BDJ Team

MAY 2015

Oral cancer: know the signs

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BDA
British Dental Association

May 2015

www.nature.com/bdjteam

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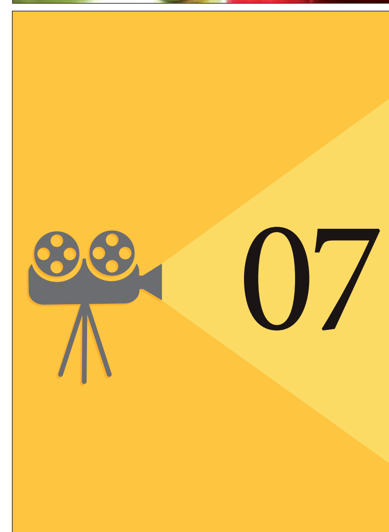

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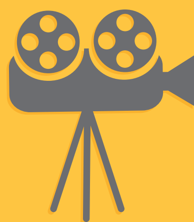


Ed's letter

Welcome to the latest issue of *BDJ Team* – my very first as editor, so a big hello to all our readers!

May's issue takes a close look at the current opinion surrounding electronic nicotine delivery systems, more commonly known as e-cigarettes. As sales continue to outstrip research, we seek opinions on whether we should be recommending them to patients, and if so how.

Also in this issue Xperient LLP partner Nicola Burnett Smith discusses how to stay out of trouble at work and remain professional in practice. She looks back on her career to date and picks out some of the classic ways practice staff fall short of good practice – without even knowing it.

As many of you will know the BDA Conference & Exhibition has now finished for 2015. We take a look at some of the highlights of this year and whet the appetite of things to come in 2016.

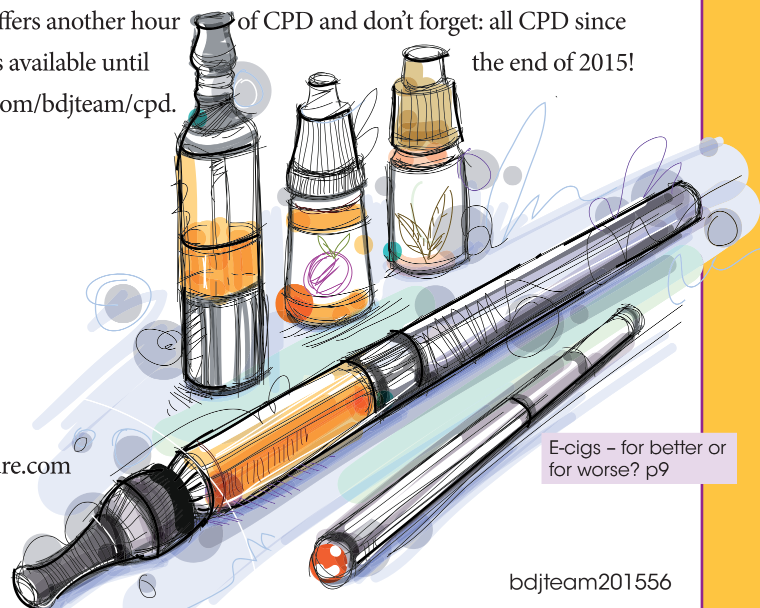
To wrap things up, Clinical Services Director at {My} dentist Steve Williams discusses the practicalities of skill mix and what successful implementation can mean to your practice. Steve gives us his insight into what makes skill mix work and what we can learn from practices embracing role substitution.

This issue offers another hour of CPD and don't forget: all CPD since March 2014 is available until the end of 2015! www.nature.com/bdjteam/cpd.

See you in June!

David

David Westgarth
Editor
David.Westgarth@nature.com



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THE TEAM

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NEW CDO ANNOUNCED

Following the retirement of Barry Cockcroft in February of this year, NHS England has announced that his successor will be Sara Hurley BDS(UBrist) MFGDP(UK) MSc(UCL) MA(KCL). Sara will serve as principal dental adviser and the professional head of dental staff in England. Sara will act as a senior member of the Medical Directorate, and work collaboratively to improve outcomes for patients, and champion the role of dentists and dentistry within the health system.

Sara Hurley qualified from the University of Bristol Dental School in 1988. Commissioned into the Royal Army Dental Corps, she has continued to broaden her clinical dentistry portfolio gaining Membership of General Dental Practitioners (UK) in 2003, a Masters in Dental Public Health at University College London 2004, and a King's College MA in Defence Studies 2007.

Her career has flexed across the domains of dental public health, wider healthcare policy and healthcare commissioning as well as undertaking operational healthcare management and strategic leadership assignments in a range of UK and overseas locations. She commented: "I am delighted and honoured to be taking up this new challenge as an integral member of the Medical Directorate at NHS England. The role of Chief Dental Officer remains a crucial link between decision-makers, patients and the wide range of front line providers that enable dental health. I am determined to use this position to articulate the dental health needs of our patients and, working collaboratively across the breadth of the dental healthcare profession, present directly to Ministers and NHS leaders our fresh ideas; ideas that will contribute to achieving our shared goals of quality health outcomes and better oral health for all."

Sara will now leave her post with the Royal Centre for Defence Medicine where she worked closely with the NHS in assuring access to, and quality of, healthcare for injured personnel. Concurrently, she also acted as the Chief Dental Officer for the Army and, in recognition of her work, was appointed as a Queen's Honorary Dental Surgeon in September 2014.

BSPD WELCOMES BSDHT'S FIRST SMILES CAMPAIGN

A campaign to introduce young children to oral health education in the classroom has been welcomed by the British Society of Paediatric Dentistry (BSPD) as an admirable initiative. The First Smiles campaign has been launched by the British Society of Dental Hygiene & Therapy (BSDHT). Members of BSDHT are being encouraged to make contact with local schools and nurseries to organise a visit on 19 June to teach oral health in a fun and informative way. BSDHT is providing ideas and resources.

Claire Stevens, spokeswoman for BSPD, said: 'We know from recent surveys how important it is to ensure that all children have access to oral health advice, ideally at pre-school age. BSPD would love visits such as these included as part of a nationwide programme of prevention. When combined with targeted measures for those in greatest need, we may finally be able to reduce the large number of children experiencing dental decay and the current inequalities in oral health. Until then, it's admirable that hygienists and therapists are taking the initiative and going into schools and nurseries to make oral hygiene fun.'

NEWS IN BRIEF

Researchers at King's College London have urged people who take up e-cigarettes in an effort to stop smoking to consider 'upping the nicotine dose they get' by using them twice a day.

Birmingham City university lecturer Mel Wakeman is lobbying retail giants to replace sweets and chocolate on the checkouts with healthy alternatives.

Cancer survivor David Billing, 48, has been given a new tongue made out of part of his arm. Mr Billing had part of his jaw and tongue removed after surgeons removed a tumour that stopped him from swallowing.

Writing in the British Journal Of Sports Medicine, experts claim the obesity crisis is down to poor diet rather than a lack of exercise.

Do you have a news story that you would like included in BDJ Team? Send your press release or a summary of your story to the Editor at bdjteam@nature.com.

SUBJECT SUGARY DRINKS TO SAME RULES AS TOBACCO

Sugary drinks should be subject to the same advertising and sponsorship rules as tobacco, according to the British Dental Health Foundation (BDHF).

The BDHF believes if major sporting tournaments banned sugary drinks sponsorship – similar to the ban on tobacco advertising introduced in 2003 – there would be a reduction in consumption and an improvement in the health of thousands of people.

Experts suggested more than 3,000 lives could be saved by the tobacco ban, and the BDHF believes a similar ban involving sugary drinks could have benefits for a number of health conditions, notably obesity and oral health.

Sugary drinks are the largest source of sugar for children aged 4-12 and teenagers. This could be why more than one in four (27 per cent) five-year olds[1], one in three 12-year olds and nearly half (46 per cent) of 15-year olds show signs of obvious dental decay[2].

BDHF trustee Professor Nairn Wilson leads the calls for the government to intervene and treat sugary drinks advertising the same as tobacco.

Professor Wilson said: "Sugar is the biggest health time-bomb we face today. The dangers of tobacco are very well documented and there has been significant progress made on tobacco advertising in general, and particularly sport.

"When the Indian associate of the British American Tobacco group sponsored the Indian World Cup Cricket team in 1996 with its Wills brand, a survey showed that smoking among Indian teenagers increased five-fold. There was also a marked increase in false perceptions such as 'you become a better cricketer if you smoke Wills' and 'teams with more Wills smokers will fare better'[3].

"There is every reason to believe this will also apply to sugary drinks. Some of the world's major sports events and sporting names are sponsored and endorsed by sugary drinks brands. Many of them are role models for children, so why would they not follow their idol.

"The same, it is suggested, applies to family-friendly landmarks, such as the Coca-Cola London Eye. Our own research has found that more than four in five people do not agree with their new sponsorship[4].

"The increase in consumption of sugary drinks is one of the key reasons for dental decay, particularly in children. Proposals such as the introduction of a duty on sugary drinks and brands reducing the amount of sugar in their soft drinks have both been mooted in the last 12 months, and a ban on advertising is another step the government can take to bring about significant health improvements. Levels of obesity, diabetes and heart problems would undoubtedly decrease if any of these measures were introduced.

"Cutting down on how often you have sugary foods and drinks is one of the BDHF's key messages. The key thing to remember is that it is how often sugar is consumed, rather than how much sugar, which heightens the risk of tooth decay.

"We call on the health industry to support our calls and lobby government to help safeguard children's oral health now and in the future."

1. https://www.gov.uk/government/news/survey-finds-27-of-5-year-olds-have-tooth-decay
2. Children's Dental Health Survey: England, Wales and Northern Ireland (2014). Health and Social Care Information Centre www.hscic.gov.uk/catalogue/PUB17137/CDHS2013-Executive-Summary.pdf
3. Vaidya SG, Naik UD, Vaidya JS. Effects of sports sponsorship by tobacco companies on children's experimentation with tobacco British Medical Journal August 1996; 313, 400
4. British Dental Health Foundation (2015). Your Say, April 2015.

