not everyone adheres to the same standards of cleanliness. People do cut corners. I like tea in the same mug throughout the day because otherwise it tastes of soap. Some people fastidiously clean their mug after every use. While it may be something family, friends, foes and peers frown at, there isn't too much one can do.

Dentistry – and healthcare in general, for that matter – does not adhere to the same rules. Cutting corners isn't just frowned upon, it's monitored. Re-using the same mug won't just get you a shifty look from a colleague in the kitchen.

According to one article, the scientific study of hospital or nosocomial cross-infection began '*during the first half of the 18th century, and from that time until the start of the 'Bacteriological Era' many of the most notable contributions originated in Scotland. However it was only 100 years later in 1858*

*that Florence Nightingale promoted the case for hospital reform.*[1] The author goes on to highlight the triumph of hospital reform, only for cross infection to return. It was here that scientists discovered infections occurred not only in obstetric and surgical patients, but in medical patients as well, and that air could also be a source of infection.[1]

> 'As a provider of dental care you want to ensure that you, your staff and crucially your patients are not exposed to the risk of infection.'

Decontamination and infection control may not be the most enthralling of topics but it underpins everything that goes on in a dental surgery. As a provider of dental care you want to ensure that you, your staff and crucially your patients are not exposed to the risk of infection. You don't want infection gremlins creeping in during a routine procedure, and I very much doubt they do too. The most effective way to achieve this is through a comprehensive infection control policy detailing appropriate protocols and procedures.

Your infection prevention and control policy will be a mixture of processes that are national, such as following the decontamination steps as in the Health Technical Memorandum 01-05 (HTM 01-05)[2] and local to your practice such as how you arrange staff training and responsibilities. Your policy will use a variety of advice and guidelines available with careful planning and delegation of responsibilities, ensuring that your practice is infection free should not be all time-consuming and fraught.

The whole process has become much more formalised and practices have often had to invest considerable sums to bring their standards up to scratch.

The public expect standards to be universally high and practitioners can expect severe sanctions if they fail to maintain these. Similarly, the English CQC inspection regime represented a marked shift in the regulatory burden for practices. The dust has largely settled from these changes and the profession has adapted well to the new normal.

Challenges remain – a full review of HTM 01-05 was promised within two years and, despite some amendments, this is now overdue and there is enduring confusion over access to occupational health services, with patchy cover in England, despite the recent publication of an NHS service specification document. Debate continues to rage over the spurious evidence in place for HTM 01-05 – especially contentious when it comes to storing instruments. A recent interview with Dr Divya Verma and Dr Devika Vadher in August's *BDJ In Practice* highlighted the potential for further confusion in waste management caused by interpretations of HTM 01-05.

## Eliminating confusion

So what's the solution? Infection control isn't just about keeping surfaces clean and washing hands after all. The necessity for all staff, including new staff, to be aware of infection control procedures and understand why they are necessary, be appropriately qualified and able to demonstrate competency before working in the surgery, will play a significant role in preventing issues from developing. In any case where competency cannot be proven, appropriate training must be provided.

Keeping up to date with new guidance and legislation in infection prevention and control will play a big role too. The GDC states that GDPs and DCPS are required to complete five hours of verifiable training and updates in decontamination and disinfection (infection control) in a five year cycle.

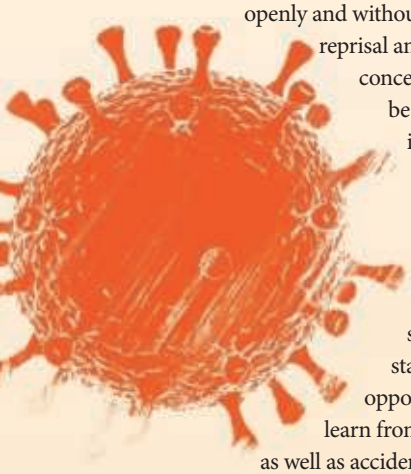
'Essential quality requirements are the minimum, and Sarah Davison, BDA Good Practice Manager, believes it is one of the key elements to a successful practice. The BDA's Good Practice requirements are set in a way that should national guidance change, then so our members should keep current with the scheme requirements. We expect our members to be compliant with HTM 01-05 or local national guidance. As the minimum expectation is to have essential standards, then this is what we expect.

'Developing systems and processes to enhance the efficiency of your practice, building an enthusiastic, motivated and engaged team, allied to creating a patient experience that allows a loyal patient base to develop, are fundamentals of BDA Good Practice. Infection control is just one area we check for, but it is arguably the most important.'

## Keep your eyes peeled

If, in the unlikely situation, a fellow member of staff cuts corners, the onus is on that individual to inform someone from the management team. Dr Caroline Pankhurst, a specialist in Oral Microbiology, says: 'Under principle 8 of the GDC's Standards for the Dental Team the expectation is that all dental professionals will 'raise concerns' if patients or colleagues are at risk and will take measures to protect them. This applies to all dental professionals, regardless their role in the dental team.

'The dental practice through their management structure and team meetings should foster and support a workplace culture where all members of staff can raise concerns openly and without fear of reprisal and that these concerns will be promptly investigated and managed. Without this open, non-judgmental approach standards can stagnate and opportunities to learn from 'near misses' as well as accidents are lost.



'We hear and read about 'whistle-blowers', which is a very emotive term and not one I like to use personally because of its negative connotations. Often the media does have an impact on how we feel we may be portrayed.'

## Team work will work

Team work is an essential component of dental practice infection prevention and control management. Everyone in the practice whatever their role has an important part to play if it is to be effective and the practice is to be run safely. Infection prevention succeeds or fails based on the weakest link. In the majority of dental practices the dental nurses undertake the instrument decontamination and environmental cleaning amongst other infection control tasks, so naturally they are a vital part of the overall process.

Dr Pankhurst added: 'HTM 01-05 requires that the registered manager ensures that the dental nurses are suitably trained and competent to perform these practical tasks.

'I think that most dental nurses are fully aware of their fundamental role in infection control and how important they are to the safe running of their dental practice. But all members of the clinical team need to have a clear understanding and working knowledge of the relevant health and safety law, modes of transmission of microorganisms, how infection control procedures can be used to prevent and control the spread of infection and methods used to validate the decontamination cycle.'

> 'Everyone in the practice whatever their role has an important part to play if it is to be effective and the practice is to be run safely.'

With the growing number of Associates, practice centred infection control induction and on-going training of Associates is vital. Of course the regulations and guidance on infection control are standardised and universal but the detailed practical implementation of these protocols will vary between practices.

Dr Pankhurst says: 'Feedback I have received from Associates whilst teaching on training days around the UK suggests that many Associates feel that decontamination and the management of infection control are tasks that have been delegated to somebody else, whether it be the dental nurse, infection control lead or registered manager. So that except for performing the absolute basics such as hand hygiene, safe use and disposal of PPE and sharps, the management of decontamination and infection control procedures is perceived as being outside of their control.

'So unlike the dental nurses who are very aware of the importance of their role with respect to infection control, Associates are often made to feel like passive bystanders. However, legally they have a day to day responsibility with regard to infection control procedures and the validation of decontamination of dental instruments carried out in the practice on their behalf. Therefore, I would strongly recommend Associates to keep themselves not only up to date with developments nationally in infection control but where possible take a more active interest and role in the management of infection control in their practice(s). For example by offering to complete the HTM01-05 national audit tool, undertake infection control risk assessments or antibiotic stewardship audits in their practice.'

## A little goes a long way

As Dr Pankhurst points out, the majority of dental practices in the UK are extremely well run. However, she still finds that there is a 'reluctance to wear plastic aprons when undertaking dental procedures where the uniform or clothing is a risk of exposure to splashing from body fluids', presumably because the dentists in particular feel that the aprons make them look unprofessional. Small things may make a big difference. Practice uniforms are permeable and are not considered personal protective equipment. Whereas a plastic apron provides an impermeable barrier that protects the wearer from the infection risks associated with splatter.

Dr Pankhurst added: 'Consideration of the effectiveness of ventilation in the dental surgery is an often neglected area. The dental team work in a microscopic mist of blood and microbes generated from the dental handpieces that persists in the surgery air for up to 30-40 minutes. Each complete air change removes approximately 60% of the remaining aerosols. Only a respirator mask provides inhalation protection from respiratory pathogens and these are very rarely worn in dental practice. Most practices concentrate on reducing the cross infection risk from aerosols using a combination of exhaust suction, and biocides in the dental unit waterlines but do also need to look at room ventilation as well.' ◆

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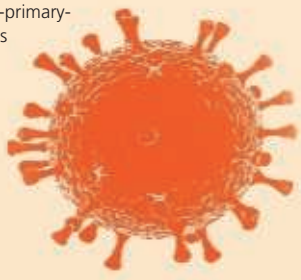


# What does BDA Good Practice expect from its members?

## Cleanliness and infection control

The practice has an infection control policy and complies with national guidance on infection control. A named person is responsible for reviewing the policy at least annually and advising other team members of any changes.

*Update infection control procedures periodically at practice meetings to ensure consistency of approach throughout the practice. Keep notes of these discussions. For practices in England, an infection control annual statement should be available.*

**Evidence**
- → Infection control policy, with named lead
- → Practice training record, showing infection control training and updates

Surgeries are uncluttered and zoning is in operation. Where possible, instrument decontamination takes place away from the clinical area.

*Check that work surfaces are free of clutter and consider moving decontamination processes away from the clinical area. Be aware of national policy on the provision of a separate decontamination room.*

**Evidence**
- → Infection control procedures

A practice protocol for selecting equipment and instruments helps to ensure that new equipment can be processed using routine decontamination processes. Where possible, single-use (disposable) items are considered.

**Evidence**
- → Procedure for disposal of single use items

The decontamination process includes: (i) pre-sterilisation cleaning (using washer disinfectors, ultrasonic cleaners or cleaning manually), inspection and function testing (ii) sterilisation, (iii) packaging, where necessary, and appropriate storage.

*Be aware of and follow national requirements on instrument storage methods and use.*

**Evidence**
- → Infection control policy and associated infection control procedures

In surgeries, clinical surfaces are decontaminated between patients and at the end of the clinical session. There are written protocols and a schedule for environmental cleaning.

**Evidence**
- → Decontamination procedure and cleaning schedule

The practice takes responsibility for decontaminating impressions, prostheses and appliances on receipt from and prior to dispatch to a laboratory.

*Check the practice procedures for decontaminating laboratory items.*

**Evidence**
- → Decontamination procedure for laboratory work

Personal protection, including immunisation, is provided for all members of the clinical team. Personal protection is provided for other members of the practice team as appropriate.

