BDJ InPractice
April 2017

Finding the right care

BDA
British Dental Association

Firm management vs bullying ■ Choosing the right job ■ Evolution of cosmetic dentistry ■ Advice pages

PROPERTY INVESTMENT OPPORTUNITY

Join a Growing Cohort of Doctors Investing in Solutions to the Social Housing Crisis

1, 2 & 3 bed flats and houses are available for purchasing with Local Authority contracts already in place and full management provided by Stef & Philips Ltd.

INVESTMENT

Long-term guaranteed rental contracts (typically 5-10 years)
Secure Local Authority agreements
100% ownership
Fully managed, hands-off investment

RETURNS

Guaranteed rent whether the property is occupied or vacant
NET returns of 6.50%
Decent capital gain forecasts
Steady income stream

Testimonials from Current Clients

"***Zero hassle investment***. *Great that someone else is picking up all the admin*"
GP

*"Knowing there are **no potential rental voids** or maintenance costs made my investment particularly attractive"*
Orthopaedic Surgeon

*"Great predictable **rising monthly income stream** to supplement earnings and my future (unpredictable!) pension!"*
Ophthalmologist

*"I have been using the services of Stef & Philips for the last three years. I have found them **very accommodating and efficient**. They have advised me of some **excellent ideas of investment** for which I have taken. They are **polite and trustworthy** and I would have no hesitation in recommending them."*
Dental Surgeon

For more information please contact us at:
doctors@stefphilips.com

Integrity
Client Care
Professionalism

BDJ InPractice

APRIL 2017

Cover illustration Danny Allison

Editor David Westgarth | **Production Editor** Sandra Murrell | **Art Editor** Melissa Cassem | **Publisher** James Sleigh | **Global Head of Display Advertising & Sponsorship** Gerard Preston | **European Team Leader – Academic Journals** Andy May | **Display Sales Executive** Alex Cronin | **Production Controller** Natalie Smith | **Editor-in-Chief** Stephen Hancocks OBE.

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

 ISSN 2057-3308.

BDA
British Dental Association

Business insight SEMINARS

BRAND NEW TO 2017

Using **Your Data** to Transform Practice Performance

Effective ways to **transform your practice performance**; ensuring your business reaches its full potential!

Seminars across the UK & Ireland

www.softwareofexcellence.eventbrite.co.uk

WATCH OUR SEMINARS AT

dentistry show — STAND **J25**

BRITISH DENTAL CONFERENCE & EXHIBITION 2017 — STAND **B11**

- **Learn –** How to identify the key performance indicators that you should focus on to meet both your business and individual objectives
- **Network –** Share ideas and experiences with teams from other practices
- **Understand –** The key daily tasks that drive performance in each role, and how to set targets based on industry benchmarks

FREE TO ATTEND

Time
Registration opens: **6:00pm**
Seminar: **6:30pm - 8:30pm**
Light refreshments provided from **6:00pm**

FREE to attend and qualifies for 2 hours verifiable CPD

@UKSOE | SoftwareOfExcellence | SoftwareOfExcellence

SOFTWARE OF EXCELLENCE
A HENRY SCHEIN® COMPANY

COMMENT

Stress and the GDC

Sir, I read with interest your March edition, not least because, having enjoyed 40 years caring for thousands of patients with few complaints, I recently had to face the very real possibility of losing of my license at the hands of a GDC PCC.

The first I knew anything was amiss was courtesy of a letter from the GDC requesting clinical records. As you read a letter like this your heart will sink and your stomach will drop with it.

In due course the matter was referred to the Professional Conduct Committee for a formal hearing. This becomes a Sword of Damocles that hangs over your head until conclusion of the case. You will find this a lonely spot.

While awaiting a PCC hearing, don't be surprised if the number of charges increases enormously. Ultimately, I found myself facing 85 charges related to two patients, after treating two teeth.

> 'In my opinion, the language used by the GDC in their correspondence to me was unnecessarily brutal and implied my guilt from the outset'

Some time ago I spent an evening talking to a senior colleague who found himself in a similar predicament, and had decided he would take his own life rather than face the music. As it turned out, he didn't and ended up with barely a slap on the wrist for poor record keeping. A less fortunate colleague hit the bottle, lost his job when he fell out with his colleagues, and lost his family when he fell out with his wife. He now lives in the care of social services, a totally broken man.

A PCC hearing begins with the charges read out by opposing counsel. Patients take the stand led by their counsel, and then cross-examined by yours. You hear dreadful things about yourself. Family and friends will be well meaning, but you will require professional help, however robust you might be.

At my own hearing, they ultimately concluded that I was a reliable and credible witness. Relief finally, you might think. But no. They declared the same of the patient, and concluded that her account was proven. So much for the balance of probability. Civil Law departs from Criminal Law in this respect. Under the former one may find in favour of 51%, under the latter guilt should be 'beyond reasonable doubt'. As the Committee reported that we were both credible witnesses, that amounts to a 50/50 split. That *should* have led to an open verdict, surely?

It is my opinion that PCCs are institutionally biased and favour whatever the patient has to say in 'evidence'. Despite the noble principle to the contrary, it seems that a defendant is guilty until they prove their innocence. I believe recent criticisms of the GDC have led to this cultural bias.

'Current fitness to practise not impaired' were the committee's concluding words. The only upshot has been that I now have less time to treat my patients due to additional paperwork.

Nevertheless, it was a deeply distressing experience. In my opinion, the language used by the GDC in their correspondence to me was unnecessarily brutal and implied my guilt from the outset. This is wholly contrary to the statement of the Chair of the Committee, who placed an emphasis on fairness. My stress levels were enormously increased for the 30 months from the arrival of that first letter to the final outcome. There were times I found myself in a very dark place.

And as if to rub salt into the wounds, despite the PCC's conclusion, the GDC nevertheless kept a record of the entire proceedings on their website for a month after the decision was made.

When I combine the brutal nature of their correspondence, the bias I perceived at the hearing, and the continued inclusion of my case on their website after judgement, it would appear that the culture of the GDC is one of complete disdain for members of our profession. It reminds me of the Spanish Inquisition and McCarthyism.
Be prepared readers, and beware.

Toby Talbot BDS MSD (Washington) FDS RCS

Simplyhealth invests £137k for Teeth Team

Simplyhealth is investing £137k into Teeth Team, a nationally-recognised child oral health improvement programme.