FLASH INTERVIEW

Angela Shutt

Angela is a 33-year-old dental nurse and practice manager at Harrowgate Hill Dental Practice in Darlington, County Durham.

Angela lives with her partner James, a sales manager, and her children Chloe (15) and Nathan (6)

How long have you worked in dentistry? 13 years (qualified 2002)

Why did you choose dentistry for your career? After having extensive ortho work in my teens, I was always fascinated by the role of the dental nurse and everything they had to do.

Do you have any special responsibilities within your dental practice? I started working at my current practice 2 days a week steadily increasing my hours around my children. I was asked to take over the managerial roll in 2006 and over saw the installation of our CSU. I missed the surgery aspect of the role that I now get to nurse 1 day a week as well as coordinating our weekly domiciliary visits in which I attend with our principal

What do you like best about your job? The satisfaction of seeing someone happy with the service they are provided with.

What is the most challenging part of your job? I have learnt over time you cannot please everyone at once but always try your best to do what is right by people.

What do you like to do outside work? Walking, gardening, eating out and travelling

Tell us a secret. No that would be telling!!

What do you like about BDJ Team*?* It gives a great insight to all aspects of the dental profession. Great informative articles

What three things could you not live without (besides people)? My dogs, my car and my bed.

Consumer credit rules *relaxed*

by **James Dawson**, Head of Advice Publications in the Practice Support team at the BDA

You can now allow patients to pay for their treatment in more instalments without needing authorisation from the Financial Conduct Authority (FCA). Not having to pay in one go can help many patients access the high quality care that they want. Generally, however, if you allow patients to pay for treatment by instalments or introduce them to a third party who will provide loans or other credit facilities you will need official consumer credit authorisation from the FCA. This can be a bureaucratic and expensive procedure, so the ability to let patients pay by instalments without needed FCA authorisation – as long as you comply with the FCA's precise conditions – can be helpful to you and your customers.

Enabling patients to get specialised care by deferring the cost over a number of payments can be done without FCA authorisation if the credit arrangement meets all of the FCA's criteria. Payment must be made in 12 or fewer instalments; the debt must be settled within 12 months; the arrangement must be for the purchase of specific goods or services – perhaps veneers or implants – that are provided directly by the practice; and the payments must be for an overall fixed amount with no charges, interest or administration fees. These rules have been relaxed by allowing up to 12 instalments – previously the rules required four or fewer instalments. This affects any arrangements made since 18 March 2015.

To benefit from the exemption you must stick strictly to the FCA's requirements. Anything outside of this and authorisation is required, for instance if you let even a single patient pay in 13 or more instalments or let them pay over a period longer than one year. Also numerous other consumer credit activities require authorisation, though dental practices are most likely to need FCA approval if they: lend money; collect debts; introduce patients to a loan company to help them to finance their treatment; arrange credit through a third party; or administer credit agreements for a third party, even if this does not involve collecting debts. Authorisation is required even if you do not charge for providing the credit. Beware, it is a criminal offence to carry out activities requiring authorisation without permission and can lead to two years' imprisonment and a financial penalty.

Applying for authorisation

If the services you offer to patients mean that you are likely to need consumer credit authorisation then you need to apply to the FCA, go to www.fca.org.uk to use their on-line Connect system. Depending on your precise consumer credit activities you will need either full permission or limited permission; see the FCA website's Credit Ready Decision Tool to decide which type of authorisation you need.

Whether you need full or limited permission depends on your consumer credit activities and the financial risk of your business; as a lower-risk business, dentists will likely meet the requirements for limited permission.

You will need to submit detailed information about your practice, how it is managed and its finances. The FCA website has checklists of the information you will need to gather and guidance on the how to complete their application form. In assessing the fitness of an applicant to offer credit, the FCA will consider: your knowledge and experience of financial issues; your proposed practices and procedures for offering credit; any criminal convictions, breaches of consumer legislation, such as trading standards or advertising standards rules; and your personal solvency or insolvency. Past criminal convictions, insolvency or breaches of trading standards or advertising standards would be evidence of unfitness. Checks would also be undertaken with the General Dental Council.

Fees are payable when you apply for consumer credit authorisation and, thereafter, on an annual basis. Fees vary widely depending on the type of permission you have, the consumer credit activities that you do and the size of your business. Precise details on fees are available from the FCA website.

Old licences

The FCA took over the administration of consumer credit authorisation from the Office of Fair Trading (OFT) in April 2014. Previous OFT consumer credit licence holders had to reapply for authorisation, the old OFT licence longer being valid after 31 March 2014. If you previously held an OFT consumer credit licence you should have registered with the FCA for interim permission by the 31 March 2014. Those with interim permission will be directed to reapply for a full consumer credit authorisation in due course, probably sometime before 1 April 2016.

Fee Collection

BDA Advice Fee Collection – which can be found on the website at www.bda.org/advice - provides further information.

James Dawson is responsible for the BDA's guidance documents for members in general practice on legal matters including associate contracts and staff employment

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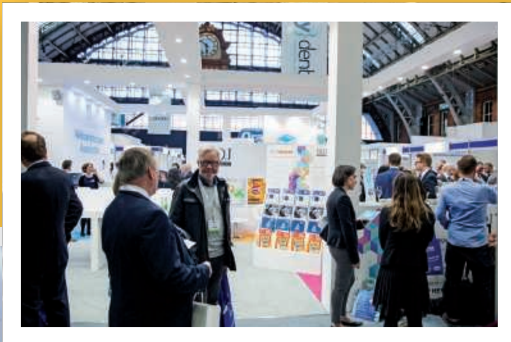
British Dental Conference & Exhibition 2015

– the show reel

The British Dental Conference & Exhibition has now wrapped up for another year. Delegates had the opportunity to listen and learn from some of the very best minds in the business. BDA members had the opportunity to join the Presidential Meeting with newly inaugurated President Professor Nairn Wilson CBE and the AGM. There was plenty of discussion on Friday morning following the Conservative's majority victory in the General election, which certainly proved a hot topic for many speakers, exhibitors and attendees alike.

If you did not attend here are some of the best images and tweets from this year and a flavour of what you can look forward to in 2016…



BDJ Editor-in-Chief thanks attendees to the conference and introduces the full BDJ portfolio to members

Plenty of interest in the BDA and BDJ portfolio titles, which now includes *BDJ Open*

Delegates had the opportunity to meet and greet with the BDA and BDJ team at the drinks reception

Seminars attracted a lot of interest throughout the three days

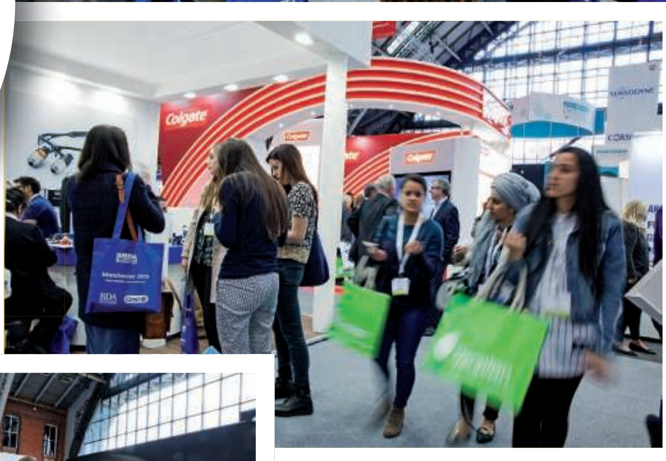
Many of the sessions were packed to the rafters with delegates keen to expand their learning

Verifiable CPD was available for all of the lectures

Mick Armstrong, chair of the Principal Executive Committee, addresses delegates

The speaker's corner proved to be extremely popular throughout the three days. BDJ Editor-in-Chief Stephen Hancocks OBE spoke to delegates on how to get published in the BDJ portfolio of publications

Could you guess which of these drinks contains the most sugar? Delegates tried, and many were surprised by the result!



Exhibitors had plenty of opportunity to chat with members of the dental team

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E-cigarettes

– should we light up or lighten up?

Seldom has there been one product that has caused so much uproar. For better or for worse, e-cigarettes (EC) are here to stay. The question is, should we be fully encouraging their use or do we need to tread carefully?

The story so far...

In 2010 *ASH* discovered that at the time only nine percent of smokers had tried an EC and less than 40% of people had ever heard of them[1]. By 2014 it was a completely different picture. Half of smokers had tried an EC and 2.1 million people were regularly using them[3].

In 2011 NICE started the process of creating what became in 2013 guidance on tobacco harm reduction. This set out clear principles regarding the use of nicotine to support people not yet ready or willing to quit to reduce the harm from smoking. Recommendations included providing licenced NRT long and short term, encouraging people who can't yet quit to cut down and providing good communication about the relative safety of long term nicotine use.