*Check that all relevant members of the dental team have been appropriately immunised, their responses checked, and documented evidence held by the practice. Ensure that, where required, booster vaccinations are received.*

**Evidence**
- → Blood test results or medical reports/ PPE policy

There is a practice policy for dealing with inoculation injuries or other possible exposure to blood-borne viruses. All practices should have arrangements in place to ensure immediate access to occupational health advice, including referral for assessment on whether post-exposure prophylaxis is required. Where access to the local Occupational Health Service is not possible, arrangements with a suitable medical practice should be in place. Inoculation injuries are recorded in the accident book.

*Review the practice policy for dealing with inoculation injuries to ensure that it includes details of relevant local contacts.*

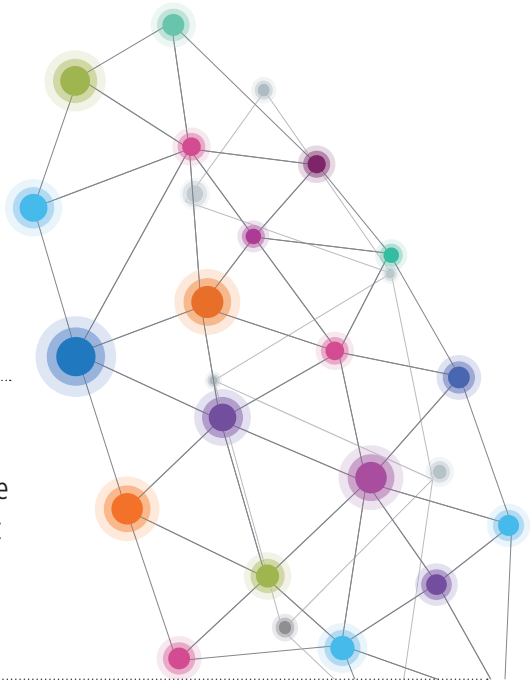
**Evidence**
- → Inoculation injuries protocol showing contact details of external occupation health advice

All dental professionals understand the need to seek appropriate medical advice if they discover they are (or suspect that they may be) infected with a blood-borne virus or other serious transmissible infection and to consider any testing or changes in clinical practice that may be necessary.

*Check that all members of the team are aware of their obligations.*

# Grasping the concept

Bob Hughes,
CEO of the Forton Group Bob Hughes on concept formation, gloom merchants and Swiss watches



The good news about leadership is that there is an excellent body of evidence around what is required in today's complex and constantly changing world, and also that good behaviours can be learnt. Each month, I will be writing about one that should support you in your work. In this article, I cover one we call 'concept formation', which sits in the first cluster of behaviours, the 'thinking cluster'. Each of the 12 behaviours can be observed at five levels, and we'll look at the differences between those.

With this insight and, where possible, with feedback from others, we can adapt our behaviours to become more effective.

I currently sit as a non-executive director on the board of an organisation called *Engage for Success*. Our remit is to raise awareness of what makes people truly engaged with their work, those willing to go the extra mile, tap into discretionary effort. Think about the times when you've gone into one shop and felt they really care about you and then in the next shop you might as well not have existed. That's what engagement looks like. There's no magic bullet that will solve engagement in every organisation, but we found four factors that were common across engaged organisations, and a leader who was less command and control and more engaging, more coach like, was the most important of these.

One of my roles is to chair a steering group of consultants, academics, researchers and practitioners that is responsible for instigating new research and for finding new ways of spreading the message of engagement to new audiences. I've been doing this for about four years and I've finally realised it's time to move on. So what caused me to have this revelation? I'm still very committed to the movement and I've still got creative input to offer. But then at one meeting I found myself saying a phrase that I thought I'd banished from my lexicon. One of my colleagues came up with an idea and I said 'we tried that once and it didn't work'.

Whilst I may have technically been correct, it really wasn't very helpful. Her idea wasn't exactly the same as mine, the people involved were different, the circumstances had changed, and time has moved on. So how could I know whether it would work or not?

When we find ourselves getting in the way of new ideas in this way, we are exhibiting a negative behaviour of concept formation. This also shows up with the naysayers, the doom and gloom merchants who trample on new ideas by pointing to all the things that would get in the way of that idea succeeding. Now, don't get me wrong, there's value in constructive criticism. When we plan the implementation of new ideas we need to analyse, and carefully manage, as appropriate, the risks. But there's a big difference between that and the general rubbishing of ideas.

There's often an explanation for this. Sometimes it's the ego of the leader getting in the way – they think that as the boss they should have all the good ideas and get irritated when someone else in the team thinks of something they feel they 'should have thought of first'. The other common explanation is just a fear of change. For many of us the unfamiliar is also the uncomfortable and in order to protect ourselves from change we try and dismiss it.

We do so from a perspective of survival. The primary function of the brain is to protect us, to keep us alive. It sees that right now we are alive, concludes that the status quo is a safe place and hence it steps in to resist when anything threatens to change that status quo.

Of course in today's world of constant change and increasing complexity, our survival actually depends on creativity and innovation. The writer Dan Pink in his book '*A Whole New Mind*' talks about

three factors that mean we cannot carry on as we are and assume success will come. The first is automation – not only the automation of manual tasks – but increasingly the professional. For example, online conveyancing or other legal advice is increasingly commonplace, cutting back on the work of the solicitors.

The second is Asia, where highly qualified graduates command lower rates than those in the West for work such as computer programming and much else. The final factor is abundance. Shopping meccas sweeping across the West and indeed Asia too.

In order to survive, we need to create great ideas. This behaviour of concept formation is all about exactly that. You might think as you read this that some people are naturally creative and others aren't, so how is it possible to build this as a leadership behaviour? Well, like any of these, it takes practice and we will look at ways to improve in this article.

If all we do is rely upon our existing knowledge and solutions that have worked for us in the past, then we're not really demonstrating this behaviour. Indeed, Einstein's adage that doing the same thing over and over again and expecting different results, as a definition of insanity, may be relevant.

We need to come up with good ideas, and when we are able to do that, whether it's options, solutions or a vision for the future, then we are starting to add real value through this behaviour. You can start by just brainstorming ideas with colleagues, or by analysing a problem's root causes. You might want to use SWOT analysis or other techniques. If circumstances dictate that you have to do come up with a solution very quickly, then take the time afterwards, perhaps with other colleagues, to analyse the problem and see what really caused it.

We can do this with good results based on our existing knowledge, looking at trends, understanding our business, through networking, through keeping up to date with new ideas and changing circumstances in our world. Whenever I'm coaching people, whether they just starting out in their profession or the right at the top, I always challenge them about their network. Some people find networking tough. It's hard to strike up a conversation with a complete stranger.

To really build this behaviour to a more strategic level though you need to do more and here are two ideas.

The first is to try and get inspiration from a completely unrelated field. The world that we know well, with its rules and procedures, its ways of working and the mind-sets of the people within it, we call a paradigm. Most paradigms have a finite life; they serve us well to solve existing problems but there comes a time when a shift in that paradigm is needed; we need radically different ideas and new ways of thinking. The problem is that the people within that paradigm find it hard to view their world from a different perspective. Plus, they are invested in that paradigm; changing paradigms can mean we go back to zero and have to learn again. So there's no real incentive to change – other than the need to survive!

> 'We need to come up with good ideas, and when we are able to do that, whether it's options, solutions or a vision for the future, then we are starting to add real value through this behaviour.'

One famous example is the Swiss watch industry. The digital watch was first invented by someone working in that industry, but none of their colleagues took it seriously. They made beautiful handcrafted, complexly engineered, timepieces and believed that is what people wanted. The Japanese picked up on the digital idea and it almost destroyed the Swiss watch industry, which eventually fought back with the Swatch brand.

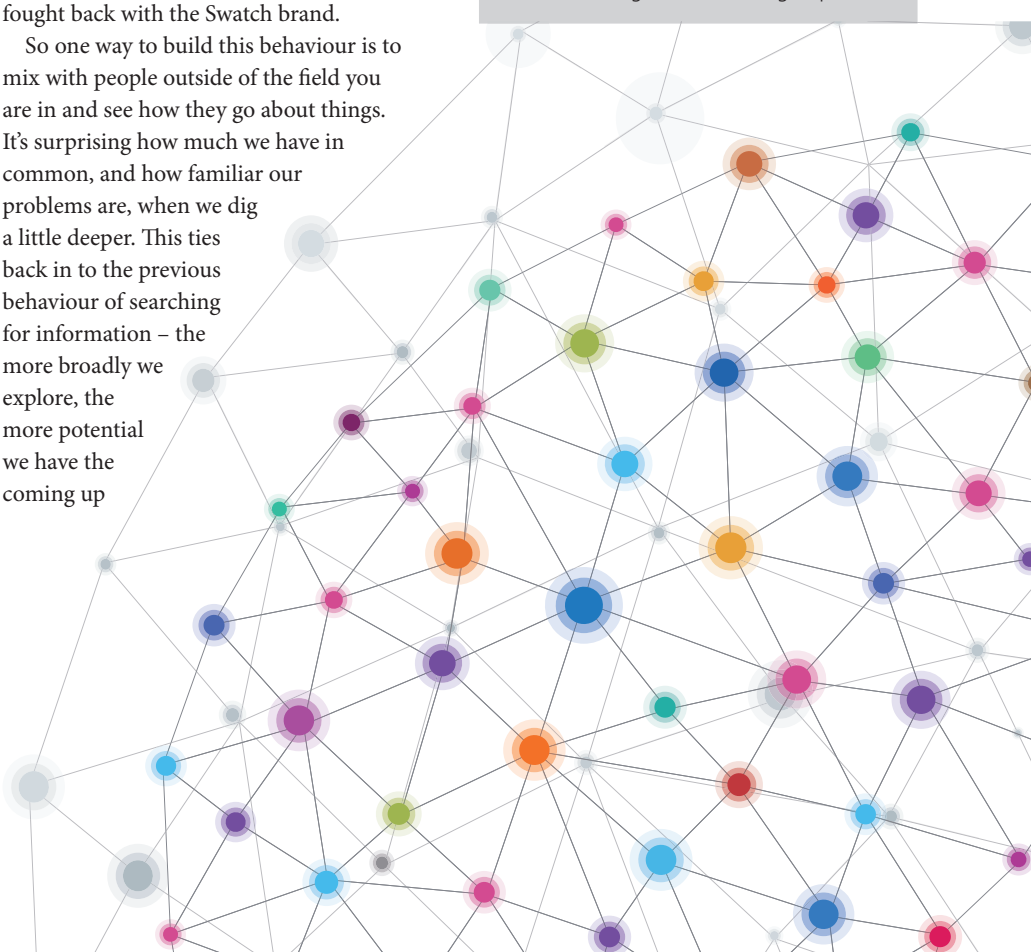
So one way to build this behaviour is to mix with people outside of the field you are in and see how they go about things. It's surprising how much we have in common, and how familiar our problems are, when we dig a little deeper. This ties back in to the previous behaviour of searching for information – the more broadly we explore, the more potential we have the coming up with a new and different approach.