Teeth Team, which was set up in 2010 in Hull, works to improve the oral health of children in socially deprived communities. The investment from Simplyhealth will enable Teeth Team to continue its work and roll out its programme to an additional 50 schools in 2017. In addition, Simplyhealth Professionals and its member dentists will be proactively involved in delivering the programme as it expands.

In the last two years, Teeth Team has recorded a reduction of 19.8% in local children experiencing dental extractions under general anaesthetic. The oral health survey for five-year-old children 2014-15 in Hull, carried out by Public Health England Survey (DPH), recorded an improvement from 43.4% to 37.8%.

Chris Groombridge, Chair of Trustees for Teeth Team, said: 'We are absolutely delighted to receive this momentous support and investment from Simplyhealth to our charity. To be working in partnership on this level means that moving forward we can expand the programme into scores of new schools in other areas of need and continue to make a real different in child oral health.'

Henry Clover, Director of Dental Policy at Simplyhealth Professionals, said: 'We are incredibly excited about being involved with Teeth Team. Simplyhealth Professionals is ideally placed to provide practical, proactive support through our member dentists, some of whom will have the opportunity to visit these schools and help children understand the importance of preventive oral health care through the Teeth Team programme.' ◆

CORRIGENDUM

In March's interview with Richard Emms, it was stated that the FGDP(UK) has launched standards for patients living with dementia.

This is incorrect; the FGDP(UK) is developing standards and the document will be sent out for consultation soon. ◆

Welsh dentists slam above inflation increases in NHS charges

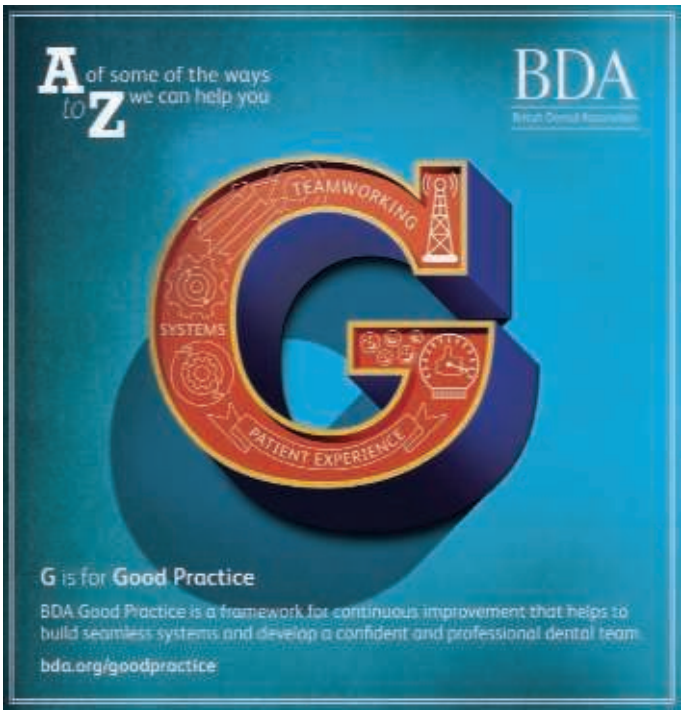
The BDA Wales has strongly criticised above-inflation increases in NHS dental charges from the Welsh Government. Charges in Wales will increase from 1 April from £13.50 to £14 for band 1 treatments including basic check-ups (a 3.9% increase), from £43 to £44 for band 2 treatments like fillings (a 2.3% increase), and from £185 to £195 for band 3 treatments like crowns, dentures and bridges (a whopping 5.4% increase).

Data from the last Adult Dental Health Survey revealed nearly 400,000 people in Wales have delayed or avoided dental treatment because of costs. Recent research in England has suggested fees place significant pressure on GP and Accident and Emergency services, as patients seek out services that are not subject to charges.

In the official memorandum heralding the increase Cabinet Secretary for Health, Wellbeing and Sport, Vaughan Gethin, said he was 'satisfied that the benefits outweigh any costs'. The BDA has consistently called on parties to maintain the freeze on charge levels and asked for NHS dental treatment to be made genuinely affordable. No official consultation was run.

NHS charges were introduced in the 1950s to lower demand for dental services. Following several years in which charge levels have remained frozen BDA Wales has urged the Welsh Government not to embrace the English model.

Katrina Clarke, Chair of the BDA's Welsh General Dental Practice Committee, said: 'The Welsh Government has absolutely no justification for giving people on low incomes reasons to avoid seeing their NHS dentist. Charge hikes do not put a penny more into the system – they simply turn dentists into tax collectors and discourage the patients who most need our care.



Important changes for non-EU medical professionals applying to work in the UK

From 6 April 2017, dentists from outside the EU applying for a UK Tier 2 visa (sponsorship by a UK-based sponsor) will be subject to a requirement under Paragraph 320(2A) of the Immigration Rules to produce a criminal record certificate from any country in which they have been resident for 12 months or more in the previous 10 years. Sponsoring dental practices must now ensure they inform any dentists of this requirement for visa purposes who they might intend to sponsor. This will help them ensure their visa application is complete when they submit it. Failure to provide the certificates may lead to the visa not being granted. Visa requirements do not currently apply to EU and EEA nationals.

The BDA cannot advise on individual immigration issues; for further information, members should contact registered immigration advice services.

Latest Capita fiasco now forcing hundreds of NHS dentists to stand idle

The BDA has called on MPs to hold NHS subcontractor Capita accountable for administrative failings that are preventing hundreds of NHS dentists from earning a living – putting their practices and their families in jeopardy.

NHS dentists have had to wait – in some cases for up to a year – to get the 'National Performer Number' required to provide NHS services. Administration of the National Performers List used to be managed by NHS England, but was contracted out to Capita alongside other Primary Care Support services in September 2015. Before Capita won the contract the average application turnaround time was approximately 6 weeks. The BDA is now aware of NHS practices that are risking closure as a direct result of this failure, and colleagues unable to meet mortgage repayments.

The BDA has been raising concerns with MPs and has thrown its weight behind Labour's Steve McCabe, who has tabled an Early Day Motion (EDM) calling for the Government to hold Capita to account. It is now asking dentists across the UK to get their MP to join the call.

Over 550 trainee dentists were expected to stop work on December 1 2016 as a result of the backlog, until the BDA managed to secure an extension to the applications process. Hundreds of other NHS dentists are still affected.

The BDA estimates practitioners from all parts of Britain – many at the very start of their careers – have lost out on tens of thousands of pounds in income as a result of the problems, and will be seeking compensation from NHS England for any of those left out of pocket.