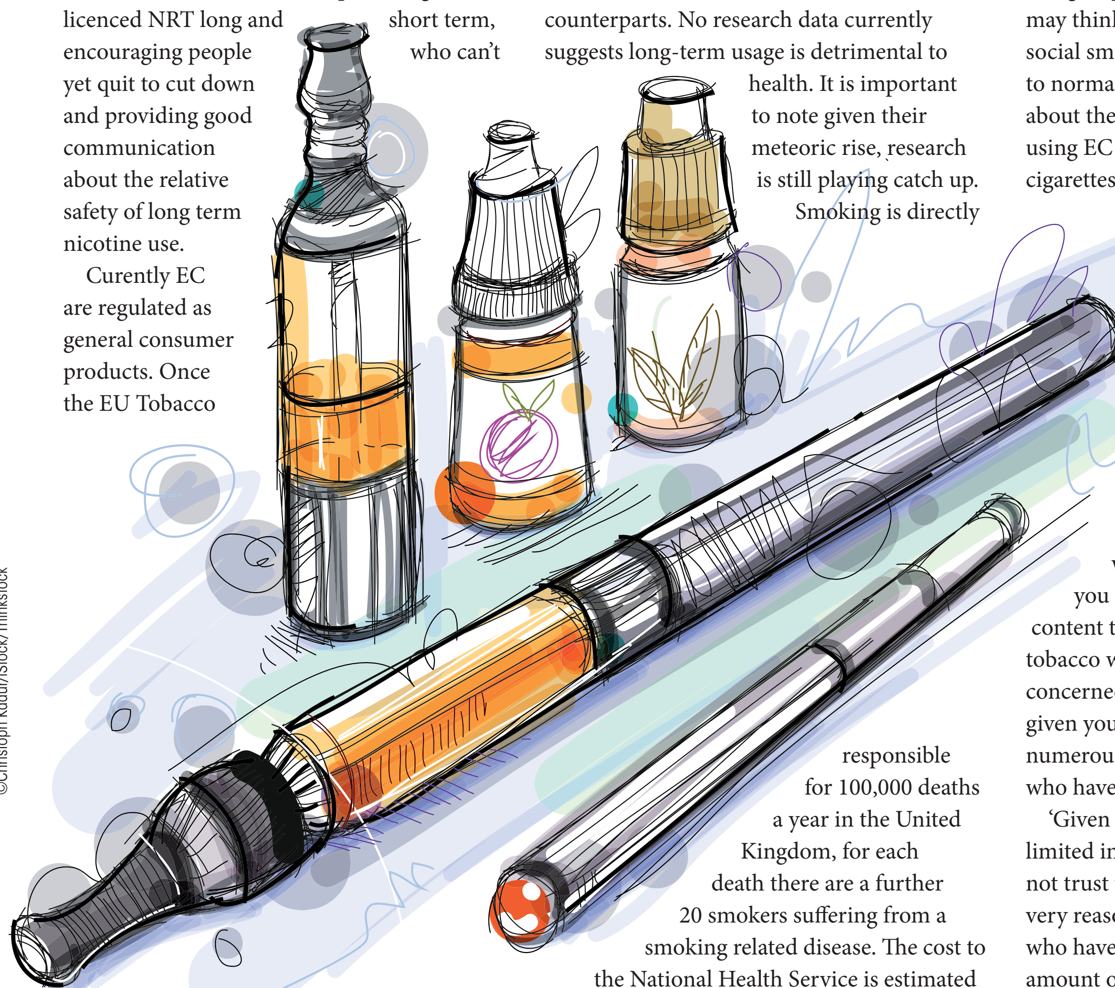
Curently EC are regulated as general consumer products. Once the EU Tobacco Products Directive (TPD) comes into effect in Member States in May 2016, EC containing up to 20mg/ml of nicotine will come under the TPD.

Above that level, or if manufacturers and importers decide to opt into medicines regulation, such products will require authorisation by the Medicines and Healthcare Products Regulatory Agency (MHRA) as over the counter medicines in the same way as nicotine replacement therapy (NRT).

Ultimately EC are considered up to 95% 'less harmful' than their traditional counterparts. No research data currently suggests long-term usage is detrimental to health. It is important to note given their meteoric rise, research is still playing catch up. Smoking is directly responsible for 100,000 deaths a year in the United Kingdom, for each death there are a further 20 smokers suffering from a smoking related disease. The cost to the National Health Service is estimated at £2billion annually[2]. Any member of the dental team who recognises a patient is a smoker has a duty to inform the patient of the options available to them. Dentists can help their patients to stop smoking by recognising oral signs of tobacco use, informing patients of these and asking patients whether they wish to stop. More and more patients are asking about EC, and opinion varies on what we should be saying.

Much like the battle with traditional tobacco companies, the greatest challenge lies within their marketing. The de Andrade *et al.*[3] report found marketing strategies targeted two groups: the committed smoker, who may think about quitting; and the younger social smoker and non-smoker. They appear to normalise 'vaping', prompting concerns about the possibility of young non-smokers using EC as a stepping stone to traditional cigarettes.

So should we lighten up, or should we tighten up? Shaun Howe and Rachael England give us their views on the burning questions.



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Can EC be trusted?

SH 'Yes. I am an ex-smoker who used e-cigarettes to stop. I was on 30 a day and was wondering if I would ever stop. If you ask me do I trust their quality or content then again I will say yes. If you smoke tobacco why on earth would you be overly concerned about what is in an e-cigarette given you inhale smoke which contains numerous carcinogenic agents? Only those who have never smoked fail to see this.

'Given how new they are, research is so limited into their long term effects. I do not trust the research at present for this very reason. Most is also written by those who have never smoked and there is a huge amount of scaremongering going on based on very little or no evidence'.

RE 'A recent systematic review of the existing evidence suggests that although an e-cigarette does release some toxic chemicals, the levels are far lower than in combustible tobacco products thus some residual risk may exist it is insignificant compared to the devastating effect of smoking. Research has been misrepresented by tobacco companies to exaggerate the harmful effects of e-cigarettes[4] (Konstantinos, 2014). In 2016 electronic cigarettes will be reclassified as medical devices. Until then we cannot be sure of the levels or quality of their content, so as before I would advise caution to patients purchasing them'.

Would you recommend them to young patients?

RE 'The effects of nicotine on children's health and dependence moving into adulthood are issues of concern. Later this year e-cigarettes will be unavailable to people aged under 18, so for this reason I wouldn't recommend them to young patients'.

SH 'I have never recommended e-cigarettes to anyone under 18 on the basis that most young adults have not smoked long enough or indeed as much (quantity per day) to be so addicted. At the minute anyone can buy one. You see them in shopping centres and corner shops. They may work as a gateway to cessation – and I am proof of this – but their usage must be limited'.

Do you think they do or could act as a gateway for non-smokers to take up the habit?

SH 'There has been talk of these products being a gateway to youngsters taking up the habit, but I personally doubt that e-cigarettes would lead to smoking. They are worlds apart, akin to cannabis use and injecting heroin. One is now seen as relatively harmless and the other, once very popular, is now abhorred and is a huge step change.

'It could be reasonably argued that some people are more 'addictive' than others and the ability for the brain to require something to help it function is possibly inherent in some and absent in others. I found it tremendously difficult to stop smoking and three years later I still get a buzz when I smell smoke. This is the nicotine receptors in my brain wanting it to be back and is not unlike the feelings an alcoholic would experience. If a child wants to smoke, they will and there is now a very real danger that by hiding cigarettes behind screens in supermarkets that young people will be attracted by the taboo... a very real danger.

'We know the poorest and most socially deprived do not attend the dentist and rarely to their doctor and do not cherish or want traditional smoking cessation techniques. This particular group would stick to traditional cigarettes unless their electronic counterparts become 'trendy' like Burberry did then they will use them. Smoking cessation does not target those who really need it in the right way. Uneducated heavy smokers from disadvantaged backgrounds are, in my opinion, highly unlikely to listen to an educated non-smoker about why the need to quit'.

RE 'The Centre for Disease Control[5] has reported an increase in children using e-cigarettes despite never having used tobacco products before and concern has been raised over an association with binge drinking'.

> ***SH 'IF YOU ASK ME DO I TRUST THEIR QUALITY OR CONTENT THEN AGAIN I WOULD SAY YES'***

> ***RE '...WE CANNOT BE SURE OF THE LEVELS OR QUALITY OF THEIR CONTENT, SO I WOULD ADVISE CAUTION TO PATIENTS'***

In your opinion how should the team approach smoking cessation and referrals?

RE 'I believe traditional smoking cessation guidelines should be followed, referral to the NHS Stop Smoking Service, recommendation of nicotine replacement therapy and General Practitioner intervention, however I would recommend e-cigarettes for adult smokers who have tried to quit and relapsed. Motivational interviewing techniques are particularly useful in establishing reasons for relapse and the patient's readiness to quit'.

SH 'Every health professional should be able to ask a patient if they have considered swapping one for the other. Even though we do not know how safe they are in the long run, they are considered up to 95% less harmful than traditional cigarettes. Referrals to e-cigarettes must involve a complete shift from one to the other or it never works. Smoking tobacco less and introducing e-cigarettes simultaneously is doomed to failure as the tobacco content is significantly higher and more enjoyable to smokers'.

1 Action on Smoking. Use of ecigarettes in Great Britain. October 2014. ONLINE http://www.ash.org.uk/files/documents/ASH_891.pdf (Accessed 12 May 2015).
2 Action on Smoking and Health Smoking Statistics Illness and Death. November 2014. ONLINE http://ash.org.uk/files/documents/ASH_107.pdf (Accessed 01 May 2015).
3 de Andrade, M, Hastings, G, Angus, K, Dixon, D, Purves R. *The marketing of electronic cigarettes in the UK*. Cancer Research UK, 2013. ONLINE. https://www.cancerresearchuk.org/sites/default/files/cruk_marketing_of_electronic_cigs_nov_2013.pdf (Accessed 06 May 2015).
4 Konstantinos E. Farsalinos and Riccardo Polosa Safety evaluation and risk assessment of electronic cigarettes as tobacco cigarette substitutes: a systematic review. Therapeutic Advances in Drug Safety. April 2014; 5:2, 67-86.
5 Centre for Disease Control. E-cigarette use triples amongst middle and high school students in one year. April 2015. ONLINE http://www.cdc.gov/media/releases/2015/p0416-e-cigarette-use.html (Accessed 01 May 2015).

Did you know?

In 2010, only 8.2 per cent of current smokers had ever tried electronic cigarettes. By 2014, this figure had risen to 50.6 per cent.

Just over a third (35%) of British adults believe that electronic cigarettes are good for public health while around a quarter (22%) disagree.

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DCP COURSE DIRECTORY 2015

THE NORTH-WEST

The University of Manchester School of Dentistry

BSc Oral Health Science

Location: Manchester

Summary: Provides the skills to register with the GDC as a dental therapist or dental hygienist.

Length: Three years full time

Places available: 12

Details: http://www.dentistry.manchester.ac.uk/undergraduate/bsc/coursedetails/

Telephone: 0161 306 0232

Email: ug-dentistry@manchester.ac.uk

Manchester Metropolitan University

Location: All Saints Campus, Manchester

BSc (Hons) Dental Technology

Summary: Provides the skills to register with the GDC as a dental technician.