Another way to create really powerful concepts with huge impact is to find an idea that can solve more than one problem. One example was work we did in a large organisation that had the classic problem we call 'silo mentality'. Different departments didn't speak to each other and certainly wouldn't implement an idea that had been invented elsewhere. There was also a problem with the managers having a default style of 'command and control'. Staff were becoming resentful at being managed in this way and also stopped thinking for themselves, because the boss told them what to do all the time.

We introduced a short training programme which equipped managers with some coaching skills that allowed them to operate, when appropriate, in more of an 'asking' style than a 'telling' style. At the same time, we encouraged managers to coach someone from a different department. This had the benefit of breaking down some of those barriers between departments, as well as creating better engagement, through more coach-like approach to leadership.

Next month we'll complete the thinking cluster and explore the behaviour of 'flexible thinking'. ◆

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



# At the core of flat foot and lower back pain

Dr Jimmy Tang,
General Dental Practitioner, NASM Corrective Exercise Specialist with special interest in postural dysfunction & lower back problems, Level 3 Personal Trainer (REP registration no R1045463), L3 Sports Massage Therapist

You may be wondering why you are still suffering from back pain even though you take particular care of your posture and do the correct stretches and exercises. You may not actually be aware that one of the contributory factors to your lower back predicament may have originated from as far down as your feet.

Please be reminded that the human movement system (HMS) consists of the muscular system, the skeletal system and the nervous system. Throughout your body, rarely does a single muscle work without other muscles contributing. Because the HMS is an integrated system, impairment in one system or in one component of each system leads to compensation and adaptation in other systems – initiating the cumulative injury cycle – causing decreased performance and injury, such as lower back pain.

During functional movements, the body must maintain its centre of gravity aligned over a constantly changing base of support. If change in alignment occurs at one joint, changes in alignment at another joint must occur to compensate. You will be able to see from this article that the joint biomechanics of the ankle can affect the length-tension relationship of the muscles that are attached to the lumbo–pelvic–hip complex, thus contributing to lower back pain. The reverse is true – muscle imbalances of the hip can affect the lower extremities, contributing to knee pain and problems that are related to flat foot, such as plantar fasciitis.

## What is pronation?

Pronation, also known as eversion or external rotation of the foot, is natural in the body's regular movement and occurs when weight is transferred from the heel to the toes during walking and running. The foot naturally rolls inwards and the medial arch of the foot flattens to provide shock absorption at the foot. The term 'flat feet' is used to describe the effect of overpronation.

Overpronation can cause problems throughout your body. This is because the overpronated foot is not properly absorbing the shock of your stride but instead transmitting that shock up through your knees and hips, which can have a profound effect on the balance and length-tension relationship of your lower back and pelvic musculatures.

As mentioned, it is natural for the foot to pronate during walking or running, and the tibia, knees and hip correspondingly rotate internally. For individuals with overpronated feet, this internal rotation of the knees and hips is exaggerated.

Furthermore, hyperpronation of the foot induces an anterior pelvic tilt. The additional 2–3 degrees of foot pronation leads to a 20–30% increase in pelvic alignment while standing and a 50–75% increase in anterior pelvic tilt when walking . Anterior pelvic tilt is correlated with hyperlordosis (an increase in the curvature of the lumbar spine) and this in turn alters the length-tension relationship of the muscles that are attached to the lumbo–pelvic–hip complex; for example, tightness of the back muscles (such as the erector spinae and quadratus lumborum) and lengthening of the abdominal muscles (including the main

core musculature transversus abdominis) – both tightened and lengthened muscles are dysfunctional as they are weakened. Muscle dysfunction essentially refers to abnormality in muscle function but with no pathology.

The body will adapt to any stresses placed upon it. When these stresses are balanced, the body will remain in balance. Dysfunctions can begin with one small imbalance, which could be a shortened or weakened muscle. Over time, if this is not addressed, the imbalance can have a cumulative effect, causing a downward spiral which may eventually result in the development of trigger points leading to lower back pain.

## How can I tell if I overpronate?

Firstly, conduct a static postural assessment – take a look at your feet when you are standing and see if you have a clear medial arch. If the inner sole touches the floor, then your feet are overpronated. Secondly, take a look at your running shoes. If they are worn down on the inside of the soles in particular, then you may have overpronation/flat feet.

### *'Normal' foot arches*

1. The medial longitudinal arch is the primary arch.
2. The lateral longitudinal arch runs along the outside of the foot and is not as deep or as wide or as long as the medial longitudinal arch.
3. metatarsal heads. It traverses the ball of the foot, at the front of the foot between the toes and the mid-foot.

Each of these arches, along with the bones, joints, ligaments, tendons and muscles, is designed to provide adequate support and flexibility for the foot.

## Causes of overpronation of the foot

Your feet are not designed for standing or walking on hard, flat and unyielding surfaces such as concrete, wood or carpeted floor.

Your feet were created to function on unpacked earth that yields with pressure and encourages normal dynamics of the bones, joints, ligaments, muscles and arches because the earth is a natural arch support and shock absorber.

**1. Walking on a flat, rigid and unyielding surface**, your heel strikes the surface, which does not yield (no shock absorption), causing forces to be transmitted up your body, through the knees and up to the lumbo–pelvic–hip complex.

As you go into mid-stance where the entire foot is flat on the surface, there is no upward support for the three arches, causing them to collapse further than normal in order to meet the flat surface below.

Finally, when you toe-off, again there is no give in the surface and forces are exerted into the toes and balls of the feet.

The body is efficient in adapting to stresses that are placed on it but it is not very smart. These adaptations, over time, cause muscle imbalance – the muscles around the ankle joint may tighten or be overactive in an attempt to minimise the stress at the involved segment. Muscle imbalance and tightness are theorised to contribute to foot pronation , specifically tightness of the lateral ankle musculature including the lateral gastrocnemius, soleus and peroneals. If the antagonistic muscles including the medial gastrocnemius, anterior tibialis and posterior tibialis are weak, they may be unable to overcome the valgus joint positioning. This process initiates the cumulative injury cycle.

> 'Your feet are not designed for standing or walking on hard, flat and unyielding surfaces such as concrete, wood or carpeted floor.'

**2. Weakness of pelvic muscles**

Foot placement during the swing phase of gait depends on the balance of hip abduction and adduction movements (abduction and adduction of your legs refer to motions that move your legs away from or towards the centre of the body) because stabilisation of the pelvis is vital for maintaining balance and control of the lower extremities. Weakness of the main lateral hip stabilisation muscles, e.g., the gluteus medius, contributes to altered lower extremity alignment, leading to increased foot pronation, especially when the tensor fasciae latae muscle, a synergist to the gluteus medius and an internal rotator of the hip, becomes synergistically dominant.

Just to remind you, prolonged sitting causes your hip flexors to be tight with the antagonists (gluteal muscles) being weakened due to reciprocal inhibition.

## Effect of flat foot on the lumbo–pelvic–hip complex

Individuals with this type of lower extremity movement impairment syndrome are usually characterised by excessive foot pronation, increased knee valgus (femur and tibia internally rotated and adducted) and increased anterior pelvic tilt during function movements. In addition, they tend to have predictable patterns of injury including plantar fasciitis, anterior knee pain and lower back pain.

## Summary

If you suffer from repeated episodes of back pain with no means of relief, apart from paying attention to your back musculatures, you may need to have your ankle alignment assessed as well. If you are flat footed, this may have contributed to the recurrence of your back pain. In this scenario, simply carrying out the 'usual' exercises (such as glute and core activation) and stretches (such as those for the hip flexor complex) to relieve back pain may not be adequate. You may have to seek advice from a podiatrist who can prescribe you with orthotic devices that can correct your lower extremity movement impairment syndrome.

Foot orthotics can help manage lower back pain by improving and stabilising the position of the feet, which in turn improves every aspect of the HMS kinetic chain. The feet represent the base of the kinetic chain, and each subsequent joint above the feet can be considered to be a "link" in this chain which goes all the way up the trunk of the body to the neck.

You may also need to consult a corrective exercise specialist to identify the overactive muscles (e.g., lateral ankle musculature including lateral gastrocnemius, soleus and peroneals) so that these can be deactivated with myofascial release and stretches. Similarly, underactive muscles can be activated through the prescription of a series of corrective exercises. For example, if there is weakness in the tibialis posterior, the most central and deepest of the calf muscles which help to support the medial arch of the foot, this muscle may need to be strengthened.

Again, the author is merely highlighting that what happens in your feet can affect the structures all the way up to your hip, lower back and even your neck and shoulder. He is not offering you medical advice or diagnosis. It is important to remind you that you should seek help from an appropriate professional in order to identify the root cause of your musculoskeletal lower back disorder. ◆

1. Khamis & Yizhar (2007) "Effect of feet hyperpronation on pelvic alignment in a standing position", *Gait Posture,* pp. 127–134.
2. Bell, Padua & Clark (2008) "Muscle strength & flexibility characteristics of people displaying excessive medial knee displacement", *Arch Physical Med Rehabil,* **89**, pp. 1323–1328.