Henrik Overgaard-Nielsen, the BDA's Chair of General Dental Practice, said: 'This latest failure from Capita has forced hundreds of NHS dentists to sit idle for months. It's a disgrace that practitioners are being denied a livelihood, while hundreds of thousands of patients are being left without access to NHS dentistry.

Spring budget 2017: key announcements for dentists

Expectations were that this could be a boring Budget but Charles Linaker, a tax partner with NASDAL member UNW says that several measures announced will have an impact on dental practitioners.

'As anticipated, the Chancellor announced measures to relieve the impact of the business rates relief revaluation. In particular, no business coming out of small business rates relief will pay more than £600 extra in business rates in 2017/18 than it did in 2016/17 and local authorities will be provided with funding to provide discretionary relief to those businesses most affected by the revaluation. Dental practitioners adversely affected should make representations accordingly.

'HMRC's Making Tax Digital (MTD) programme and the requirement to file quarterly returns marks a major change to the tax landscape and particularly so for dentists who, unlike other businesses of comparable size, have not had to grapple already with the requirement to file quarterly VAT returns.

'Following strong representations, the Chancellor announced that there would be a deferral on the implementation of HMRC's MTD strategy for businesses. However, this was disappointing in that it only extended to the self-employed and landlords whose turnovers are below the VAT threshold (increased to £85,000 from April 2017). These will not now have to start making quarterly digital returns to HMRC until April 2019, instead of April 2018.

'This will bring them into line with businesses which are registered for and who pay VAT, where the start date for MTD had already been announced as April 2019, and will mean that many dental associates will have an extra year to prepare for MTD.

'But the sting in the tail is that those unincorporated businesses whose turnover is above the VAT threshold and who are not registered for VAT will still be required to make quarterly digital returns to HMRC from April 2018. This will include most dental practitioners and many dental associates. HMRC is seeking business volunteers to beta test the MTD programme during the coming year, before it goes live in April 2018, and practitioners may want to consider getting involved in this so that they can be well prepared for its eventual implementation.

'Dental practitioners operating via limited companies will not have to file quarterly MTD returns with HMRC until April 2020, so any unincorporated practices which have already been contemplating incorporation for other reasons may want to consider getting a move on!' ◆

©Dan Kitwood / Staff / Getty Images Plus

New NHS complaints procedure in Scotland

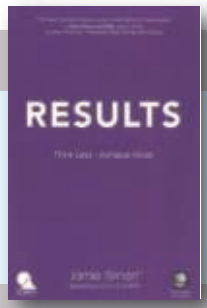
A new NHS complaints procedure will bring dentistry in line with all public sector complaints in Scotland.

The new procedures, effective from 1 April 2017, will mean dental practices will need to change how they handle complaints.

Within dental practices all NHS contractors, whether practice owners or associates will need new documentation, including a complaints procedure based on Scottish government template. The template has guidance for practice internal use on how to handle complaints and a procedure for patients on how their complaints will be handled. This is a one-size-fits-all across the NHS and whole public sector in Scotland that dentists must use.

More information is available if on the Scottish Government Health & Social Care Directorates' website at www.sehd.scot.nhs.uk you search for you search for '*NHS Scotland Model Complaints Handling Procedure*' – the document reference is DL(2016)19. ◆

BOOK REVIEW



Results – think less. achieve more
Jamie Smart
Capstone, 2017
ISBN: 978-0-857-08709-6
£10.99

Smart's latest book, Results, draws on his previous one inasmuch as his clarity concept of thinking and working has now evolved into his CLARITY® brand. He frequently refers to various CLARITY® models including a Calibration model (used to determine his clients' true requirements) and the CLARITY® Impact Model – a simple method for relating an innate capacity for learning, changing, growing, communicating and crucially, getting results.

At nearly 300 pages, the book goes into a considerable amount of detail and is divided into 3 broad sections: Grounding ('your personal transformation'); Impact (your interpersonal transformation) and finally Leverage (your commercial transformation). Within the context of a highly theoretical and iconoclastic treatise, Smart is also at pains not to lose touch with reality by punctuating the chapters with 'reality check' boxes. He states very early on that we are living in a world characterised by increasing volatility, uncertainty, complexity and ambiguity, or VUCA for short. This is echoed towards the end of the book where, in reference to the Future Work Skills 2020 report (2011), he cites the skills that in the future might help to stay relevant in a VUCA world.

Ultimately he posits, that 'bottom line results' comprising perceptiveness, creativity and social intelligence are key to business prosperity in the next 20 years. In summary he concludes the major factor in thwarting success (and getting results) is, as he puts it, 'contaminated thinking'.

For more about this book visit www.bda.org/booknews

Pressures of practice pushing dentists to the brink

The pressure of dental practice, including increasing patient demands, business worries and rising complaints and claims, is pushing some practitioners to the brink, the Dental Defence Union (DDU) has warned.

A survey of just under two hundred dental professionals carried out by the DDU1 found that over half of dental professionals (59%) involved in a GDC investigation or negligence claim in the previous five years worry about a further investigation. Additionally, 14% suffered serious health problems following the complaint or claim.

In the latest DDU journal, dento-legal experts and a dental practice owner interested in occupational health matters, advise that a successful coping strategy is more important than ever and provide advice on sources of help and support.

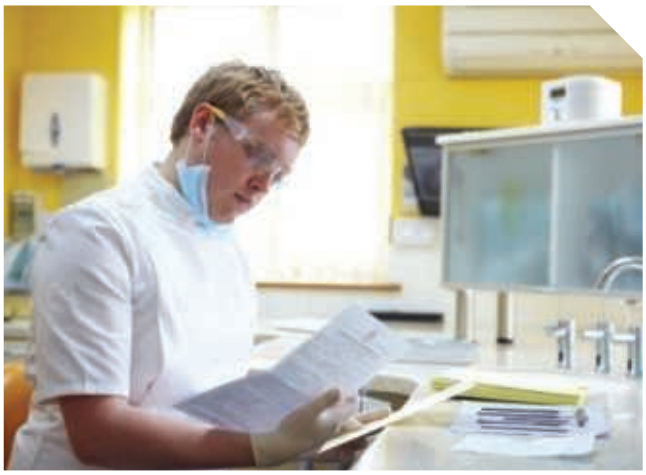
Eric Easson, DDU dento-legal adviser said: 'Dentistry can be a rewarding profession when treatment goes according to plan and patients are happy. Unfortunately there are times when it can also be difficult, and all dental professionals will go through times of stress during their working life.