Length: Three years full time or 5-6 years part time, with the option to undertake a year in practice prior to the final year.

Details: http://www2.mmu.ac.uk/study/undergraduate/courses/2015/11495/

Telephone: 0161 247 6969

The Greater Manchester School for Dental Care Professionals

Diploma in Dental Hygiene and Dental Therapy

Location: Greater Manchester and Salford

Summary: Prepares candidates to take the Diploma in Dental Hygiene and Dental Therapy of the FGDP(UK), Royal College of Surgeons of England and register with the GDC as a dental hygienist and dental therapist.

Length: 27 months full time. Closing date for January 2016 applications is Friday 3 July, 2015.

Places available: 10

Details: http://www.mandcp.co.uk/courses_dental_hygiene.html

Telephone: 0161 212 4809

Email: julie.horrigan@cmft.nhs.uk

University of Liverpool School of Dentistry

Combined Diploma in Dental Hygiene and Dental Therapy

Location: Liverpool

Summary: Leads to registration with the GDC as a dental hygienist and a dental therapist.

Length: 27 months full time. Applications open 30 September 2015.

Details: https://www.liv.ac.uk/study/undergraduate/courses/combined-diploma-in-dental-hygiene-therapy

Telephone: 0151 706 5046

Email: dentenq@liverpool.ac.uk

University of Central Lancashire School of Medicine and Dentistry

BDS Dentistry (Graduate entry)

Location: Preston

Summary: Designed to train dental care professionals as orthodontic therapists. Students who successfully complete the coursework and examination elements will then undertake the Diploma in Orthodontic Therapy final exams offered by the Royal College of Surgeons (Edinburgh) in order to register with the GDC as an orthodontic therapist.

Length: Five years

Places available: 29

Details: http://www.uclan.ac.uk/courses/bds_dentistry_graduate_entry.php

Telephone: 01772 892400

Email: cenquiries@uclan.ac.uk

Certificate in Oral Health and Application of Fluoride Varnish

Location: Royton, Oldham

Summary: A short course for dental nurses wishing to extend their knowledge and scope of practice in providing oral health care advice and application of fluoride varnish.

Length: Part time. One term or five weeks.

Details: http://www.uclan.ac.uk/courses/cert_oral_health_application_fluoride_varnish.php

Telephone: 0161 665 2882

Email: enquiries@vsmhealthcare.com

Dentrain

Location: Bolton and the north-west

Apprenticeship in Dental Nursing (Level 3 Diploma in Dental Nursing)

Summary: On successful completion of the course and qualification, you will be able to register as a dental nurse with the GDC and work legally in a dental surgery. Four days a week in a dental practice combined with one day a week attending the Dentrain Training Centre.

Length: 15 month paid apprenticeship (see Dentrain website for more information)

NEBDN National Diploma in Dental Nursing

Summary: Qualification for individuals working as a dental nurse, leading to GDC registration via completion of the theory, a record of experience and an exam at a centre near you.

Length: 10-12 months starting in June or January.

CPD courses

- Radiography & Radiation Protection
- Disinfection & Decontamination
- Medical emergencies part 1
- Medical emergencies part 2
- Oral health promotion and preventive dentistry
- Communication
- Pain and anxiety control in dentistry
- Dental drugs, materials, instruments and equipment
- Oral surgery
- Restorative dentistry
- Assessing patients' oral health needs and treatment planning
- Patient care and management
- Anatomical structures and systems relative to dental care
- Legal and ethical issues in the provision of dental care
- Oral disease and pathology
- Orthodontic procedures.

For details of all Dentrain courses: www.dentrain.net
Telephone: 01204 528652
Email: info@dentrain.net

Training 2000
Location: Carlisle, Blackpool, Kendal, Lancaster, Manchester, Bury, Blackburn
Dental nursing apprenticeships
Leading to the NEBDN Level 3 Diploma in Dental Nursing
Duration: 18 months
NEBDN Certificate in dental radiography
NEBDN Conscious sedation
NEBDN Oral health education
Details: http://www.training2000.co.uk/category/dental#viewcourse
Telephone: 01254 54659

SMG Training
Location: Lancashire (online or classroom based)
Certificate in dental radiography
Certificate in dental sedation nursing
Certificate in oral health education (fluoride application and plaque indices)
Certificate in special care dental nursing
Certificate in orthodontic nursing
Certificate in competency in impression taking
Certificate of competency in fluoride application
Details and more courses at: http://www.smgtraining.co.uk/
Telephone: 07967 531185
Email: info@smgtraining.co.uk

Aspiradent
Location: Manchester but courses at run at various locations nationwide
Local anaesthetic refresher
Tooth whitening techniques
Diagnosis and treatment of periodontal disease
Clinical examination and assessment and recognition of oral lesions
Standards for examination of the new patient and the recall patient
Details: www.aspiradent.com
Telephone: 0800 024 8668
Email: info@aspiradent.com

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ANN FELTON SCHOLARSHIP

Oral Health Education

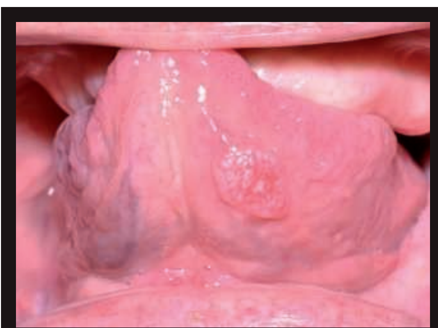
The dental nurse who is awarded this exceptional prize will be allocated a free place on BDA Education's online Oral Health Education (OHE) course, which leads to the BDA qualification in OHE. All other scholarship applicants will be offered a £100 discount on August and September 2015 OHE courses.

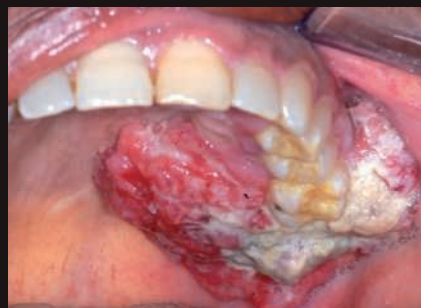
For more information about the scholarship and an application form visit www.bda.org/ohe/scholarship. **Closing date 26th June 2015.**

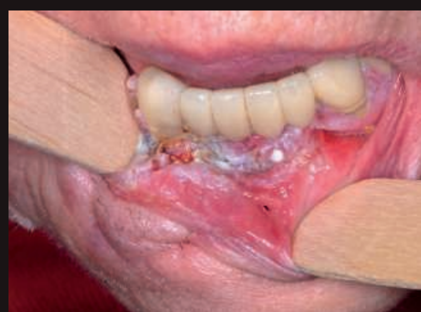
Making oral cancer screening a routine part of your patient care

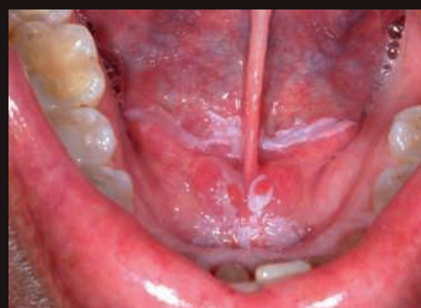
PART 1

By Linda Douglas RDH









Figs 1-4 Examples of squamous cell carcinoma
Images courtesy of Dr Fayette Williams DDS MD

On completion of this CPD paper, the participant should achieve the following:

- Discuss the rationale for a comprehensive approach to dental patient examination
- Enhanced working knowledge of head and neck anatomy
- Discuss current risk factors for oral cancer
- Enhanced awareness of the most common sites for oral cancer
- Identify oral lesions of concern and accurately describe and document them
- Knowledge of the appropriate action to take if a lesion is found
- Educate your patients in self-examination techniques.

Introduction

Oral cancer kills one person every hour,[1] and oral cancer malpractice claims against dental professionals are increasing. With the increasing incidence of oral and oropharyngeal cancers due to changing risk factors, the role of the dental professional must go beyond examination of the dentition and periodontium. We also need to examine the head and neck, and all of the oral tissues. Early detection and treatment of oral cancer is crucial, as progression is rapid in the oral tissues due to the rich blood supply to the head and neck. **Our goal is to discover oral cancers early, before patients present with symptoms.**

Risk factors for oral cancer, and oro-pharyngeal cancer:[2]

- Historically that has been males over 50, who have used tobacco or are heavy alcohol users. Tobacco use is associated with about 75% of oral cancer cases
- When an individual is both a heavy smoker and drinker, the risk is greatly increased compared to a heavy smoker, or a heavy drinker alone
- Patients are at a higher risk for oral squamous cell carcinoma after stem cell transplantation, this is related to immune suppression, and oral graft versus host disease
- In some Asian cultures chewing betel paan is known to be a strong risk factor for developing oral cancer
- Research also suggests that a diet low in fruit and vegetables could be a risk factor
- A slightly higher rate of squamous cell carcinoma (0.2%-3.3%) has been found in patients who have oral lichen planus, in particular the atrophic, plaque and erosive forms (the non-reticular varieties)
- Sunlight exposure is a risk factor for lip cancer, especially the lower lip.