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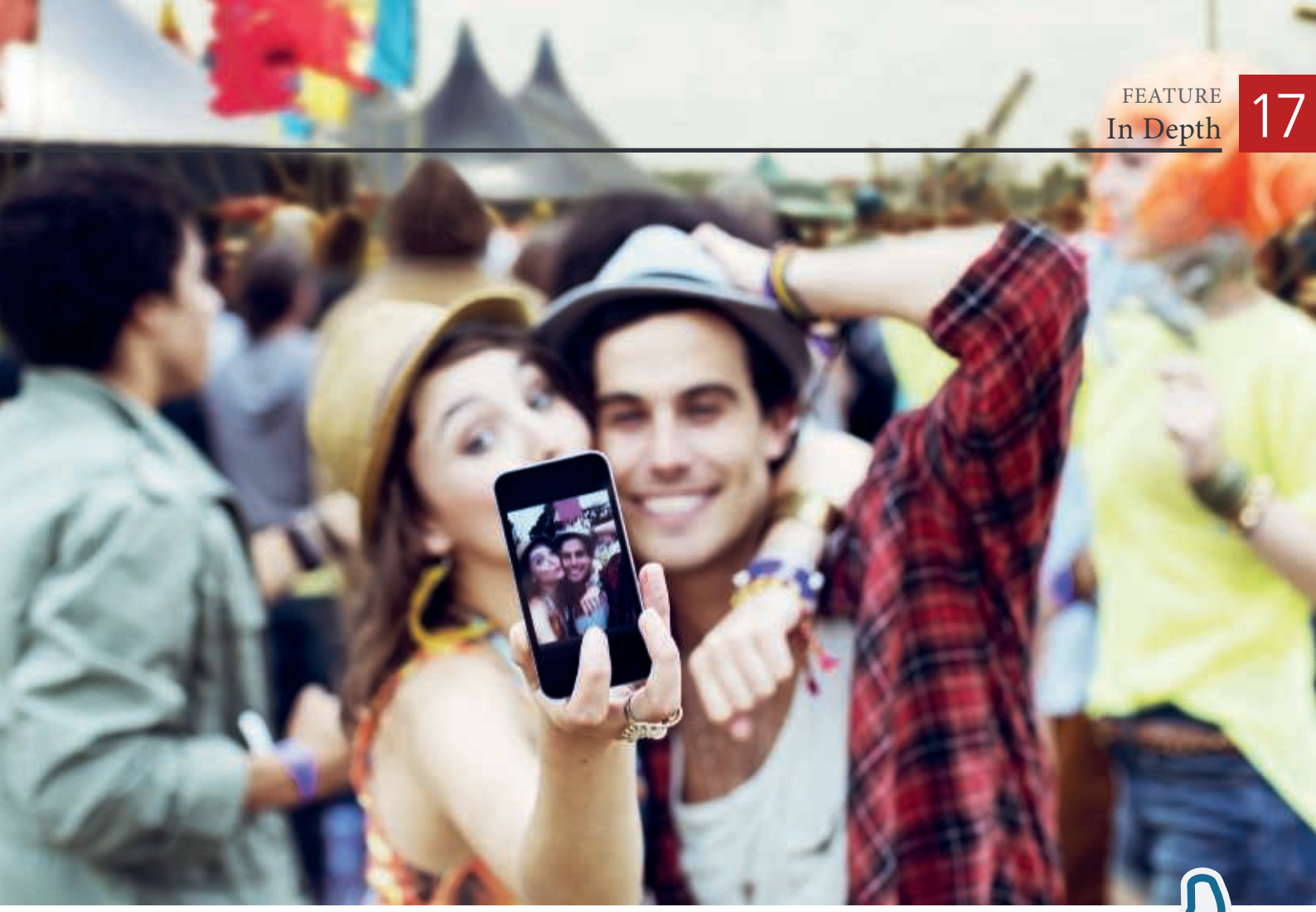


# Social media sickness

Illness befalls everyone at some point. I'd go as far as saying you could add it to life's certainties. It comes in all shapes and sizes, and there isn't a one size fits all approach to how employers should handle it.

Step forward social media, which, like in many other facets of daily life, has been a bit of a game changer. It has changed the way we communicate all the way up to changing our own aesthetic values – i.e the 'selfie' generation.

The same rings true of how employers approach staff sickness. Once upon a time it was face value. At school it was a note from your mum. Now there's every chance employers and colleagues alike will get an insight into the days spent recovering.

So what happens if you're tagged in a tweet on safari in Kenya, or perhaps mentioned having a picnic in the park with friends? What happens then?

In a nutshell, an ill member of staff posting about their activities on social media sites creates an instant disciplinary problem, raising the suspicion that they are not genuinely ill. Like many situations in life it depends on the specifics – someone with a broken leg may be encouraged by their physio to go to the gym or for light exercise. Likewise someone absent from work due to stress may be pictured on holiday getting away from their day-to-day business.

Social media is designed as a tool whereby people can interact and exchange information in an informal setting. It is great for members of staff for team building and camaraderie, but posting about a night out when you are supposed to be sick can cause disharmony and poses the question to practice owners about what sort of action – if any – is reasonable to take. Mark Oborn, Dental Online Marketing Expert, has one rule of thumb for all social media users.

'My advice to anyone posting anything online in any circumstance, whether personal or professional is that everything online is public and will be there for ever' he said. 'Even if someone posts a status update on social media and then either deletes that post or changes the audience to which that post is delivered there is no guarantee that this will be hidden from the people required. A post needs only to be public for a couple of seconds in order for someone to notice it, screenshot it and then share the image of that screenshot.

'People need to be aware that what they say in the public domain is public and can be seen by anyone. People also need to be aware that other people will make value judgements based upon those social media posts.'

## Protecting privacy

All social media channels have varying degrees of privacy settings. Some are total blanket lockouts, some offer a degree of transparency. As a general rule employers can rely on information that is freely available, but if an account is private then they cannot rely on information that is unreasonably obtained. Employers may be able to obtain information because they are a direct friend or contact of the employee, effectively allowing the employer access into what could be considered as private matters.

From a legal standpoint, the law is still developing – generally if an employer is not directly friends with their staff on social media, it is questionable whether employers should rely on this information in the first place. Mark added: 'It is also possible to limit the audience of posts. I indeed do this myself. I have local friends to my geographical location, these are in a Private Facebook list that I have created within Facebook. I have close friends who are in a separate list and I have business acquaintances who are in a final list. When I post I choose which list may see this post. Some posts are public and some posts are accessible to friends only. So if you want to have all of your work colleagues in one list seeing certain things and the rest of your friends seeing other things, it is possible.'

## Does the illness match the report?

Employers have to think long and hard about this aspect. If you're ill due to cold or flu-like symptoms, it's irresponsible to be visible on social media doing things that would question the legitimacy of the illness. Even something as simple as 'being out shopping' – a perfectly harmless post about going out to pick up chicken soup, tissues and medication – could be construed incorrectly. At the very least employers would have the right to ask if such a post was seen.

Mark explained: 'I would advise people to think of social media in exactly the same way as they would real life. Ask the question, in real life, would I want to spend time with this person and share my personal life with them? If the answer to that question is no then do not befriend them on social media. However, if one was in a pub socially and someone that we did not want to be in our friend circle was close and could overhear our conversation, then we would be aware of what we were saying. The same rule applies with social media.'

> 'From a legal standpoint, the law is still developing – generally if an employer is not directly friends with their staff on social media, it is questionable whether employers should rely on this information in the first place.'

So where does he draw the line with employers using social media as a legitimate method of monitoring staff?

'Status updates are public. It is down to the person posting to ensure that they are acting appropriately. One must work on the premise that there are people who will actively look on someone else's social media newsfeed, if one doesn't want them to see it, one should not post in the first place.

'Many people use Facebook for business and personal use and this is where the confusion comes in. It is far better to use a business page for business use and use a personal profile for everything personal. The personal profile should be made up of people that are actual friends.'

## Returning to work

It is not uncommon for practices to have a sickness and injury absence policy in place. Often these involve return to work meetings with employees whenever they have been absent. These discussions help to establish why the employee had time off and allows emplyoers to ask about any inconsistencies between what information they were given and information garnered from social media postings.

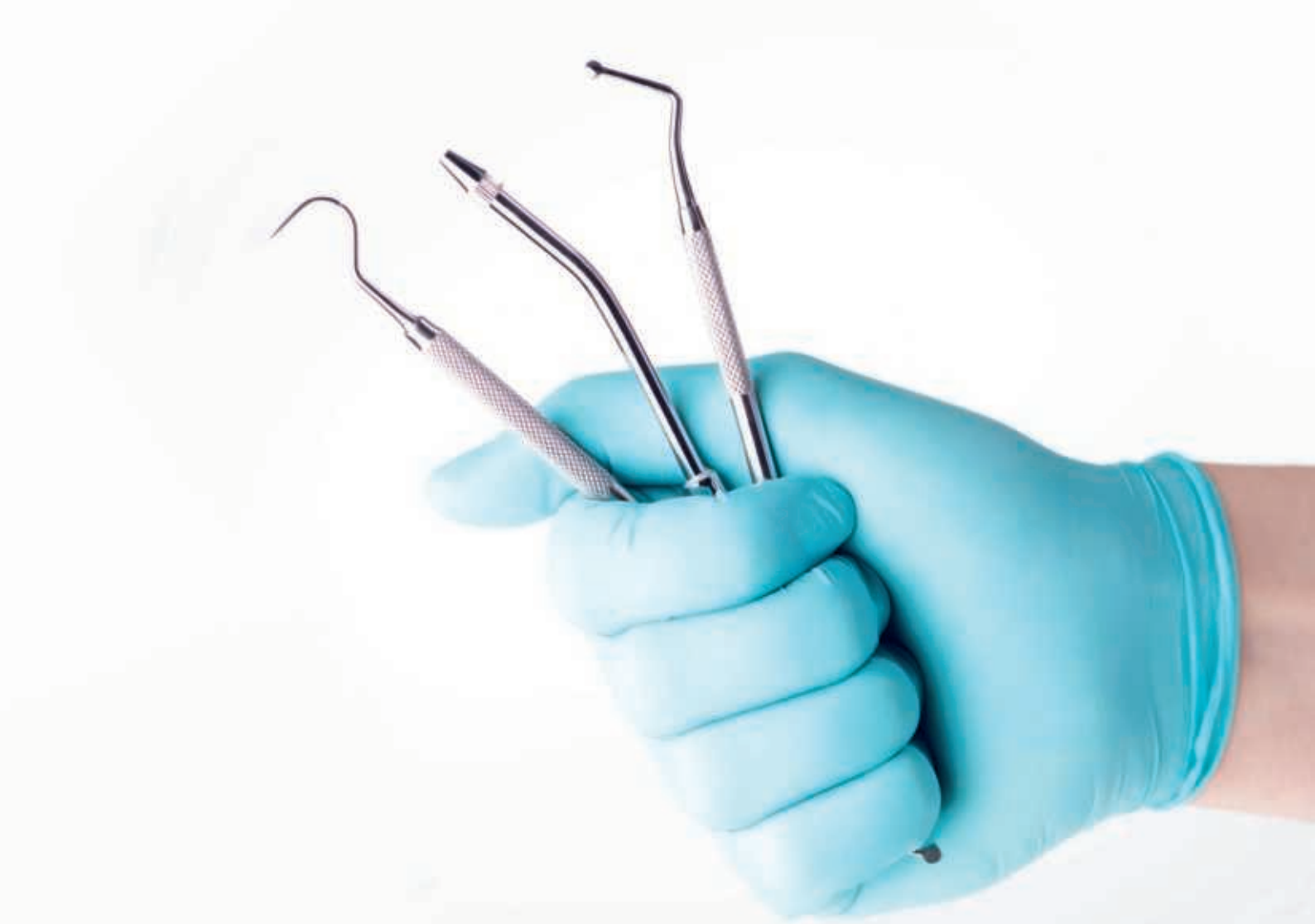
Return-to-work meetings are an effective intervention to manage short term absence – the discussion should be informal but confidential, it is just for fact-finding and is not disciplinary so the employee does not need to bring a companion. Practice managers might bring up the fact they have seen a social media post during the employee's absence and wish to question them on it. Practice management should approach with sensitivity and tact – and not be accusatory – in discussions with the employee. Seeking an explanation is a perfectly valid request. If an employer has sufficient evidence that an employee has abused sickness absence and was not genuinely ill, then it would be a disciplinary matter.