'GDC fitness to practise investigations, complaints and other complex difficulties faced by dental professionals can be particularly stressful when they have the potential to adversely impact that person's career and livelihood. Some of these processes can be long, and mean that members often suffer prolonged times of stress which can impact on physical and mental health.'

Dentist Malcolm Prideaux, who is an active member of a local Practitioner Advice and Support scheme, says: 'Practitioners might be under pressure because of the constraints of their NHS contract or they could be struggling with the demands of regulation and compliance. This is on top of the demands of treating patients and meeting their commitments outside work.

'Our goal is to help professionals with performance or health problems and avoid the need for a GDC investigation. This might range from simple telephone advice and practice visits through to coordinating mentoring, further training or counselling, although we have to refer drink and drug problems for specialist support.'

The DDU survey had 187 responses from dental professionals and was carried out in February 2016.




belmontdental.co.uk
020 7515 0333
Belmont
The Beauty of Dentistry
CLEO II is a highly compact Below-the-Patient treatment centre with folding and extending legrest

Finding the right job

James Richards,
Classified Advertising Manager,
BDJ Portfolio

There's a plethora of research that suggests job satisfaction and morale among dentists is at an all-time low[1]. Targets and UDAs have taken their toll on a significant portion of the profession, with many unwilling to move.

Taking the plunge and committing to searching for another job isn't always the easiest to make. It's a leap into the unknown for starters, and there's always that nagging feeling that the grass isn't always greener. However, once you've taken that leap, you often wonder why you didn't do it sooner.

To make that process easier, BDJ Portfolio Classified Advertising Manager **James Richards** spoke to *BDJ In Practice* about the benefits of BDJ Jobs.

What would you consider the most significant addition to BDJ Jobs?

All of the old functionality is still there, but for jobseekers you can now set up and create personalised job alerts. You can decide whether these come through on a daily or weekly basis. That's the first thing I would recommend any jobseeker do.

You don't need to sign up to the website in order to apply for a job either. However by doing so you can set up a candidate profile and upload your CV, which makes applying for jobs a far easier process than ever before. You don't need to worry about your application looking unprofessional as it's coming from a mobile phone. It will look exactly the same as if you applied through a desktop.

How else has the mobile-optimisation of BDJ Jobs made life easier?

You can quite literally apply from wherever you want. If you're unwinding in bed at the end of the day you're only a few clicks away from applying for a new job. If you've decided you want a change of direction on the commute home from work you can do it. That's why uploading your CV and creating a profile is a good idea.

If you are on the move and don't have time to apply for a job, you can save it and come back to it later. It's worth noting however that we've had some great successes. One practice posted a vacancy and after in excess of 20 applicants 24 hours later filled the position, so don't wait too long.

So the site is popular?!

We're averaging more than 500,000 page views a month. We have a huge number of people looking for jobs. Vacancies in major cities and towns tend to attract the most applications, however you may find there is less competition for jobs in rural locations, as well as more UDAs and often a better quality of life. It's important you approach a job search with an open mind. It may result in you securing a better-paid position.

How can applicants do that?

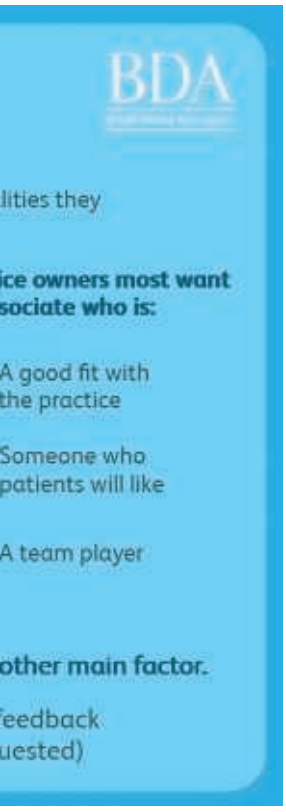
We have a range of new filters designed to get you the job you're looking for. It sounds pretty simple, but being able to choose the location, the employer type, the salary, the

Postgrad

One way to increase your job prospects as an associates might be to stand out from the crowd of other applicants by having a postgraduate qualification. Though, ideally it should also be relevant to the practice to which you are applying. The jobs market for associates in many parts of the country has changed over the past few years, with young dentists in particular having to put more effort into finding the right job. Practice owners in London and other metropolitan areas particular have a good choice of applicants for associate posts and having a qualification might help get an interview.

hours and the organisation type means the results you get back are 100% tailored to what you're looking for.

The new geographical targeting feature gives you the opportunity to view jobs that are potentially within walking distance of where you live. You can choose a radius of 5, 10 or 15 miles away, and you can even put your postcode in and see which jobs are available around you. Numerous studies have shown that commuting is one of the most stressful parts of the working day, with the average worker in the UK is spending 54 minutes commuting each day. According to a 2014 study carried out by the Office for National Statistics, people's feelings of life satisfaction and happiness decrease with every successive minute of travel to work and those with journeys between 60 and 90 minutes suffer the most negative effects on personal well-being. Interestingly, after three hours of commuting, the negative effects mentioned in the ONS study dropped off.



The BBC reported in February 2014 that, "Commuting journeys increase because people move out of towns and cities to find better housing, more green space and a higher standard of living." With every minute of commuting time affecting well-being, this seems to be an increasingly difficult situation for workers.

Unlike some professionals, however, dentists and dental care team members are fortunate that their working spaces are often located in residential areas shortening the usual commute already if you are lucky enough to find a workplace near your home.

If you are stuck with a lengthy commute, *BDJ Jobs* is now able to make it quicker and easier for you to find a new job with the new postcode search facility.

Registration

You will have to register with or be licensed by the appropriate regulatory authority. Dentistry is highly regulated in every country ensuring that only those who have been properly trained and are competent to practise dentistry are able to do so. However, regulations and the regulatory authorities differ widely.

Immigration

Within the European Union, the principle of free movement applies to citizens of EU countries, although if you are not an EU national different rules might apply. Generally, if you go somewhere outside the EU, you are likely to need a visa or work permit. Check the immigration and visa requirements with the country's embassy or High Commission in London. Many visas are principally for tourists and if you rely on them to take up employment you may be contravening that country's law. ◆

1. British Dental Association. Is there a well-being gap among UK dentists? 2015. Available online at www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/wellbeing (accessed February 2017).