Changing risk factors

Infection with the human papilloma virus (HPV), particularly types 16 and 18, is a known risk factor and independent causative factor for oral cancer.[3] Non-smoking patients between 20 and 50 years old are the fastest growing segment of the oral cancer population: recent research indicates that HPV is the primary risk factor in this new population of oral cancer victims. Between 1988 and 2004, the incidence of HPV-related oropharyngeal cancers increased 225%.[4]

With early diagnosis the five year survival rates for oral cancer can be 80-90%.[5] Unfortunately, five year survival rates have generally remained at about 56%, due to late diagnosis. In the USA, 66% of all oral cancers are being diagnosed at stage III or IV.[6]

Common sites

Seventy-five percent of all head and neck cancers begin in the oral cavity (Figs 1-4). According to the National Cancer Institute's Surveillance, Epidemiology, and Ends Results (SEER) programme in the USA, 30% of oral cancers originate in the tongue, 17% in the lip, and 14% in the floor of the mouth. Oropharyngeal cancer related to HPV mostly

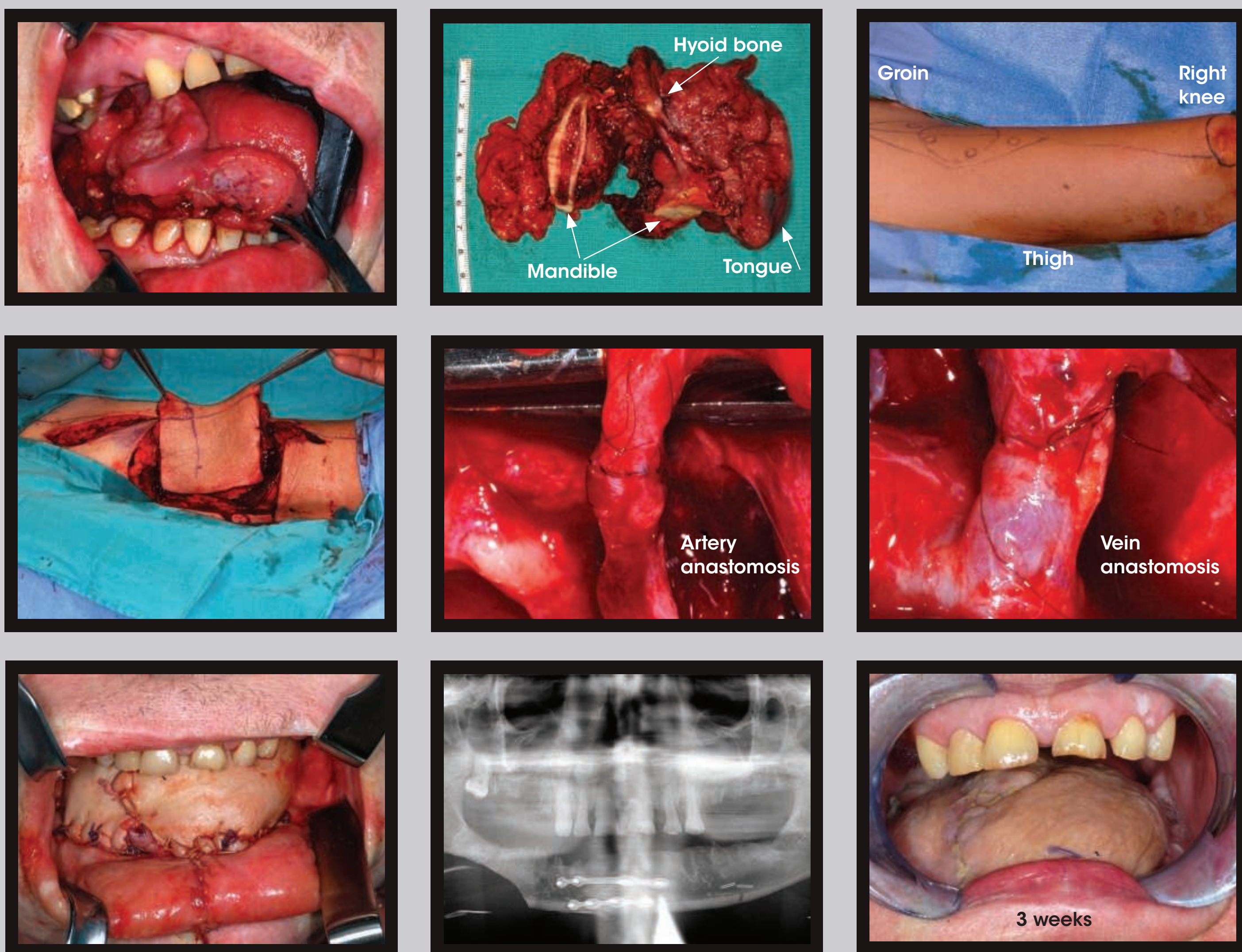


Fig. 5 Excision of a tongue tumour and reconstructive surgery
Images courtesy of Dr Fayette Williams DDS MD. Dr Williams explains:
'This is one of the bigger tongue cancers I've seen. Unfortunately many people wait until it's too late to do anything simple. This lady's entire tongue was cancerous and it was eating into her right mandible. I did a total glossectomy, partial mandibulectomy, and bilateral neck dissection. Her cancer was so big that I did a "mandibular swing" to open her mandible up like a book to get access to the base of tongue area down by her larynx. Her tongue was reconstructed with an anterolateral thigh free flap. The skin and muscle from her leg is isolated on a pedicle of the artery and vein that supplies the graft. The vessels are clamped and re-anastomosed to vessels in her neck under a microscope using 9-0 nylon sutures. This is a transplant within her own body so that the new graft is viable and living just like it was at her leg so that it withstands radiation therapy very well.'

occurs on the tonsil and tonsillar pillars, base of the tongue, and the oropharynx.

Types of oral cancer

Around 90% of oral cancers are squamous cell carcinomas (SCC).

Rare forms of oral cancer include oral malignant melanoma, mucoepidermoid carcinoma, and adenoid cystic carcinoma.

Stages used to describe cancer of the lip and oral cavity:

Stage I The cancer is less than 2 cm in size, and has not spread to lymph nodes in the area.

Stage II The cancer is between 2-4 cm in size, and has not spread to lymph nodes in the area.

Stage III Either of the following:

- The cancer is more than 4 cm in size
- The cancer is any size but has spread to only one lymph node on the same side of the neck as the cancer. The lymph node that contains cancer measures less than 3 cm.

Stage IV Any of the following may be true:

- The cancer has spread to tissues around the lip and oral cavity. The lymph nodes in the area may or may not contain cancer
- The cancer is any size and has spread to more than one lymph node, or to any lymph node that measures more than 6 cm
- The cancer has spread to other parts of the body.

Recurrent disease means that the cancer has recurred after it has been treated. It may recur in the lip and oral cavity or in another part of the body.

Treatment options

Surgical excision combined with radiation therapy, or with chemotherapy and radiation therapy. Reconstructive surgery is required after removal of advanced tumours (Fig. 5).

The role of the dental hygienist

The dental hygienist plays an important role in the preliminary observation and documentation of oral pathologies. The UK dental hygiene scope of practice includes recognition of oral lesions.[7] In North America performing a head and neck and intra-oral examination is the standard of care for the dental hygienist. The American Academy of Periodontology's (AAP) updated position statement summarises the essentials of a comprehensive periodontal evaluation; this includes extraoral and intraoral examinations to detect nonperiodontal oral disease.[8]

General appraisal

Assessment begins as soon as we greet our patient, before they even sit in our chair. We should observe the following:

- Gait and posture
- General appearance and cleanliness
- Respiration
- Signs of confusion
- Changes in voice - hoarse? Nasal?
- Hands: eg colour of fingertips
- Facial symmetry, swelling
- Skin colour and texture
- Eyes.

The medical history is reviewed for known risk factors for oral cancer, history of cancer, medications, and systemic diseases. **Oral cancer screening can be done in less than four minutes.**

Examination techniques

Visual inspection, and bimanual, digital, bidigital, and bilateral palpation techniques are used to examine the head and neck and intra-oral tissues for lesions and swelling.

Extra-oral examination of the mandible, parotid gland, thyroid gland, larynx, temporomandibular joint, and the lymph nodes of the head and neck (Fig. 6).

What to do if a lesion is found

Dental professionals need to track any lesion or deviation until it disappears. If it persists after two weeks and the diagnosis is unknown, it must be biopsied.

Biopsy is the gold standard for definitive diagnosis of oral lesions.

Lymph nodes

- Pre-auricular (parotid nodes)
- Post-auricular
- Occipital
- Submandibular
- Submental
- Posterior and superior cervical
- Supraclavicular.

11 steps of intra-oral examination

1. Lips - vermilion border and commissures
2. Labial mucosa and fraenum
3. Alveolar ridges, gingiva
4. Buccal mucosa, parotid duct
5. Retromolar pads
6. Maxillary tuberosity
7. Tongue - ventral surface (underside), floor of mouth, submandibular and sublingual salivary glands
8. Dorsum, base and lateral borders of tongue
9. Hard and soft palate
10. Uvula, tonsillar pillars
11. Tonsils, posterior wall of pharynx.

When a suspicious area is identified, the dental professional needs to determine how long it has been present. If any of the following signs or symptoms persist for more than two weeks, they need to be investigated.[9]

Oral lesions of concern, and other signs[10]

- Ulcers or other lesions that cannot be related to trauma or infection
- Leukoplakia (white lesions); this is the most common precancerous lesion, particularly on the floor of the mouth or ventral (under) surface of the tongue
- Erythroplakia (red lesions) could also be precursors to cancer
- Erythroleukoplakia (combined red and white lesions). Lesions with a red component have greater potential for becoming cancerous
- Palatal soft-tissue masses, and mucocele-like lesions in locations other than the lower lip, floor of mouth, or ventral surface of the anterior tongue
- Lumps or thickening in the oral soft tissues
- Pigmented lesions
- Swellings.

Symptoms usually noted in the later stages

- Difficulty moving the jaw or tongue
- A sore throat or a feeling that something is caught in the throat
- Difficulty chewing or swallowing
- Pain or numbness of the tongue or other area of the mouth (paraesthesia)
- Chronic hoarseness
- Swelling of the jaw that causes dentures to fit poorly or become uncomfortable
- Persistent earache.

Action

1. Document and describe the patient's known risk factors, and description of the lesion(s) (Fig. 7). A photograph can also be taken.
   - History: duration, symptoms
   - Location, number of lesions, size, margin configuration (distinct, or irregular)
   - Colour: normal, red, white, yellow, pigmented
   - Surface texture: smooth, hyperkeratinised, ulcerated, erosive, verrucous, or papillary
   - Consistency: firm (indurated) or soft
   - Attachment: broad base, (sessile), on a narrow stalk (pedunculated)
   - Contour: raised (nodular) or flat (macular)
   - Mobility: movable, or fixed.