Mark thinks there's one way to navigate the issue – for both employer and employee.

'I would treat social media the same as real life. If we know that someone always drinks in the same pub, is it acceptable to go to that pub specifically to see if we can find them? If we know that someone lives in a particular street, is it acceptable to walk down that street regularly in the hope that we see them?

'By the same token, if we happen to be out socially walking down a street or in a pub and then bump into someone, is that acceptable? Both parties have a responsibility to behave in an ethical manner. Whatever you post, always bear in mind the practice's social media policy and the GDC's standards.' ◆

Further information is available at www.bda.org/advice in the BDA's Sickness absence and Disciplinary procedures and dismissal publication.



# Think patient safety: buy the genuine article

GDC action and a criminal conviction highlight the dangers of using counterfeit and non-compliant devices. The risks to you, your patients, colleagues and practice are very real.

As part of an industry-wide response to the issue the British Dental Industry Association (BDIA) operates the Counterfeit and Substandard Instruments and Devices Initiative (CSIDI).

CSIDI facilitates the reporting of those selling such products and promotes responsible purchasing throughout the dental supply chain.

The key is to get to know your suppliers.

BDIA members adhere to a strict Code of Practice giving you confidence that the products you purchase are of guaranteed quality and provenance.

**Download the latest tips on how to spot fake dental products, find trusted dental suppliers or report anything suspect now at www.bdia.org.uk**

BDIA CSIDI
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*Image of counterfeit products confiscated by the MHRA.*

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# The great marketing debate: Practice vs personal


## Nicki Rowland

Nicki's career began in 1992 as a chartered, state registered physiotherapist with a special interest in head and neck pathology. She has lived and breathed practice management since opening Perfect 32 Dental Practice in East Yorkshire with her husband in 2005 and has recently established Practices Made Perfect by Nicki Rowland, primarily as a dental consultancy and training organisation.


Marketing can come in many different forms, shapes and sizes. It can be an email, a leaflet or an open day. Traditionally marketing has always been about a practice, a new treatment or an organisation, but there's a new type of marketing we need to consider.

The rise of the foot soldier – the Associate – effectively means there is a pool of skilled workers clamouring for the same jobs. It's rather like the green aliens on *Toy Story* – they're just waiting for 'the claw' to choose them. And so Associates must consider how to separate themselves from the next person, which now means marketing.

To find out how an Associate markets their skills and how this matches up against practice marketing, David Westgarth spoke to Practice owner Nicki Rowland and Associate dentist Dr Shiraz Khan.


## Shiraz Khan

Dr. Shiraz Khan graduated from the University of Birmingham Dental School in 2013. Having successfully completed foundation training and winning several prizes, he finished his dental core training in a range of specialisms including Restorative Dentistry at Croydon University Hospital, Guys and St Thomas's. He is currently placed in practice in the heart of London, Clapham and suburban Hemel Hempstead


*What's your golden rule of marketing?*

**NR** Without a shadow of a doubt, my number 1 principle for marketing is to establish your business strategy and position in the marketplace. Time after time, I visit dental practices that are marketing their services and products without a business framework in place. How can these practices know what patients want? How do they know what their competitors are doing? And how do they know what they are aiming to achieve without business objectives in place? After managing a dental practice myself for 10 years, I acknowledge that time is always against us and strategic business planning activities can often end up at the bottom of the priority list. However, my experience in other practices is that this area of critical work is totally misunderstood or not understood at all!

**SK** For me it's in something Steve Jobs said. He said the only way to be good at work is to love what you do. I have several arms of dentistry that I love and can apply that mantra to. If you have a broad base of skills, it allows you to specialise and refine as your career develops. I have experience in a dental practice, hospital, writing, social media, marketing and a number of specialities, and I love them all. I believe having a base portfolio of achievements is crucial, but perhaps just as important as loving what you do.

*How has marketing changed and developed over the years? We're seeing a bigger pool of Associates every day – not to mention the ways in which practices speak to patients*

**SK** I have never worried about differentiating myself from other Associates. It's important to realise your skills probably match up to someone else's. Practices have the luxury of having a brand, a logo, a website and a patient base. Most Associates do not have that. That's why I created a website, a logo and a brand. Clinics and patients begin to understand my brand stands for patient care that exceeds their expectations.

**NR** It's interesting you mention practices having brand awareness and a patient base, because over the past 10 years, the face of dentistry has dramatically changed, the economy being one of the major influencing factors. We are seeing fewer patients less often as the financial fist has tightened. Many regular visitors to the dentist have opted not to go at all; patients needing intervention are choosing less expensive treatments; and people are purchasing sundry items from cut-price superstores. Proactive practices have reduced their external marketing expenditure. They are changing their focus to internal marketing activities. These proven strategies have been successful in enticing previous patients back to the practice and increasing footfall through word of mouth referrals. When implemented correctly, internal marketing is the most successful, least expensive way of identifying, segmenting and attracting the right patients.

*What common mistakes do you see in marketing?*

**NR** The most common mistake I see is that a marketing strategy (that should dovetail with the business strategy) is not communicated to the team. This means that the management team knows what is happening behind the scenes but staff does not understand how this translates to the way in which they should be working. I often see reception teams being coached to convert NHS patients to private without little or no reference to how these conversions impact on the bigger business picture. Business and personal objectives are not set so there is lack of direction and motivation to achieve what they are learning.

**SK** I see associates – and practices for that matter – comparing themselves to others. If you're always trying to measure up against someone, it inhibits potential. Potential for growth, for development, for being proactive like Nicki mentioned earlier. You need to understand your own level of experience from an Associate's point of view. Everyone has a CV, and it's difficult to get across who you are in that, so conversations and people knowing about you before they have even met you is important.

**NR** It happens in practice marketing too. I talk to so many people who just do not understand their competition and how to approach them. Whether you like it or not, they are hungry for your patients and implementing their own strategies to attract them. Researching your competition gives you 'market intelligence', perhaps like a practice owner researching an Associate!

> 'Dental practices are increasingly using Facebook, LinkedIn, and Twitter as marketing outlets. Tune in and you might pick up some useful information.'

*How does social media fit into all of this?*

**SK** You have to be extremely savvy. The way I approach my social media strategy does cause some disgruntlement among peers, but I like to think the effort I put in gets me results. For instance I recently lectured in Germany as a result of a Facebook conversation. Without the brand awareness, it's unlikely I would have done that.

**NR** Dental practices are increasingly using Facebook, LinkedIn, and Twitter as marketing outlets. Tune in and you might pick up some useful information. They are great platforms for reaching a certain audience and as Shiraz says for building brand awareness. But it's more than that for a practice. Using newsletters and ecomms to talk to a patient before and after their treatment will go a long way to retaining them.

*What happens if you stand still for too long?*

**SK** I think you can, but there has to be some natural movement within that. Think of it like interest rates. They stay constant but markets do fluctuate on a daily basis. If you play at your level and know where your areas of development lie, you shouldn't get left behind. It is more important than ever for Associates to do this, given the increase in numbers.

**NR** It's the same for dental practices too. Knowing where your strengths and weaknesses lie helps immensely. Knowing you patients is vital in keeping you ahead of your competition too. Surveying your patients to find out what is important to them is one way to do that. In this difficult fiscal climate, if price is an issue, try and offer flexible payment methods and revise your sales and marketing strategy accordingly. This may mean expanding your service offering but giving patients what they want has been proven to strengthen patient loyalty. Look after your existing patient base. They are your bread and butter and could very easily be swallowed up by a competitor if you do not meet their expectations. Remember that it is more cost effective to look after your current patients than to attract and sign up new ones.

**SK** That principle applies to Associates too. I can't imagine a constant turnover of associates is good for the practice. It's good to bear in mind that the time you invest in a website, in social media, in articles doesn't pay immediate dividends. If you be yourself, you will stand out. That will keep you ahead of the competition.

*So what do you consider the most effective form of marketing?*

**SK** To recognise that when others see confusion and uncertainty I see opportunity. The only thing that is constant is change, so be adaptable. You have to be social media savvy in this day and age, so invest time in it. To do all of this, you have to be dedicated. As an Associate, that's your secret weapon.

**NR** I have found that a patient-centred, forward thinking approach to marketing to be the most effective method. Internal marketing, by far, gives the greatest results. Marketing to patients that are already loyal to your brand is so much easier and more cost effective than engaging in costly external marketing activities that, more often than not, give a poor return on investment. However, if patient numbers are an issue at your practice, I have found that running a PR campaign to be highly effective in generating new footfall. A few years ago, our practice ran a free oral cancer screening day using a traditional exam reinforced by an advanced screening tool. This was marketed to non-patients via a radio interview, flyers and a newspaper editorial feature. We were inundated and ended up offering a second day of free screening. On calculation, the conversion rate of non-patient to patient was 60%. Remarkable! ◆


# if

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# Recovering training fees

by Claire Bennett
a Practice Management Consultant in the BDA Practice Support Team, she qualified as a solicitor in 2008 and advises members on associate contracts and employment law issues.

Many practice owners invest substantial sums of money in the training of their staff. It can therefore be a source of great frustration when an employee who has recently attended a training course decides to leave before the practice gets any return on its training investment. It is understandable if employers want to attempt to recover from the departing employee the costs they have incurred on training. However, this can only be done in certain circumstances – the key is having a carefully drafted training agreement with a repayment provision as part of the employee's contract of employment.

## Repayment clauses

Typically, the terms of a repayment clause will be that, if the employee leaves the practice within a specified period of time, the employee has to repay the costs incurred by a practice owner as a result of training. There is a danger, however, that unless the repayment clause is drafted precisely, it may be regarded as a penalty clause, which is unlikely to be enforceable.

To be enforceable, the amount of money which any repayment clause permits a practice owner to recover must be a genuine estimate of the losses they are likely to suffer in the event that the employee leaves the practice. In many situations this would be the amount spent on course fees. However, if the employee has finished the course a repayment clause should set out a sliding scale of repayment, whereby the amount to be repaid reduces according to the length of time the employee remains with the practice following the completion of their training. This is to reflect that fact that the longer the employee remains with the practice the more benefit the practice owner derives from the employee's training. The clause will also only be valid if the employee has signed and dated their contract.

Employers should avoid making the repayment period too long. Twelve to twenty-four months is common. What is reasonable will depend upon a number of factors, including the level of the costs incurred by the practice owner and the intensity and length of the course itself.

Repayments also should not apply where an employee leaves because of redundancy since the employee is not leaving voluntarily.

## Training agreements

Whilst an appropriate clause in an employee's contract is always advisable, practice owners should also require an employee to sign a training agreement when they sign up for a new course. This enables you to specifically identify the course and the amount of fees concerned. You can also include commitments for the employee to make their best efforts to attend and successfully complete the course. Make sure the agreement is signed and dated by the employee.