A seven-step checklist for finding an enjoyable and rewarding dental job

Sometimes it is very tempting to take the first job you are offered, especially if you have been searching for a long time or if the thought of being out of work for a long time is a difficult prospect. It is important, however, not to rush into a role you might later regret and which could be detrimental to your future health, wealth and happiness.

Here are seven essential things to ask yourself before accepting a job offer:

1. Is the job perfect and does it matter if it's not?
2. Does the location work for you?
3. What are your colleagues like?
4. Will you have the opportunity to learn and develop with a varied dental workload?
5. Do you have any concerns about the pay and UDA targets?
6. Can you work with the Practice Owner?
7. Should you use the BDA's contract checking service?

Working abroad

Dental skills are global, giving you the option of working in another country at some point during your career. Allowing you to broaden your horizons by gaining professional experience abroad. However, any dentist thinking about this needs to look at two vital pragmatic legal questions: am I able to register my qualification there; and what are the immigration rules that I need to comply with? Both depend on the laws in the country you're heading to and compliance with both is essential.

Where is the line?

David Westgarth,
Editor, *BDJ In Practice*

In many different facets of life, there is often a discussion about 'a grey area'. It happens in policy, in interpretation, in sport. In fact, it probably happens more than we actually realise.

Another grey area is the distinction between what constitutes firm management and bullying. We're not talking Horrible Bosses style, but with morale at an all-time low in the profession, it's only right to ask whether there are too many shades of grey in this area.

Think of two rutting stags in a field, or two dogs in the park, one furiously barking, one shying away. The two stags will constantly clash until one wins. The dog will continuously bark until the other dog decides to bark back. We're not saying bark at another member of staff or go charging at them like you're a stag, but the point is there are two different ways to approach things; combative, or authoritative.

Alison Miles-Jenkins, Chief Executive of Leading Light Learning, said: 'What I know from 30 years of immersing myself in training others in management and leadership is that times have changed dramatically. Management theory and academic approaches aren't what many people need to start or progress their management career anymore. Fine in the University lecture theatre but that's a million miles away from the current everyday work reality for most.

'For those in a leadership/management role within Dental Practices a practical and pragmatic approach seems to work best. Time and people are their most precious resources and implementation is key. From my experience, there's a want and need to focus on the answers to the 'how to' questions: the tips, techniques, shortcuts and must haves that are easy to implement and drive results.

'One of the top challenges I constantly hear is how to handle difficult situations with staff – anything from how to get them onside, working as a team, willing to go that extra mile, keen to develop themselves, motivated and enthusiastic, through to how to get them to do what they are supposed to do in the way they are supposed to do it.

'One of the problems is that those with management responsibilities often lack the skills and experience, techniques and skills to create the culture in the first place where people thrive and flourish. Or perhaps unwittingly they appoint the wrong person and destabilise a previously high performing team. Of course equally they could be up against poor performers for a whole variety of reasons and at their wits end trying to improve the situation. One option seems to be to put on the blinkers and stick their head in the sand.

'Others resort to a 'firm management' approach, a kneejerk reaction to deal with the situation. Instead of having the skills and techniques to explore causes and solutions, an aggressive approach may be taken. If so, then it's quite feasible that what follows is a perception that the member of staff is being bullied. A classic is the grievance process then being evoked for the alleged bullying.'

A two-way street

James Goldman, Head of Employment and General Practice Advice at the BDA believes a two-way street. He said: 'Managers have to be aware that different people work in different ways and require different ways of encouragement. Sometimes a manager needs to dangle the carrot on a stick, and sometime a manager needs to keep their staff going by using the stick. The art of man-management is figuring out which members of staff fall into which category, and being able to keep them motivated.

'From a legal standpoint, cases can often descend into a 'she said he said' scenario. It is damaging for both parties, and can be time consuming too. We encourage in-practice resolution as a starting point. In my experience disagreements can often be traced back to contractual obligations. For instance meeting targets, expected working hours and clawback are topics we regularly address. If both parties sit down, look at the contract and amicably agree on a way forward that works for them both, this often brings a resolution.

'But some practice owners take a less conciliatory approach to disputes. And such approaches, which can sometimes amount to bullying, can lead to disaffected associates and high turnover. Furthermore, some associates who are subjected to bullying are able to claim that such treatment amounts to unlawful discrimination. The Equality Act 2010 makes it unlawful to discriminate against someone because of one or more protected characteristics. The protected characteristics are age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex and sexual orientation. If, say, a practice owner treats a pregnant associate badly, that associate may be able to claim that such treatment is because they are pregnant.'

Chris Barrow, dental practice coach and speaker said: 'I'm 25 years into coaching dental practice owners and their teams and still have to deal with performance and behaviour issues on a daily basis.

'You can grow a business with time, money and the correct people. Finding time and money is a straight-forward process. Finding the correct people still represents the biggest challenge. Leadership and management are distinct skills that must be learned.'

> 'Bullying exists in the absence of consensual agreement. A manager that says 'do this or else' is about fear of loss. One who says 'do this because' is about the anticipation of gain, worth, confidence, recognition.'

So how would Chris define firm management and bullying?

'A great leader or manager creates an environment in which teams want to do the work because from that work they derive self-worth and purpose', he said. 'A firm manager creates clarity by spelling out tasks, deadlines and expectations whilst subtly reminding the employee of the 'why' we do things a certain way.

'Bullying exists in the absence of consensual agreement. A manager that says 'do this or else' is about fear of loss. One who says 'do this because' is about the anticipation of gain, worth, confidence, recognition. The difference might only be two words, but the effect is significant.'

Alison added: 'Obviously, all managers have the right to manage – that is why they are called managers and they clearly have the right to use approaches to improve performance. But there is a fine line between firm management and bullying. The line in my view is crossed when there is a deliberate intent to intimidate, or a misuse of power or position, that leaves someone feeling hurt, vulnerable, isolated and angry.

One size for all?

We must remember that what is a 'firm' approach to one can be perceived and received as bullying by another. I prefer the term 'assertive management', which is based on respect and aims for a win/win outcome rather than 'firm' - which infers 'taking a firm hand' and may be interpreted as parental, aggressive or bullying. Bullying lies in the eyes of the beholder. So, if someone says they have been bullied many would argue then that they have. Remember there's a huge raft of employment legislation that all managers must tread carefully through and around these days.'