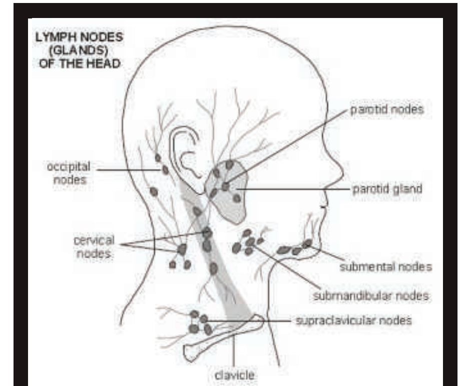


Fig. 6 Diagram of the lymph nodes of the head and neck

(c)EMIS 2011 as distributed at http://www.patient.co.uk/diagram/Lymph-nodes-head-and-neck.htm, used with permission.

2. Evaluate in two weeks: many benign lesions mimic oral cancer.
3. If it has healed, document this, and continue with regular oral cancer screenings at recalls.
4. If it is still present at the two-week. evaluation, refer to an oral pathologist or oral surgeon for further examination and biopsy.

Self-examination

Oral cancer self-examination is recommended by the American Association of Oral and Maxillofacial Surgeons. Patients should be educated to observe for signs and symptoms between dental visits. They should perform a head and neck and oral self-examination every month.

'Patients should be educated to observe for signs and symptoms between dental visits. They should perform a head and neck oral self-examination every month.'

Conclusion

Because we see our patients quite frequently for regular oral care, dentists and dental care professionals are in a crucial position to make a significant difference in the early detection of oral cancer. We should also educate our patients to be partners in monitoring and maintaining their oral health. Our combined vigilance contributes to timely diagnosis and less disfiguring treatment, with improved survival rates and quality of life for our patients. Make oral cancer screening a routine part of your patient care.

Part 2

In part two of this series, we will discuss adjunctive technologies for oral cancer screening, plus evolving techniques for diagnosis, and treatment of oral cancer.

1. US Government Surveillance, Epidemiology, and End Results (SEER) report on the incidence of oral cancers divided into Age, Sex, Location Etc. http://oralcancerfoundation.org/facts/index.htm
2. National Institute of Dental and Craniofacial Research. *Detecting oral cancer: a guide for health care professionals.* http://www.nidcr.nih.gov/OralHealth/Topics/OralCancer/DetectingOralCancer.htm
3. Fakhry C, Gillison M L. Clinical implications of HPV in head and neck cancers. *J Clin Oncol* 2006; **24:** 2606-2611.
4. Chaturvedi A K, Engels E A, Anderson W F, Gillison M L. Incidence trends for human papillovirus-related and -unrelated oral squamous cell carcinomas in the United States. *J Clin Oncol* 2008; **26:** 612-619.
5. Gloeckler Ries L A, Miller B A, Hankey B F, Kosary C L, Harras A, Edwards B K (eds). SEER cancer statistics review, 1973-1991. Bethesda, Md: US Department of Health and Human Services, Public Health Service, National Cancer Institute, 1994. Report no. NIH-94-2789.
6. Neville B W, Day T A. Oral cancer and precancerous lesions. *CA Cancer J Clin* 2002; **52:** 195-215.
7. General Dental Council. *Standards for dental professionals.* http://www.gdc-uk.org/dentalprofessionals/standards
8. Comprehensive periodontal therapy: a statement by the American Academy of Periodontology. *J Periodontol* 2011; **82:** 943-949.
9. Koerner K R. Evaluation and treatment by general dentists of oral soft-tissue lesions. *Dent Today* 2006; **25:** 90-95.
10. Kratochvil J. *Oral lesions of concern.* pp 8-9. Oregon/SW Washington: Doctor of Dentistry, March 2002.

Useful resources

Gotodds.com
This self-study course includes an instructional DVD, a mail-in test, and a wall chart demonstrating examination techniques.

YouTube medical school videos of examination techniques. https://www.youtube.com/watch?v=GQe0fwhdrdo

Dentalcare.com
This site has free online CE courses on oral pathology.

Drbicuspid oral cancer and diagnostics insider is an e-newsletter, providing literature on the latest research. https://www.drbicuspid.com/index.aspx?sec=sup&sub=orc

Mouth Cancer Action Month
A month-long campaign dedicated to raising awareness of the disease www.mouthcancer.org

Canadian Dental Hygienists Association Oral Cancer Awareness online course, '4 Life Saving Minutes: The Extraoral and Intraoral Examination', with a demonstration video.

Oral Cancer Foundation http://oralcancerfoundation.org/facts/index.htm

Dr Randy Otterholt's website-download oral pathology forms *www.drotterholt.com/downloads.html*

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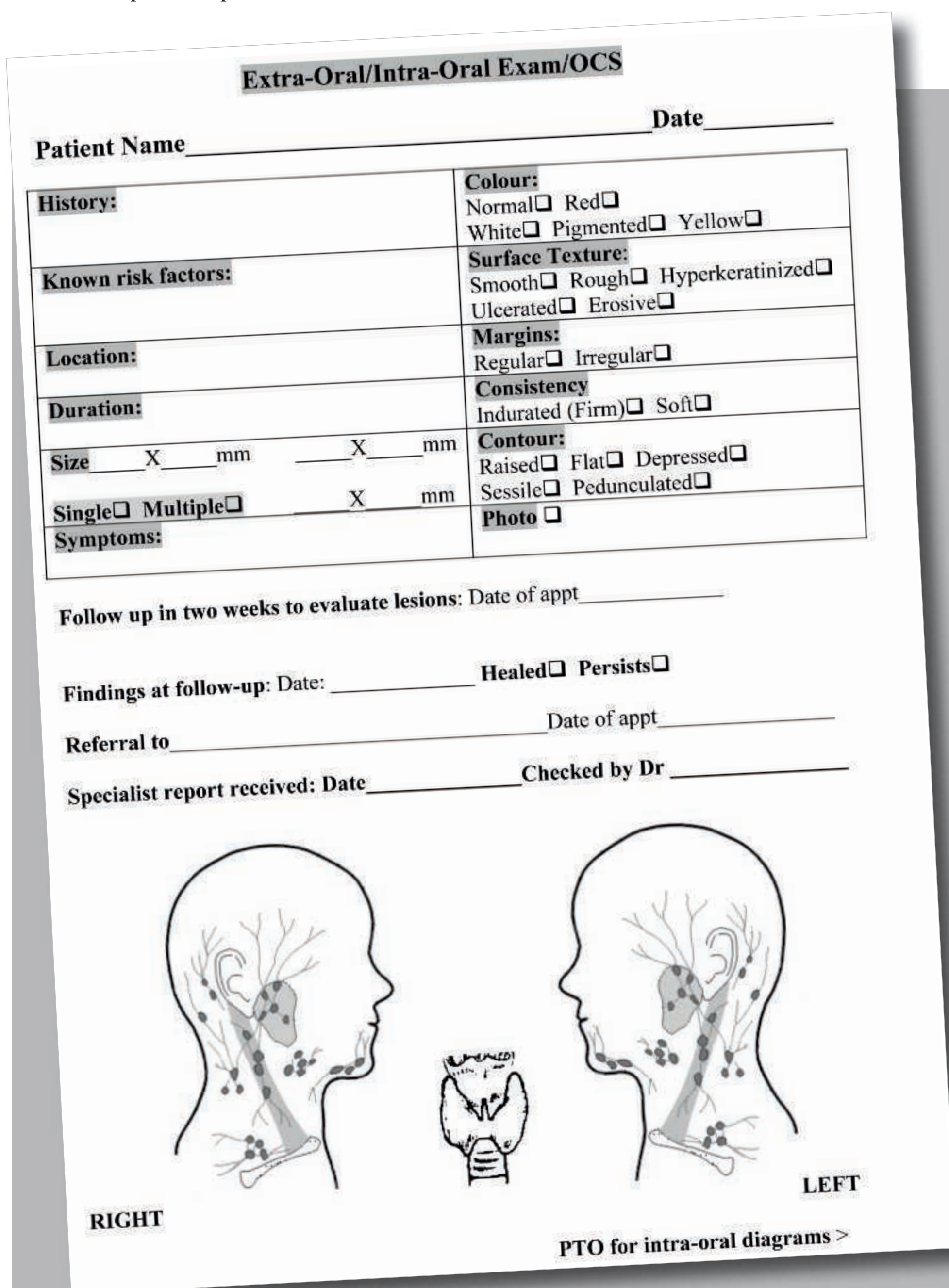


Extra-Oral/Intra-Oral Exam/OCS

Patient Name ________________ **Date** ________

History:	**Colour:** Normal❑ Red❑ White❑ Pigmented❑ Yellow❑
Known risk factors:	**Surface Texture:** Smooth❑ Rough❑ Hyperkeratinized❑ Ulcerated❑ Erosive❑
Location:	**Margins:** Regular❑ Irregular❑
Duration:	**Consistency** Indurated (Firm)❑ Soft❑
Size ____X____mm ____X____mm	**Contour:** Raised❑ Flat❑ Depressed❑ Sessile❑ Pedunculated❑
Single❑ Multiple❑ ____X____mm	**Photo** ❑
Symptoms:	

Follow up in two weeks to evaluate lesions: Date of appt__________

Findings at follow-up: Date: __________ **Healed❑ Persists❑**

Referral to __________ Date of appt__________

Specialist report received: Date__________ **Checked by Dr** __________

PTO for intra-oral diagrams >

Fig. 7 A form to document the findings of oral cancer screening

Products & services

Product news is provided as a service to readers using text and images from the manufacturer, supplier or distributor and does not imply endorsement by *BDJ Team*. Normal and prudent research should be exercised before purchase or use of any product mentioned.

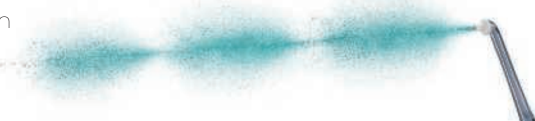
TRIPLE SHOT BURSTS ONTO THE SCENE

Philips Sonicare has announced the latest edition of its award-winning AirFloss range and the first flossing device which is clinically proven to improve gum health – The Philips Sonicare AirFloss Pro. It has several new design features to further improve interproximal cleaning performance and ease of use, with particular benefits for patients who floss inconsistently.