## Deductions

Crucially, a repayment clause or training agreement must give the practice owner contractual authority to deduct the sum of money directly from the employee's salary or final payments (such as accrued holiday and bonuses). Otherwise you may encounter difficulty in recovering the money should the employee refuse to pay. You cannot simply deduct money owed to you from an employee's wages, you need a specific clause that allows you to make deductions. The clause must also state the reason for which deductions can be made. If contractual authority is not obtained and an employee successfully claims an unlawful deduction of wages, a practice owner will not later be able to recover any part of the deduction that is found to be unlawful.

If an employee objects, a practice owner should ascertain at the outset whether or not the employee wants their objections to be treated as a formal grievance. If the employee does want the issue to be treated as a formal grievance, the practice should ensure that their concerns are listened to and a formal response is given in line with you practice grievance procedures.

Generally, a practice owner will be able to rely on a properly drafted repayment clause or training agreement that has been signed and agreed by the employee. However, it is important that the size of any deduction does not infringe upon the employee's right to receive National Minimum Wage, so any deduction should not take their wage levels for the pay period below the applicable rate of minimum wage.

Any remaining debt after the deductions are made and the employee has left the practice's employment could be recoverable through a civil court claim. However, in view of the costs involved in civil litigation, both financially and terms of management time, it will often be in the interests of both parties to come up with an agreed repayment plan for the remainder of the debt. ◆

For more information on setting up training agreements with staff to cover the deduction of fees if the employee leaves Extra and Expert members can contact BDA Practice Support on PracticeSupport@bda.org or telephone 020 7563 4574.

# Confidentiality and keeping records

by James Dawson

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

Taking and keeping contemporaneous records for each patient would be a natural part of providing patient care even if it was not the key ethical requirement of the GDC. However, you also have to make sure to comply with the rules set out in the Data Protection Act[1], including only keeping patient information for a 'specific and lawful' purpose. This should be easy patient records are kept so that you can give the patient appropriate and safe dental care. You should clearly state this reason in a data protection policy for patients. Your reason is not valid unless you have informed patients about it – for example through a freely available data protection code of practice policy. that tells them what information you keep and what you do with their information.

Apart from the obvious treatment benefits of charting a patient's mouth and noting the treatment options available and the treatment given, you probably also need the information for administrative purposes. This could be processing claims under private dental plans or NHS regulations, so make sure that this is covered in your policy. This is important because if you use patient data for any other reason you would have to go back to the patient and get their specific permission.

## Registering with the ICO

When it comes to registering with the Information Commissioner's Office (ICO) – something that those responsible for processing data electronically have to do – include your reasons for collecting and processing personal information. By doing so you are ensuring that you are in full compliance and that there can be no doubt that you are keeping records for a proper purpose.

## Compatible

The things you do with the information recorded must fit with your stated purpose. Information must be directly relevant to the care you provide to that patient, so their name, address and a daytime telephone number are useful. On the other hand if their daytime telephone number happens to be a work one, there is no need for you to also record the employer's name and address. Do not hold information just in case it may be needed. Again you should not be recording the details of a patient's employer because a need may arise for you to contact them at work.

The information you collect on patients cannot be used for promoting other services that you or related businesses offer. For example, if you treat a patient treated for a sports injury, you should not send them information about the physiotherapist that you rent the room downstairs to; contacting them about other services even if they seem relevant would not be right.

## Referrals

Your reason for collecting patents' personal information is also important when you need to disclose it to a professional colleague. Generally, it is justifiable to share information with another healthcare professional where you discuss treatment options with team members within the practice or you refer for specialist treatment – in these instances information on the patient is shared so that so you they can receive the most appropriate care. When you discuss the referral with the patient, you should explain to the patient that you will send their records to the specialist; and note their consent in the patient records. Reassure patients that these sort of disclosures will take place on a 'need-to-know' basis. Only those who need to know in order to provide care to the patient will be given the information, and only the information that is necessary for the recipient to do their job will be disclosed.

## Research

Once you have stated your reason for collecting patient information the law says you cannot use it for another incompatible reason. That is generally fine as the reason most practice should use – giving patients appropriate and safe dental care – is wide-ranging. However, one situation it may not cover is Continuing Professional Development (CPD) and research.

For these purposes data from your practice can be very useful, but you cannot say this is directly connected to their dental care. If you are using purely statistical information this is specifically allowed by the Act[2], as long as its use does not cause substantial damage or distress to anyone. For other information what you should do, when you have a specific project for which you want to use the data, is explain to the patients involved how the information or images will be used and check that they understand. The patient's consent should be recorded in their notes; they should understand that they can withdraw consent at any time. You should use the minimum information necessary and ensure that anonymity is maintained. ◆

1. Data Protection Act 1998, Schedule 1, Part I, sections 1-8; 1998 Chapter 29; Her Majesty's Stationery Office.
2. Data Protection Act 1998, section 33; 1998 Chapter 29; Her Majesty's Stationery Office.

A template Data Protection Code of Practice for patients is available at www.bda.org/ExpertSolutions

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## Expand your CPD horizons

Johnson & Johnson, the makers of LISTERINE, are delighted to bring you new online content, to help support the ongoing CPD needs of dental healthcare professionals in improving and maintaining the oral health of their patients.

This is free to complete and each module accounts for 1 hour of verifiable CPD.

The programme delivers recent clinical findings, useful information for in-practice management of oral diseases and patient communication strategies for improved preventive home care, as well considering the effects of lifestyle and other external influences on your patients' oral health.

The module includes new pieces on:

- The adjunctive benefits of a daily use mouthwash
- Evidence-based decision making
- Communicating with children
- Dr Elizabeth Kay: Psychology in communicating with patients.

In addition, soon to be made available are CPD articles on:

- Dental care for older patients
- In support of prevention.

Upon completing each module successfully, you can either select to save and print your certificate and/ or have a copy emailed to you directly.

Visit www.listerineprofessional.co.uk/cpd-educational-programme to earn verifiable hours from the continuously expanding library.

## Facial Aesthetics in Brazil and Argentina Tour

Examine surgical orthodontics and facial aesthetics through a range of CPD lectures and visits in countries where these specialities are well developed. Along the way gain a fascinating insight into the vibrant culture, beauty and rich history of Brazil and Argentina.

Tour leader Paul Johnson, consultant in Oral Maxillofacial Surgery at the Royal Surrey Hospital is accompanied by guest speakers Karen Johnson, a barrister specialising in clinical negligence and Orthodontist, Dr Gerry Bellman.

Taking place from 29 January – 8 February 2017, you will arrive in Rio and visit Copacabana Beach, Christ the Redeemer and Sugar Loaf Mountain. Fly to dramatic, tropical Iguazu Falls for stunning views from both the Argentinian and Brazilian side of this natural wonder. Onto Buenos Aires, the seductive 'Paris of South America' and wander along gracious boulevards, explore the colourful artists' quarter, San Telmo antiques market and see the legendary tango performed in its home town.

At the end of the tour there is an optional post tour extension to Patagonia to visit spectacular glaciers and cruise past vivid blue icebergs.

For more details: please visit www.jonbainestours.co.uk/rio or call 020 7223 9485.

## Brexit – the positive side

Since the results of the referendum we have been questioned by sellers and buyers alike as to the potential impact on dental practice sales. As we do not have a crystal ball we have to rely on hard evidence and whilst the Friday after the referendum was much quieter than normal, business soon returned to normal and we have seen some significant offers on practices for sale, one in North London has achieved 261% of goodwill, a mixed NHS practice. We have also seen bank funding being agreed on a variety of practices and some in excess of a million pounds.

A specialist dental accountant did comment to me that he thought Brexit may result in more money being made available for NHS dentistry.

So, if you are looking to sell or buy a practice call Frank Taylor & Associates on 0330 088 11 56 to find out more.

## Interested in a Genius?

Dental Showcase is ***the*** number one dental show in the UK and is therefore a natural partner for Oral-B, Much interest is expected in Dental Showcase's Headline Sponsor Oral-B's new power toothbrush, Oral-B Genius.

By combining motion sensor technology located in the brush, and video recognition using a smartphone's camera, all areas of the user's mouth can be tracked so that they know exactly where they've brushed and where they've missed!

Patients receive instant feedback on the brushing of each zone of the mouth via the Oral-B App 4.1, including guidance on pressure applied and brushing duration.

The mechanical benefits of Oral-B's power toothbrushes compliment the chemical efficacy afforded by their Pro-Expert toothpaste. It's the inclusion of stabilised stannous fluoride ($SnF_2$) that makes the difference. Stannous fluoride was the first scientifically recognised fluoride and has been stabilised and combined with sodium hexametaphosphate, to provide additional protection.

To see Genius for yourself visit Oral-B at stand I40.

## A voyage of discovery at BDIA Showcase

Philips continues to build on its legacy of clinical achievements and an ethos of perpetual R&D and innovation to introduce yet more technically advanced dental products to its portfolio at the BDIA Showcase in 2016.

This year it will be taking Showcase delegates on a voyage of discovery.

### Passport to improved oral wellness

At the start of the Philips journey is the ubiquitous Sonicare – the innovation which initiated a whole new dental sector for sonic tooth cleaning and has become the sonic toothbrush most dental professionals worldwide recommend for good reason. Patients can chose from the classic EasyClean – which a recent super study showed achieves significant plaque removal at an entry level price - to the pinnacle of desirability - the designer DiamondClean – which BBC Watchdog tested and reported was *the* best brush for plaque removal. 2016 sees the launch of a new fashion-forward colour choice for the DiamondClean ensuring this multi award winning brush continues to go from strength to strength this year. 2016 also saw the launch of Sonicare for Kids Connected, and Showcase will see the Sonicare FlexCare Platinum take adults to an exciting new level of connectivity.

Sonicare brushes are even better when used with the pioneering AirFloss Pro interproximal cleaner, which sets the gold standard for exemplary oral care and improves gum health in 2 weeks. This, when coupled with TongueCare +, cleans areas of the mouth even devices cannot reach for the ultimate in fresh breath.

### Helping dentists to see the light

Philips Zoom is the number one patient-requested professional whitening treatment. It comprises Zoom WhiteSpeed – the only in-practice light-activated system with variable intensity settings to maximise patient comfort and a gel which includes amorphous calcium phosphate (ACP) to further minimise sensitivity and protect tooth enamel. The chairside system achieves 6 shades whiter in just 60 minutes. This is best combined with Product of the Year Winner, Philips Zoom NiteWhite and DayWhite at-home whitening for a visibly whiter smile in 1-2 weeks. They are the only at-home whitening products on the market to contain ACP. The newest introduction to the tooth whitening portfolio is Zoom QuickPro with its paint on, brush off convenience, and four shade results in four days – and this too will be on show at Dental Showcase. A new Zoom whitening initiative will also be unveiled at the show.