While one person may need an arm around the shoulder, another may need a kick up the backside. Man-management is considered an intangible skill and one essential to the smooth running of a practice – or getting on with colleagues – but could the preferential treatment towards staff be taken out of context?

'At the risk of sounding pedantic, managers manage systems, leaders lead people. We need both', Chris said. 'People-management is impossible. People-leadership is what we aim for. When a leader focuses their efforts on one individual, that becomes mentorship. Mentorship carries with it an element of preferential treatment because not every apprentice requires – or deserves – the same attention. The whole point of mentorship is to build on strengths and to eliminate (or delegate) weaknesses. That is positive discrimination.'

It's completely understandable that people who have been in the dental profession for decades may have developed a style of management that's more autocratic than most approaches these days', Alison commented. 'Currently there is more emphasis on an empowering approach with specific skills and techniques to bring out the very best in people, just as there are skilled approaches and techniques to challenge, support and turn around underperformance.

'These aren't just 'common sense' approaches and they need training and coaching to apply successfully. The management toolkit these days is infinitely deeper and more varied than ever. The good news is however that it's never too late to learn how to be a better manager.' ◆

Alison's Latest book *'New Manager Secrets' – How to accelerate your success as a manager immediately'* is available to buy at http://amzn.to/2n0BWQP

If this then that

By David Westgarth,
Editor, *BDJ In Practice*

There's an app on my phone that if X happens, Y follows suit. For example, if I post to Instagram, it appears on my Twitter feed. It's terrific – and rather clever. It's nothing new by all accounts, but it does harness one of life's great predicaments; consequences.

It's like a dangerous game of dominos. One thing happens, and a multitude of other things follow. Yes you can skimp on materials, but the final product may be of lesser standard, and the patient might complain, which might mean a trip to Upper Wimpole Street, which will mean stress. Get the picture?

The same applies to where children – and adults for that matter – are accessing dental care. If they head to A&E, there's a chance they won't get seen by someone with the right tools to fix them, which means they will be discharged with painkillers or antibiotics, which further increases anti-microbial resistance, which also means they haven't seen the right person, which also means additional pressure on the NHS. I could go on.

The fundamental principle is this: adults and children alike aren't visiting the right places for the right care, and issues will follow.

The reality of the situation is that a significant number of children still attend A&E services for non-traumatic dental problems, placing great pressure on an already overburdened NHS.

Tooth decay is an entirely preventable condition, but is the leading cause of child hospital admissions. The condition can be effectively managed in primary care – minimising distress to patients and the costs to the health service. Figures from NHS Digital reveal 160 children and teenagers are undergoing tooth extractions under general anaesthesia in hospitals in England every day.

Latest annual data on NHS spending in 2015/16 reveals there were 40,800 extractions of multiple teeth in under 18s in England at a cost of more than £35.6 million. For GDPs in England 179,000 teeth were removed from children aged nine and under – costing £14 million.

The BDA has long raised concerns about the persistent oral health inequalities that are borne largely by the most disadvantaged communities in England, while independent studies show that oral health problems can have a lasting impact on children's school readiness, impair their nutrition, development, and ability to socialise with other children.

Treating dental disease costs the NHS £3.4 billion a year in primary and secondary dental care (2014). Over 26,000 children aged between five and nine were admitted to hospital in 2014/15 for dental reasons.

Many of the children's tooth extractions carried out in the NHS under general anaesthesia are performed by dentists in the Community Dental Service (CDS). CDS dentists treat vulnerable adults and children and in recent years have faced major problems with low morale, recruitment issues, shrinking services and ever increasing demands. The Community dental services are under attack at the moment with services being tendered out with even tighter budgets resulting loss of jobs and increased pressure on dentists that remain. As the BDA's evidence to the Review Body on Doctors' and Dentists' Remuneration revealed, many community dentists are nearing retirement age and many will look to retire as soon as they can in the face of low morale, increasing stress and increasing pension and GDC costs. Children with the most acute treatment needs can ill afford to lose their expertise.

> 'Treatment in hospital, by its very nature is going to be more expensive than treatment in a primary care setting. What is needed is a national programme of prevention.'

Children who are referred to hospital for general anaesthesia are assessed and GA is only offered to those who really require this level of intervention. Nevertheless there are long waiting lists in many areas and children have to endure ongoing pain, repeat courses of antibiotics and continuing interruptions to schooling and family life.

Treatment in hospital, by its very nature is going to be more expensive than treatment in a primary care setting. What is needed is a national programme of prevention, focussing on children from deprived areas that will reduce the need for dental general anaesthesia. We are expecting an announcement from NHS England that will focus on the areas that have the worst and not improving oral health for under five year olds and provide a practice based intervention that will reach out to local communities.

What's out there already?

In the Emergency Department at North Manchester General Hospital, a significant number of children were attending with non-traumatic dental problems such as toothache, abscesses and swellings. In reality these patients are the ones adding pressure to the NHS and overcrowded A&E wards. Given that doctors don't have too much training in the way of dentistry, many of these patients were referred to the max fax team, often un-necessarily. These referrals meant that children were in the department for longer – which isn't great for the children or the (often very busy) department.

Dr Rachel Isba, a Consultant in Paediatric Public Health Medicine working in the Emergency Department at North Manchester

General Hospital audited the attendances and discovered that of all the children who came to the department, only 1 in 8 ended up actually being admitted to the ward. 'The vast majority of children were sent home from the department and told to see the dentist, with no formal follow-up', Dr Isba explained. 'Additionally, the discharge letter from the hospital automatically gets sent to the GP, so even for the children who had a dentist – and we know that some of our local families don't access primary dental care for a variety of reasons – they wouldn't necessarily know that the child had been to hospital. We realised something needed to be done to join up our secondary medical care with existing primary dental care services and to improve the management and referral of these children in the department.'

In a nutshell, the programme enables children who access emergency care to get the right treatment, both in the emergency department and in the community. Dr Isba brought together staff from the emergency department, max fax consultants, community dentists and local commissioners to develop a system that didn't just send children back out of the medical system into the community without being signposted to the correct dental services.

Dr Isba explained: 'One of the important developments in the programme was to develop a clinical pathway for use in the emergency department that would help support the correct management and appropriate referral of children within the hospital as well as identifying those suitable for referral to services.