Despite dental professionals recommending flossing for over 200 years, only approximately 22% of the UK population floss at all. Whilst many start full of good intentions, compliance levels are low because flossing is technique sensitive and generally takes time to get right. Philips Sonicare AirFloss Pro is designed specifically to change this. Cleaning interproximally with AirFloss Pro takes only 60 seconds once daily, so can easily be built into an oral care routine – even by inconsistent and reluctant flossers.

In clinical studies, the Philips Sonicare AirFloss Pro was proven to be as effective as string floss for gum health, with nearly 90% of patients reporting that they found it easier to use than string floss. Similarly, dental hygienists involved in the studies reported improved gum health in up to 95% of patients, including a significant reduction in gingival inflammation and bleeding. 96% of dental practitioners surveyed said they would recommend the Philips Sonicare AirFloss to patients who don't currently floss and 3 out of 4 said they would recommend the Philips Sonicare AirFloss Pro over a leading oral irrigator.

The new Philips Sonicare AirFloss Pro features new 'Triple Shot' functionality which delivers a powerful, three burst shot of either water or mouthwash and air to remove plaque even more rapidly and effectively than previous models. The newly designed high performance nozzle tip also allows for greater control and improved targeting between teeth with less splash back, whilst three modes mean that patients can tailor the experience to their specific flossing needs.



NAVIGATING THE PITFALLS OF PRACTICE VALUATION

Christie + Co appreciates the complexity of the dental market and has the experience and expertise to guide practitioners through valuations in this sector.

Christie + Co understands the implications of ownership, income mix, contract type, UDA value and location on a practice's value and can help practitioners navigate the many pitfalls of practice valuation.

When trying to understand what a practice is actually worth, achieving a true market value assessment from a RICS Registered Valuer will always be extremely beneficial. If you are looking to sell your practice and are unsure of how to proceed, contact Christie + Co today for expert and experienced advice.

For advice on practice valuation call Christine + Co on 020 7227 0700.

BRAND NEW CENTRES FOR DENTAL SCIENCE STUDENTS

The development of two state-of-the-art centres has recently been announced by Genix Healthcare, which will bring amazing new opportunities to local people and the dental sector.

The centres, due to be opened at the Barnet and Southgate College and the University of Bolton, are hoped to be fully operational and accepting students during 2016/2017, with top class apprenticeship training available in:

- Dental Nursing
- Dental Hygiene
- Dental Therapy
- Dental Practice Management
- Dental Laboratory Technician and
- Dental Technician Assistant.

These will be delivered in the new, purpose built facilities at both campuses, with work placements available in dental practices and other clinical dental facilities. In the future, additional courses will be added to the range of high quality dental science subjects, including, for example, non-surgical facial aesthetics and CPD for all members of the dental team. Courses will provide training at Certificate, Diploma, Degree and Higher Degree levels, to suit students of all academic abilities.

The exciting venture has the potential to boost the dental industry through first-class instruction and education.

Find out more today about all of the exciting courses on offer and how these centres can boost your future.

For additional information please call 0845 838 1122, or email advice@genixhealthcare.com or visit www.genixhealthcare.com

If you would like to promote your products or services direct to the dental industry in *BDJ Team*, call Andy May on 020 7843 4785 or email a.may@nature.com.

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Professionalism in practice

– how to stay out of trouble

By **Nicola Burnett Smith**

In 2004 I was recruited as a Lay Member of the General Dental Council (GDC) Fitness to Practise Panel (FtPP). I'd spent most of my life to that point as an actor and musician and remarkably little of it in the dental surgery. Unlike those of you who work in a regulated, healthcare role, artists don't have to worry about patient safety or the reputation of an entire profession. In fact having a criminal record or indulging in wild behaviour has enhanced many an actor's career instead of ending it.

I had ten years of sitting on a huge variety of cases and watching the story behind each emerge. When the whole dental team became regulated in 2008, I noted a slow change in the type of cases we saw, as DCPs gradually started to appear before us. Before then, we rarely saw a DCP as a respondent – mostly, they were witnesses in cases of a dentist's alleged misconduct. I often thought how difficult it must be for a dental nurse to come and give evidence about a current or former employer and I greatly admired the courage that your colleagues showed in doing so.

'UNLIKE THOSE OF YOU WHO WORK IN A REGULATED, HEALTHCARE ROLE, ARTISTS DON'T HAVE TO WORRY ABOUT PATIENT SAFETY OR THE REPUTATION OF AN ENTIRE PROFESSION.'

Nowadays, more and more cases with a DCP as respondent are appearing before the FtPP. However the numbers are still very small, whatever way you look at it: only 14.5% of cases in 2014 featured DCPs. As the largest registrant group – there are 66,607 DCPs to 39,418 dentists – it looks like DCPs are pretty good at staying out of trouble.

Putting statistics aside for a moment, I will go back to my own, personal experience of DCP misconduct cases and see what common factors seemed to emerge. I am not a legal or dental expert, so my input comes from the perspective of a lay member, which means that I am a member of the public, put there to represent the public interest, protect patients and make sure that the process is as fair and open-minded as possible. I now work in the training world and have developed expertise in designing and delivering training events. This means that every day I explore motivation, behaviours and insight in all walks of the working life. My training company, Xperient, uses interactive techniques to explore issues around communication and so it was inevitable that my eye and mind would be most drawn to the issues in a case where communication was the common factor. Gradually I realised that almost every case had a communication (or miscommunication) issue at its heart, even when the allegations focussed on clinical treatment.

'APART FROM MISCOMMUNICATION, ANOTHER COMMON FACTOR THAT I NOTICED WAS A LACK OF INSIGHT OR SELF-AWARENESS.'

Apart from miscommunication, another common factor that I noticed was a lack of insight or self-awareness. These 'blind spots' would lead to unfortunate decisions being made where the patient was not being put first. You may have heard of 'reflective practice', which is how we all develop insight in the real world when mistakes inevitably do get made. And finally, in many of the cases involving DCPs, I noticed a naivety about professionalism and the responsibilities of being a regulated professional. This was reflected in personal behaviour in and out of the workplace that brought the profession into disrepute and seriously damaged public confidence.

Before 2008, my window into the world of the nurses, receptionists, practice managers, therapists, technicians and hygienists came through the evidence given by them as witnesses. After 2008 I was commissioned to create some training workshops for DCPs about the responsibilities of being a registrant. I spoke with many of your colleagues to discover what preoccupied them: some of you were deeply concerned about the responsibility to 'whistle-blow' as you didn't want to get the blame for something that wasn't your fault nor get sacked for being a troublemaker. It also brought up confusions and irritations about Professional Indemnity, CPD, the Annual Retention Fee and for some, fears of being expected to perform outside of your Scope of Practice. At this time, the profession lost many of its DCPs who did not want the added cost and responsibility.

I could see how many of you were struggling to 'manage upwards'. In other words, struggling to say 'no' to your boss, or tell a senior colleague that you weren't happy with a decision they'd made or the way they had behaved. Many of you were uneasy about some of the standards under which you had to work or were uncomfortable with the culture and atmosphere of the workplace but you didn't feel empowered to do or say anything about it. Regulation brought this power to you all but it also brought other responsibilities and, critically, it brought accountability.

So what are the actual issues that bring a DCP in front of his or her regulator? Are there any patterns and are there any pitfalls to avoid? The best way to put your mind at rest is to inform yourself. Reading the summaries of cases on the GDC website is a useful education. When I looked today for recent DCP cases, I found one 'theft by employee' in a case where the DCP had a criminal conviction, another where the DCP had failed to declare a conviction on the GDC application form (which was found to be 'dishonesty') and another where a DCP registrant had a conviction for 'actual bodily harm'. I then researched the bigger picture by looking at all the issues that led to 28 DCP cases in front of the Professional Conduct Committee in 2014. 17 of these respondents were nurses, ten were technicians and one was a hygienist. When I read through the summary of issues, some phrases leapt out at me, for example: 'uncooperative and obstructive', 'gave no clear warning of risk' and 'had many opportunities to correct the situation, but did not do so'.

These were classic example of the insight and communication issues that I mentioned earlier.

With the seventeen nurses, the issues were as follows:

- Failure to disclose a criminal conviction or police caution (disorderly behaviour, criminal damage and a dangerous dog)
- Inappropriately claiming sick leave
- Creating a false patient record
- Operating beyond scope of practice (in one case, re: tooth whitening)
- Not obtaining patient consent
- Theft
- Embezzlement of over £19,000
- Drink driving and cannabis conviction
- Dishonesty about qualifications and
- Convictions for Actual Bodily Harm, Harassment and Violence.

Amongst the ten technicians, I found the following:

- Making inappropriate sexual comments
- Police caution for possessing indecent pseudo-photographs of children
- Allowing a dispute with a dentist to compromise quality of patient care
- False statements in advertising and
- 8 of the 10 cases related to Exceeding scope of practice.

For the solitary hygienist, the case surrounded deficiencies relating to record keeping, communication and consent.

Very few of you reading this will ever be involved in a case that reaches that level of seriousness. You are still more likely to appear as a witness, if at all. So if we take these themes away from the court room, so to speak, what is there to be learned from the mistakes that others have made? What about all the small, apparently trivial incidents in your everyday working life that challenge your professionalism? What can you do to make your personal approach to your practice more patient-centred and more professional?

In an ideal world we would all like to work in a team where we were encouraged to take responsibility, show initiative, ask difficult questions, were able to admit when we were confused or had made an error. I hope that many of you enjoy that working environment. However through the cases I have sat on at the GDC, I have seen that in many workplaces your colleagues endure difficult and unrewarding work cultures. In an 'ordinary', non healthcare job many people 'put up and shut up'. They can walk away from the job at day's end and forget all about it, just enjoying the pay packet. For members of a dental team, the issue of public safety and the reputation of your profession effects all the choices you make, in and out of work. It makes it so much harder to accede to a culture of carelessness, or ego-driven bad decisions. Yet many people do turn a blind eye to their own or others' behaviour. It was clear to me that some of the DCPs we saw giving evidence at a hearing had not realised that they could lose their right to practice and seemed to take no responsibility for patient safety. It was possible for a DCP to get all the way to a hearing without having taken any professional advice, perhaps because they didn't have indemnity to that level and sometimes because they didn't realise the potential seriousness of the outcomes.