To embark on a journey of discovery with Philips Oral Healthcare please visit Stand N40 at The BDIA Showcase or www.philips-tsp.co.uk/sonicare for new product launch information.

## Performance, value and peace of mind

If you're looking for top quality decontamination equipment with outstanding service and value, don't miss Eschmann at BDIA Dental Showcase. Having driven standards in infection control for the last 50 years with the Little Sister range of autoclaves, Eschmann offers an array of solutions designed to deliver maximum performance, durability and functionality.

What's more, all products including the Little Sister SES 2010 and Little Sister SES 3000B autoclaves come with free installation, CPD training for staff, annual validation and a Lifetime Breakdown Warranty as standard. Providing all the on-going support and ultimate peace of mind you need, Eschmann's dedicated, fully qualified engineers already care for half of all dental practices in the UK.


For more information on these services and products, as well as the latest Meile PG8581 washer disinfector, visit Eschmann on stand G54 at BDIA Dental Showcase.

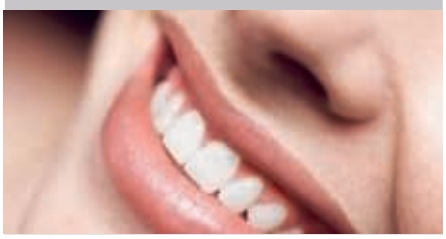
## Support a cause

Falling just before the start of Mouth Cancer Action Month 2016, Dental Showcase is the perfect opportunity to pledge support to the fight against mouth cancer. Even though cancer rates are decreasing in the UK mouth cancer rates are bucking the trend and continue to rise dramatically, figures released recently show that cases have now topped 7,300 per year in the UK for the first time ever and overall have increased by more than a third in the last decade alone.

Over the years, more and more dental professionals have embraced the subject and educated patients about mouth cancer. The dental community is vital in helping to spread oral health messages and with your support we can reach the public and make a real difference.

The team will be on hand to talk to you about how you can get involved with this year's campaign at stand M74, it only takes a minute to sign up and show your backing. By pledging your support we'll send you a campaign guide, poster and further information; as well as a series of digital packs and uploads in the lead up to the campaign with great tips and advice on how you can get involved and show your support.

It's up to you how much you do to get involved, find out more information at www.mouthcancer.org.



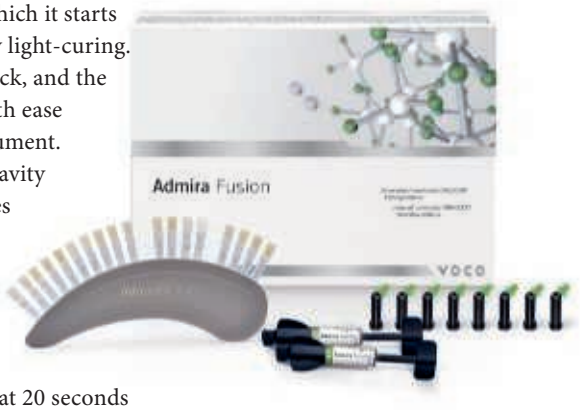
## Pioneering innovations and bestsellers at BDIA Dental Showcase

VOCO presents several very remarkable novelties at the BDIA Dental Showcase. The Admira Fusion, the world's first restorative material to combine ORMOCER with nanohybrid technology, will be present. In this case, both the fillers and the matrix are based on silicon oxide. Thanks to this 'pure silicate technology', Admira Fusion boasts excellent biocompatibility, extremely low shrinkage, optimal colour stability and a high filler content. The new filling system is complemented by Admira Fusion x-tra, which allows increments of up to 4 mm while displaying the same physical properties, and by Admira Fusion Flow, which features excellent flow properties with complete wetting of cavity walls. Admira Fusion, Admira Fusion x-tra and Admira Fusion Flow are compatible with all conventional bonding agents.

A further new product is Ionolux, a light-curing glass ionomer restorative material in the innovative VOCO application capsules. One of the characteristics of Ionolux, for example, is that the point in time at which it starts setting can be determined by light-curing. Application of Ionolux is quick, and the material can be modelled with ease without sticking to the instrument. It also adapts excellently to cavity walls. Ionolux not only makes conditioning of the dental hard tissue unnecessary, there is also no need to apply a final coat of varnish. Polymerisation times are short and practice-oriented, at 20 seconds per 2-mm layer. Ionolux is easy to polish, it is biocompatible and releases fluorides.

Another attraction and bestseller at the BDIA Dental Showcase is Futurabond U, the market's only true universal adhesive in a disposable applicator. Futurabond U offers practitioners an outstanding range of options for application, as much with regard to indications as to selection of the etching technique or the curing mode: self-etch, selective-etch or total-etch. This universal adhesive is fully compatible with all light-curing, dual-curing and self-curing methacrylate-based composites and is suitable for both direct and indirect restorations – and without any additional activator for dual-curing. Futurabond U can furthermore be used for desensitising hypersensitive tooth necks and after cavity preparation, and it is suitable as a protective varnish for glass ionomer cement restorations.

For further information visit stand L40, www.voco.com or call 07500 769613.




## Time to check your superannuation

Have you downloaded your NHS superannuation statement for the year ended 31 March 2016 from the Compass dental contact management system? If not then you should do so now.

Declared pensionable earnings and superannuation contributions are assumed to be correct unless you communicate with NHS Dental Services within two months of notification.

Many principals still believe incorrectly that pensionable earnings are 43.9% of the Associates' 'gross' fees. Pensionable earnings calculations are different for the principal dentist if trading as a limited company.

It is up to the principal to ensure correct adjustments have been made to Associates' earnings in respect of Associates' under/overpayment of superannuation for the previous year. Without this large amounts can be owing from previous years. It is also worth considering if superannuation amounts deducted from Associates' current earnings are not realistic then a contract allocation form needs to be submitted by the principal dentist.

If you need any assistance with the above then please contact Peter Howard at Booth Ainsworth LLP Chartered Accountants on 0161 475 3920 or peterh@boothainsworth.co.uk.

## Restore your patient's confidence

Up to 86% of patients are affected by food becoming trapped under their dentures.[1] This can lead to discomfort and can cause bad breath.

Results have shown that Poligrip denture fixatives have the ability to seal out food particles helping to reduce gum irritation[2] and lead to increased levels of confidence, comfort and chewing efficiency.[3]

The Poligrip range of fixatives include Poligrip Flavour Free Fixative Cream and Poligrip Ultra Denture Cream.

For further information on Poligrip and dentures, why not complete the Poligrip distance learner module and earn up to 1.5 hours of CPD. Simply visit www.gsk-dentalprofessionals.co.uk.

1. Data on file, GSK, Canadian Quality of Life Study, 2005.
2. GSK Data on File. Murphy ***et al,*** 2012.
3. GSK Data on File. Durocher *et al*, 2008.

## Perfect for patients

Patients should always be given as much information as possible, to make the right decision. This results in greater case acceptance and documents informed consent.

This only software that can deliver anatomically correct beautiful images, changing size, shape, position, colour and more, all in less than a minute! = The most advanced imaging software available.

For patients, the real power is that they can see a very accurate photo of how they personally could look following treatment, rather than showing them pictures of other cases you have completed or diagrams in books or animated software.

Patients become excited and motivated to start treatment, and like to take their photo away of the imaged smile to show friends. This always generates new patient enquires.

Smile Imaging will pay for itself after one or two cases and increase your future case acceptance significantly.

Book a FREE trial or Lunchtime & Learn at www.smileimaging.co.uk **or** for more information call Tracy on 07974 012542.

## What's new?

Dürr Dental will be exhibiting a range of their equipment at this year's BDIA Dental Showcase. Their brand is synonymous with leading edge imaging equipment. Their panoramic device is so easy to use you won't need a second take, as the first one will almost certainly be perfect. Unlike other devices this unit does not rely on experience or expertise, in fact both are almost negligible! Come and experience the difference yourself. You'll also get a chance to experiment with a totally new piece of imaging equipment!

Visitors might also be interested in the latest networking systems that can be used with your compressor and suction system. By linking them to the network, practices can see the performance of each piece of equipment at a glance. Linking the compressor, for example, to the digital network yields numerous benefits: current status, faults or messages, such as for filter changes, are immediately displayed.

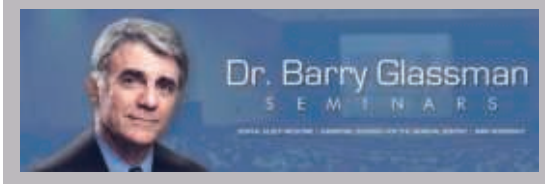
Visit stand L76 to find out more.

## Splint therapy and occlusion seminars with Dr Barry Glassman

S4S are delighted to invite Dr Barry Glassman back for a sixth year to present a series of lectures on the subject of bruxism and associated dental issues. This year Dr Glassman will be speaking in London on 27 & 28 October.

Dr Glassman is a dentist located in Pennsylvania, USA. His private practice is limited to chronic pain management, TMD and dental sleep medicine. He has a comprehensive lecture programme in the USA and internationally covering these subjects.

In a nutshell, the sessions are for every dentist wanting to learn the truth (and be willing to unlearn some of the dogma that has been taught to us as professionals over the years) about TMD and Occlusion. On day one there will be an overall in depth review of TMD, Occlusion, Bruxism and Pain Management, combining clinical experience with the current science. We will look at practical approaches to pain and dysfunction management. Attendees will have the opportunity to discuss their own cases. Day two will be a re-cap of day one followed by a Hands-On session fitting SCi appliances and adjusting them on each other.




For booking information please visit www.s4sdental.com/training-for-dentists-dcps/splint-therapy-and-occlusion-seminars-dr-barry-glassman.

## Come and see some wisdom!

With more than 235 years' success with proven oral health solutions, don't miss Wisdom Toothbrushes at stand O12 at BDIA Dental Showcase this October.

New for this year is the Wisdom Super Slim Interspace brush that features an extra-soft, longer, thinner tuft, ideal for cleaning deeper into periodontal pockets. The single tuft design is also suited to cleaning around crowns, bridgework and orthodontic appliances.

Another highlight of the extensive portfolio is sure to be the Wisdom Clean Between Interdental Brushes. Clinically proven to help reduce gingival disease, these unique flexible brushes feature a tapered design, super-soft rubber coating and micro-fine rubber filaments for a gentle yet highly effective clean.


In addition, the team will demonstrate the Wisdom Clean Between Easy Slide Y Shaped Floss Harps with PTFE tape, Wisdom Easy Flosser also with PTFE tape and the popular Wisdom Interproximal Brush, with various samples available.

To find out more visit www.wisdomtoothbrushes.com or call 01440 714800.

## Something for everyone

Are you going to the BDIA Dental Showcase this year? If so, be sure to visit A-dec on stand I20.