'If a child is identified using the clinical pathway as needing urgent dental care (but not in the hospital setting), a 'referral' is made by giving the parent or carer a 'golden ticket' voucher (we have two community services involved and parents are given the choice of which one is easiest for them to get to). The parent can then call the number on the voucher, speak to someone in the Urgent Dental Care centre, and make an appointment. These children are prioritised and are given the first available appointment. Vouchers are numbered so that we can track the scheme's success. We also developed an advice sheet for the parents and carers of children who attend the emergency department, giving them advice on how to prevent oral health problems from developing and how to access emergency dental services, should they need them in the future.

'Everything is designed to provide the most appropriate care to the children but also to try and release the growing pressure on A&E services – the theory being that if children access dental services for their toothache now, this may prevent them from re-presenting to the emergency department in the future with an abscess. This scheme will also hopefully increase the number of children receiving routine primary dental care.'

> 'It's well-documented that barriers exist for enabling children to access primary dental care, so this particular project was of great interest to me.'

Dr Richard Valle-Jones, Director for Dentistry at the Pennine Care NHS Foundation Trust, heard about the work Dr Isba was doing, and made it a priority to find out more. He said: 'A colleague of mine mentioned that a doctor at a local hospital was doing some audit work into children attending A&E with dental pain. So I hunted Rachel down, as I thought there might be some potential to collaborate to provide better care in the right setting for these children, initially utilising the unscheduled dental care services provided by Pennine Care NHS Foundation Trust and the Community Dental Service from Central Manchester NHS Foundation Trust.

'It's well-documented that barriers exist for enabling children to access primary dental care, so this particular project was of great interest to me.

'Collaborating and co-designing pathways is a new way of working, but here in Greater Manchester, devolution is enabling this to start to happen. New relationships and networks are being established. From a health economics stance, this work will help to free up significant amounts of money spent on unnecessary attendance at hospital. It takes a number of like-minded individuals including patients to get in a room and begin to understand the complexities involved and use their skills to map out pathways.

'I can't understate the importance of seeking ways in which we can deflect children – and adults for that matter – away from A&E services and into primary dental care services. This not only reduces the strain on hospitals but also provides optimal care for patients. Too many children discharged from hospital don't get the right follow-up care they need. Our team is happy to accept them because we know we are in the best position to give them the right care in the right place and at the right time. Furthermore we can direct them to a general dental practitioner after the episode of care.'

It's worth noting that the programme Dr Isba has created is actually nothing new here. There's no re-inventing the wheel. There's no 'new' service. It simply joins up two pre-existing services. Richard added: 'It's actually a classic example of putting the mouth back in the body. Many of the barriers faced are relating to attitude, understanding, time and cost. Working with non-dental partners really helps share and spread the importance of oral health.

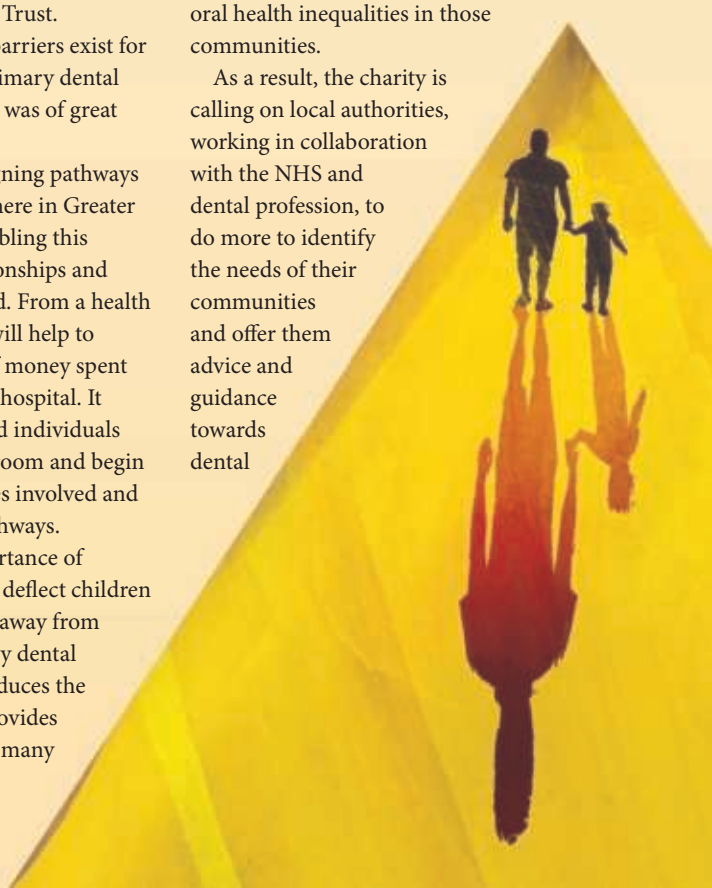
'The NHS has to deal with a high turnover of staff, this can be a positive as it allows the staff to pass on what they know to colleagues and peers, when they move into new roles, which can only be a good thing.'

Care in the community?

Following the publication of new NICE guidance on oral health promotion in the community earlier this year, it's fair to assume local authorities should improve their oral health services and the signposting of available dental services to local community dental services.

The new guidance outlines how local authorities can identify the oral health needs of people in local communities and also put in place steps they can take to address oral health inequalities in those communities.

As a result, the charity is calling on local authorities, working in collaboration with the NHS and dental profession, to do more to identify the needs of their communities and offer them advice and guidance towards dental



services which many people are currently missing out on.

Dr Ben Atkins, Clinical Director of Revive Dental Care and a Trustee of the Oral Health Foundation thinks collaboration could go a long way to improving oral health in local areas.

Dr Atkins said: 'We have to let people who are in need of help know that help is available for them.

'One of the first steps towards this is for local authorities to ensure they understand the needs of their communities when it comes to oral health and put in place the necessary interventions to address any problems.

> 'Against this background and with across-the-board cuts in Public Health budgets, it will be difficult for local authorities to justify the necessary spend to meet their obligations in oral health.'

'Some local authorities already run excellent and effective oral health services. Work done in areas such as Tower Hamlets and the London borough of Hammersmith and Fulham should be held up as a benchmark of what authorities can achieve if they put more focus on oral health.

'There are still some regions in the UK where oral health promotion is not treated with the priority that it deserves and as a result many people feel disillusioned with the help they can get.

'The NICE guidance includes some very common sense information for local authorities which can help change this. Including carrying out oral health needs assessments in their communities to identify groups at high risk of poor oral health as part of joint strategic needs assessments.'

As well as carrying out oral health assessments of communities, the NICE guidance also advises local authorities to ensure that health and social care services include oral health in care plans of people who are receiving health or social care support and are at high risk of poor oral health. They also recommend that local authorities provide oral health improvement programmes in early years services and schools in areas where children and young people are at high risk of poor oral health.