'WHEN I READ THROUGH THE SUMMARY OF ISSUES, SOME PHRASES LEAPT OUT AT ME, FOR EXAMPLE: 'UNCOOPERATIVE AND OBSTRUCTIVE', 'GAVE NO CLEAR WARNING OF RISK' AND 'HAD MANY OPPORTUNITIES TO CORRECT THE SITUATION, BUT DID NOT DO SO'.'

I could see, as a case unfolded, that an uncomfortable working environment was often the catalyst. This has a cascade effect that compromises everyone in the end. It was rare to hear cases that had occurred at attractive and professional dental surgeries with a happy team and trusting patients. It's not that they don't make mistakes too. But it did make me wonder: Could it be that the problems were likely to be communicated more clearly and dealt with more effectively at a much earlier stage? Could it be that if people are able to admit to their mistakes, they can be constructively dealt with? And what about reflective practice? Having made a mistake, could it be that the happy, professional dental practice managed to deal with that mistake at grass roots level?

I realise that it is easy for me to say, 'why didn't that DCP just speak up and say something'. I understand how difficult it might be to give feedback to an employer or your manager. I appreciate that it is very tempting to turn a blind eye and hope that someone else will deal with the situation, or have a good moan in the staff room and then just get on with the job and keep your head down. I have worked for 15 years on training events in private and public sector exploring how to manage upwards, deliver difficult messages and how to raise concerns. It is extremely human to dread and avoid such conversations. But the rewards are tremendous. Practising being a transparent, self-aware and insightful team member means that it gets easier every day and your behaviour will influence others and can change the culture of the workplace. Reflecting on your own choices and behaviours adds to your credibility daily with patients and colleagues. You may even want to keep a reflective log of the issues that most challenge you so that if, God forbid, trouble does strike, you know that you have documented, robust reasons for your decisions. And you will know that you are doing the best you can for yourself, the team, the profession and, most importantly, your patients.

Nicola Burnett Smith runs a series of national training workshops for the Dental Team entitled 'Professionalism in Practice'. For more information, contact nicola@xperient.co.uk.

(If you have serious concerns about public safety and conduct in your workplace and want some advice, contact Public Concerns at Work http://www.pcaw.org.uk)

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What does skill mix mean to your practice?

'Jack of all trades, master of none'. A phrase believed to have been introduced somewhere around the 1800s, and one that still holds true today

In a recent interview in the *BDJ*, Paul Brocklehurst, Senior Clinical Lecturer, IHR Clinician Scientist and Honorary Consultant in Dental Public Health at the University of Manchester, discussed the benefits of a mixed skill set in practice. Gone is the idea of a jack of all trades, master of none. Healthcare professionals across the board can now be trained to become interchangeable, and in doing so become greater assets to their respective teams.

Direct Access sought to bring about these changes when it was introduced in May 2013. For the first time in the UK, patients were permitted to access dental hygienists, dental therapists and the dually-qualified without needing to see a dentist beforehand. Supporters claim more patients would have access to care while critics say a lack of thorough training could result in lower standards.

In his interview, Paul said: '*the greater use of the whole of the dental team is paramount; care for routine adult patients, primary, secondary and some tertiary prevention could be undertaken by members of the team other than the dentist, with the dentist taking on the leadership role and the provision of more complex care. I think a 'systems' approach is needed to appropriately plan the future of the dental workforce based on future changes in demographics, population need, the level of service required to meet this need and the number and mix of clinicians that are required to provide this level of service. In short, a needs-based planning model*'.

So how can it benefit your team? Replacing one healthcare worker for another as a result of their skills or widening of professional duties can have outstanding results. Evidence shows that it results in high-quality healthcare, but dentistry has been slow to adapt to these changes. We talk to Clinical Services Director at {My}dentist Steve Williams about his thoughts on the practical side of skill mix in the practice and how it can – and already has – improved patient care.

Why do you think dentistry has been slow to adapt to skill mix in practice?

Given the pressure many GDPs are under, it's not unreasonable to think dentists know what their standards are having run the practice and overseen all the activity for so long. Ultimately dentists are responsible for their treatment. The discussion around stress and pressure concerning UDAs is well-documented. What many seem to realise is hygienists, therapists, the dually-qualified and nurses are more than simply those titles. Through training courses and CPD many of them have extended duties and are extremely capable of taking on added responsibilities and complementing the work dentists carry out.

How can we change that perception?

NHS dentistry is extremely efficient, particularly comparing against other EU member states. If you have a larger practice and the right settings you can accommodate the full range of skill mix. It doesn't quite seem fair on newly qualified trained therapists who can bring a range of skills to a practice that compulsory vocational training is not mandatory, as they need support in their early careers to ensure they receive the right development.

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Does that mean training and education will form a fundamental part of bringing skill mix to the fore?
Absolutely. All members of the team have the right to training. Individuals as well as practices will stagnate if this does not happen. We have found many nurses want to attend courses and take on greater responsibilities. Our Training Academy in Manchester helps dental nurses, hygienists, therapists and the dually-qualified to develop their skills. Upon completion nurses are becoming OHEs and are able to apply fluoride. Currently we have over 650 practices spread throughout the UK.

Where do you see skill mix fitting into the new contract?
We have a number of pilot practices who are telling us what works for them. Consistently a team of three or more in surgery is ideal for utilising all of the team's extended skills. A key learning from what they are telling us is that once the system is implemented correctly it is extremely successful and substantially better for patients. The standard of care and outcomes for patients have shown positive results as there is more time to spend with patients reiterating self-care plans so that the patients can improve their oral health regime.

'ULTIMATELY DENTISTS ARE RESPONSIBLE FOR THEIR TREATMENT. THE DISCUSSION AROUND STRESS AND PRESSURE CONCERNING UDAS IS WELL-DOCUMENTED'.

What will it take for this to become commonplace in practice?
There needs to be a buy-in from the entire team. It will more than likely be some time before it is commonplace in all UK practices. Change has started, and it is now about securing traction. Provided there is no problem with referral guidelines, I fully expect a significant number of practices to open their doors to a mixed skillset. At present there are more than 400 practices within {My} dentist offering Direct Access, yet under current regulations this can only be offered privately, as they do not hold a performer number. A change in those regulations would help to speed up the process.

Moving forward where do you see some of the biggest challenges?
In general, disease rate is going down. Surveys looking into children's oral health and that of the nation paint a picture of improvement, as we must collectively strive to ensure these improvements do not plateau and there are pockets of the community where disease rates are unacceptably high. The population is getting older, and we are keeping natural teeth for longer. The biggest risk and resulting challenge I can see is treating dentate patients showing early signs of dementia. Root caries is a problem for this group of people, and symptoms – both dementia and oral health – can decrease rapidly. We must look to an integrated health system whereby nurses can have more of an influence in the care homes and of the elderly in general to maintain the health of those in need. Dentistry can play a large role in that, but under the current system there is a gap as many of these patients are not receiving adequate treatment and also adequate oral health support and advice.

We have spoken in some detail about the current system and set-ups. In your opinion, what does your ideal NHS dental contract look like?
Good question. The care pathways piloted have ensured a consistent approach and this should remain central to any contract reform. There has been a shift towards preventive dentistry, and my ideal contract would put prevention first and be rewarded to drive behaviour. In addition we need a reward mechanism to treat the most vulnerable groups, including the elderly, but also those with high disease rates. Finally clear guidelines need to be included regarding NHS and private treatment to ensure consistency for patients but also to help the profession.

'My ideal contract would put prevention first and be rewarded to drive behaviour' – Steve Williams, Clinical Services Director at {My} dentist

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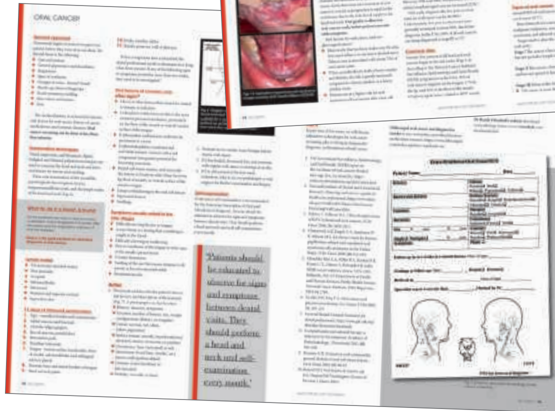
BDJ Team continuing professional development

CPD questions – May 2015

ORAL CANCER

Making **oral cancer screening** a routine part of your patient care

PART 1



ORAL CANCER

CPD ARTICLE: Making oral cancer screening a routine part of your patient care

1. What was the increase in HPV-related oropharyngeal cancers?

A. 50%

B. 100%

C. 175%

D. 225%

4. What percentage of oral cancers originate in the floor of the mouth?

A. 14%

B. 19%

C. 27%

D. 36%

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2. How many things should be observed prior to the patient sitting in the chair?

A. 5

B. 7

C. 9

D. 11

3. How long can it take to perform an oral screening?

A. Less than three minutes

B. Less than four minutes

C. Less than five minutes

D. Less than six minutes

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Disposing of clinical and dental waste

➤ May 2014: **Emergency oxygen therapy in the dental practice**

Emergency oxygen therapy in the dental practice

➤ July 2014: **Needlestick and occupational exposure to infections**

Needlestick and occupational exposure to infections

➤ August 2014: **Medical emergencies: the drug box, equipment and basic principles**

Medical emergencies: the drug box, equipment and basic principles

➤ October 2014: **Radiation protection in dental X-ray surgeries**

Radiation protection in dental X-ray surgeries

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	A	B	C	D
Q1	☐	☐	☐	☐
Q2	☐	☐	☐	☐
Q3	☐	☐	☐	☐
Q4	☐	☐	☐	☐

4. Please add any comments or feedback that you might have below or email bdjteam@nature.com.