As one of the world's foremost manufacturers of high-quality dental technology, A-dec has something for everyone – and will be showcasing its extensive and widely popular range of dental chairs, stools, lights and cabinets to delegates.

This, of course, includes products such as the premier A-dec 500, which has been designed for optimal ergonomics and patient access, or the newly updated A-dec 300, with unprecedented modular flexibility and adaptability.

What's more, the friendly A-dec team will be encouraging delegates to try designing their next A-dec chair using the new my A-dec App – an innovative programme that allows practitioners to design the chair they need, to their own preferences and clinical specifications. All delegates that take advantage of this excellent opportunity will also be entered into a draw to win a short break for two in the UK.

This is an unmissable chance to talk to the A-dec team and learn more about the wide range of dental solutions, so make sure you save the time to visit their stand at the BDIA Dental Showcase 2016!

For more information about A-dec Dental UK Ltd, visit www.a-dec.co.uk or call on 0800 2332 85.


## A display of partnerships

If you are planning on visiting BDIA Dental Showcase 2016, then be sure to visit Wrights on stand L30 – the portfolio of quality products is not to be missed.

Wrights will be exhibiting an eclectic catalogue of top solutions in partnership with leading brands and manufacturers – including the popular range from G&H Orthodontics, high-tech CAD/CAM equipment from Planmeca and the innovative practice management software from Dentally.

Plus, Wrights will be showcasing first rate Bien-Air handpieces, such as the Bora L, Boralina, Eolia B, Prestige L and Presilina, of which it is now the exclusive distributor of in the UK.

For more information contact Wrights on 0800 66 88 99 or visit www.wright-cottrell.co.uk.

## Make friends with PerioChip at BDIA Showcase

A friendly team of experts will be on stand O22 waiting to show you the amazing benefits of PerioChip. With product demonstrations and practice-based applications to show you how to treat periodontal disease effectively without antibiotics, it's a must see when you visit the BDIA Dental Showcase.

PerioChip is an easy to use, highly effective non-antibiotic adjunct treatment to reduce pocket depths in patients with adult periodontitis. After root surface debridement (RSD), PerioChip works with you to control bacteria, prevent infection and minimise the risk of tooth loss.

Designed specifically for periodontal pockets >5mm, this innovative, biodegradable insert optimises treatment outcomes by eliminating 99% of subgingival pathogenic bacteria over seven to ten days after placement. As well as this, the antimicrobial effects of PerioChip carry on working to suppress bacterial growth for up to 11 weeks, allowing effective healing and stabilisation.

Clinical studies into the efficacy of PerioChip show that combining RSD with PerioChip can offer five times more effective results in the reduction of periodontal pockets versus RSD alone.

When you have PerioChip at your side, you have a product you can count on. There is no wonder it's been described as a 'first line treatment' for patients with periodontal disease.

For further information visit stand O22, call 0800 013 2333 or email team@periochip.co.uk.

# Seminar Series

BDA
British Dental Association

# Whiter than white

Latest trends for achieving predictable whitening to grow your business and manage complex cases

This seminar will be delivered by a panel of expert speakers.

LEEDS | Friday 23 September 2016
LONDON | Friday 30 September 2016

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

## Learning objectives

- Confront teeth whitening myths and facts and know what actually works
- Treat discoloured teeth using safe, predictable and legal internal bleaching
- Consider how resin infiltration can be used in the treatment of superficial and deep white spot lesions
- Understand clinical issues for predictable whitening
- Use digital marketing to attract patients for whitening
- Make whitening the profit centre of your practice
- Discuss the latest whitening protocols – is power bleaching dead?

Supported by:

BACD British Academy of Cosmetic Dentistry

Book online:

## www.bda.org/seminars

020 7563 4590 | events@bda.org

# Dentist to Dentist

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

## Scotland

### BLACKHILLS SPECIALIST REFERRAL CLINIC
www.blackhillsclinic.com

5 Maidenplain Place, Aberuthven Perthshire PH3 1EL
**Tel:** 01764 664446
**Email:** info@blackhillsclinic.com
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

## Midlands

### PARK ROAD DENTAL PRACTICE
www.parkroaddentalpractice.co.uk

20 Park Road, Melton Mowbray, Leicestershire LE13 1TT
**Tel:** 01664 568811
**Email:** info@parkroaddentalpractice.co.uk

**Interests:** Periodontics, Orthodontics, Implants

**Dr Ayodele Soyombo**
**On Specialist List:** Yes, Orthodontics

**Dr Bola Soyombo**
**On Specialist List:** Yes, Periodontics

**Dr O Onabolu**
**On Specialist List:** Yes, Periodontics

209439

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

Pinfold Lane, Penkridge, Stafford, Staffordshire ST19 5AP
**Tel:** 01785 712388
**Email:** info@thepriorsdentalpractice.co.uk

**Dr Mark Emms L.D.S.R.C.S (Edin) MSc (UCL)**
**Interests:** Dental Implants, Fixed and Removable Prosthodontics, Bone Grafts, Sinus Lifts, Full Mouth Reconstructions, Periodontics, Occlusion, Restorative and Cosmetic Dentistry, Implant Mentoring

**Mr John Scholey BDS, FDS, RCS (Edin), FDS (Orth) RCS (Edin) MOrth RCS (Eng), MDentSci**
**Interests:** Specialist Orthodontics, Mini-Screw, Lingual Braces
**On Specialist List:** Yes

**Dr Lukas Javorskis MSc Endodontology (Kaunas, Lithuania)**
**Interests:** Endodontics (including Instrument Removal), Use of on-site Microscope

CT Scanner and dedicated implant suite on-site.

236739

## North

### SPECIALIST DENTAL CARE
www.specialistdentalcare.com

**Mr Martin F. W-Y. Chan**
**BDS, MDSc, FDS (Rest Dent) RCPS (Glasg), DRD, MRD, RCSEd.**
29 The Grove, Ilkley, W. Yorks, LS29 9NQ
**Tel:** 01943 608090
**Email:** info@specialistdentalcare.com
**Interests:** Restorative and Implant Dentistry, Prosthodontics, Periodontics, Endodontics
**On Specialist List:** Yes, as above

261782

## South East

### GROVES DENTAL CENTRE
www.grovesdentalcentre.co.uk

72 Coombe Road,
New Malden,
Surrey, KT3 4QS
**Tel:** 020 8949 5252
**Email:** info@grovesdentalcentre.co.uk
**Dr Alix Davies BDS Hons MFDS RCSEng MJDF MClinDent Endo MEndo RCSEd**
**Interests:** Endodontics
**On Specialist List:** Yes

279798

### DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
**Tel:** 01908 630169
**Email:** admin@dentalspecialistmk.com
**Interests:** Orthodontics, Periodontics, Implants, Prosthodontics, Endodontics, Oral Surgery, Restorative Surgery, Sedation, CT scanner and Zeiss microscope on site
**On Specialist List:** Yes, Orthodontics, Periodontics, Prosthodontics, Restorative Dentistry, Endodontics and Oral Surgery

209440

## TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

## AYUB ENDODONTICS
www.ayub-endo.com

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

270171

## DENTAL SPECIALISTS ST ALBANS

96 Victoria Street, St Albans, Herts AL1 3TG
**Tel:** 0172 7845706
**Interests:** Periodontics, Orthodontics, Implants, Prosthodontics, Endodontics and Restoritive Dentistry
**On Specialist List:** Yes, Periodontics, Orthodontics, Prosthodontics, Endodontics and Restorative Dentistry.

239826

## WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

21 Reading Road, Pangbourne, Reading, Berks, RG8 7LR
**Tel:** 0118 984 3108
**Email:** referral@woodboroughhouse.com

**Interests:** Implants, Periodontics, Endodontics, Prosthodontics, Oral Surgery, Bone Augmentation, Sinus Lifts, I.V Sedation, Facial Aesthetics, CT Scanner.
**On Specialist List:** Yes Prosthodontics and Periodontics

266913

# North West

## ST GEORGE'S DENTAL PRACTICE
www.stgeorgesdentalpractice.co.uk

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

261006

# East Anglia

## DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

2 Queen Edith's Way, Cambridge CB1 7PN
**Tel**: 01223 245266
**Email:** enquiries@devonshirehousedental.co.uk

**Specialist Referral and Education Centre**

**Interests:** Prosthodontics, Implants, Endodontics, Periodontics and Orthodontics, Dental Education and Mentoring.

**Specialist Prosthodontists:**
**Julian Martin**
**Kevin Esplin**
**Ian Pearson**
**Wail Girgis**
**Cyrus Nikkhah**
**Nick Williams**
**Philip Taylor**
**Assad Khan**

**Interests:** Restorative Dentistry, Dental Implants, All-on-4®, Aesthetic Dentistry, CT Scanner, OPG Service and Dental Education

**Specialist Endodontists:**
**Elisabeth Smallwood** and **Julian Martin**

**Specialist Periodontists:**
**Trisha Whitehead** and **Puneet Patel**

**Specialist Orthodontist:**
**Dirk Bister**

269120

# Clinical Expert Series

BDA
British Dental Association

A day with
Prof Trevor Burke

## Bonding, composites and all ceramic crowns and bridges – what works where?

### Translating research in dental materials into clinical practice

LONDON | Friday 23 September 2016

**Learning objectives:**

- Assess the optimum methods of bonding resin-based restorative materials to teeth
- Reduce post-operative stress and sensitivity following posterior composite placement
- Treat worn teeth in a minimally invasive way
- Identify the material most likely to perform best in a given clinical situation
- Be aware of the potential performance of all ceramic crowns and bridges.

bda.org/seminars
020 7563 4590 | events@bda.org

6 hours verifiable CPD

# Business skills CPD

**Q1:** Complete this sentence: The transverse arch...

**A** Is the primary arch

**B** Runs along the bottom of the foot

**C** Runs along the outside of the foot

**D** Runs along the back of the foot

**Q2:** Why are return to work meetings effective?

**A** They manage short term absence

**B** They manage long term absence

**C** They are ineffective

**D** They are good for managing long and short term absence

**Q3:** What is a common time frame for employers paying back training fees?

**A** 6-12 months

**B** 12-18 months

**C** 12-24 months

**D** 24-36 months

**Q4:** What caveat is there for using a patient's information in a statistical context?

**A** You cannot use it whatsoever

**B** You can use it provided it does not cause distress or damage to the individual

**C** You can use it only with their written approval

**D** There is no caveat

**Q5:** How many hours of CPD per five-year cycle are required in decontamination and disinfection?

**A** 2

**B** 3

**C** 4

**D** 5

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

To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists polish their business and practice-management skills.

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

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

## Need help?

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

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

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

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

For support use: cpd.hub@bda.org

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# Pearl Dental Software

# Putting you in control

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**Stand H22**

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