Dr Atkins continued: 'These are two of the most 'at risk' groups which we are currently seeing, by addressing these areas local authorities can really make a statement about how serious they are taking oral health in their communities.'

But does the money exist in order to carry out oral health assessments of communities in the current financial climate? Chief Executive of the Oral Health Foundation, Dr Nigel Carter OBE, thinks some areas benefit more than most.

'The pattern seems to be very mixed across the country in terms of local authority involvement with oral health and oral care', Dr Carter said. 'Unfortunately, we are seeing areas with previously excellent oral health programmes such as toothbrushing in schools lose 100% of their budget and other areas where all of the oral health promotion team have lost their positions. Against this background and with across-the-board cuts in Public Health budgets, it will be difficult for local authorities to justify the necessary spend to meet their obligations in oral health whilst cutting other vital services such as tobacco cessation and sexual health.'

Show me the money

Although Dr Atkins cited Hammersmith and Fulham and Tower Hamlets as benchmarks of what can be achieved, areas in Yorkshire, for example, suffer from a chronic lack of funding, a situation made clear when Dentaid provided emergency care in Halifax. Besides financial assistance, I asked Dr Carter what he thought could be done in order to improve care pathways for children accessing secondary, let alone primary dental services.

'The one trend in common across the country is a chronic lack of funding for local authorities to take on, what for them, is a new area and look seriously at the oral health of their population using the recently issues series of NICE guidelines.

'For mainstream dental practice we do need much better provision of up-to-date data so that patients can determine, without marathon effort, what practices in their area have openings. This is a historic challenge existing over many years and not the fault of the local authorities. Obviously the dental practitioner acts as the gatekeeper for secondary care for those patients attending. There is a real issue with the number of patients either attending their medical GP or turning up at A&E with dental problems. Not only is this not the most appropriate route to receive care but in the lack of appropriate training very often the advice or treatment given is not entirely appropriate.

'For an unregistered child with dental problems this may well be the best way of accessing secondary care. The local authority's role here needs to be less on manging the care pathway and more on preventing the need for treatment in the first place. The huge majority of child admissions to hospital for general anaesthetics are entirely preventable as we all know and the local authority role needs to major on ensuring that these preventive messages are received. Integration of oral health into all policies is also important. The mouth does not exist in isolation and dental caries is the most common non-communicable disease worldwide but shares common risk factors with obesity and diabetes and here local authorities can help with an integrated approach.'

Barriers

According to Dr Carter, last year's 5% rise in patient charges against a background of very low inflation really amounted to an additional tax on dentistry. In successive surveys over many decades patients have cited dental charges as one of the major barriers to attendance. Against a background where the rest of the health service is free at the point of delivery (with the exception of prescriptions – where effectively the patient has no option but to pay) even those who attend have always resented dental charges. 'It will certainly send poor signals of the government support for dentistry if charges rise ahead of inflation again this year', Dr Carter added.

Of course the trickle down (or, trickle up. It depends where along the river you are) effect impacts on community dental services. It's a service that's underfunded and overstretched across the board, and Charlotte Waite, Vice Chair England Community Dental Service Committee, thinks community dental services would benefit from a different approach.

She considers that more specialist training posts based in Community Dental Services would enable the training of future specialists where they are needed. The current system of national recruitment for specialist training discourages those community dentists, who already have personal 'roots' and knowledge of local health needs from applying. They are not able to take up training posts at the other end of the country, nor should their expertise be lost from the area where they are based.

'The lack of paediatric specialists is a significant problem. There are calls for CDS to be specialist-led, and I feel this would be a huge stride forward. The scope for 'top-up' training and bringing in specialists through a different route would reduce the burden greatly. NHS England's Guide for Commissioning Dental Specialities set out the case for change with the 'getting serious about prevention' mantra in mind. The publication of the long-awaited commissioning guide for paediatric dentistry is urgently needed.

'The issue is that CDS is very much a reactive service. Local patient needs assessments need to be robust. Services need to be taking care to the right people in the right places. Local NHS Commissioners must be pressed to budget for the appropriate services.

'This can only feasibly be achieved if we have the right workforce in place to deliver care. CDS is a female-dominated environment, which does need to be taken into account. Flexible working hours and career breaks are just two areas that do need to be factored in. The workforce is a highly-skilled one, but without the development afforded by training posts in dental hospitals, we will always be playing catch up.'

Although the shortage of specialists isn't extending waiting times for GA, British Society of Paediatric Dentistry spokesperson Claire Stevens thinks more can – and should be – done locally.

'The shortage of specialists in paediatric dentistry means more children are being referred out of primary care and into secondary care because their care is not being managed locally', Claire told *BDJ In Practice*.

> 'Every area should have a specialist in paediatric dentistry as a resource and to help raise the standard of care of children in that locality.'

'For example, we know that Hall crowns work and are very easy to place, yet few GDPs have the confidence and experience to do so. BSPD would like to see more specialists working in the community as part of managed clinical networks and a more even distribution around the country. Every area should have a specialist in paediatric dentistry as a resource and to help raise the standard of care of children in that locality. In February 2015, there were 167 Specialists in Paediatric Dentistry registered in England, with a total of 228 in the whole UK.

'Where there is a specialist working in the community, at a community clinic, local GDPs can refer to him or her for an opinion. The dentist may need advice on the management of the child or refer to the specialists who will provide care. Ideally, the advice or treatment from a specialist will mean that the child's dental health issues are managed, preventive advice given and the child does not end up needing a GA for multiple extractions.

'Specialists working in the community are likely to influence and input into clinical standards in that area Support GDPs, input in the provision of care, provide appropriate clinical intervention to obviate a referral for a GA Identify children, families or communities and for those who are at high risk prescribe fluoride varnish, offer preventive advice and implement shortened recall intervals. These skills are necessary for the often challenging nature of the patients seen.

'More specialists in paediatric dentistry should reduce the number of children needing GA. It's better to have diagnosis and treatment planning undertaken by a specialist. There is evidence that a child whose GA is treatment planned by a specialist is less likely to fail the treatment plans and require a repeat operation.'

Allied to Dr Waite's comments, those most at risk of poor oral health are the most vulnerable in society, who may not understand referral pathways and not have English as a first language. Taking the care to them is one thing, but engagement is another.

'This really is the value of programmes that take dentistry and oral health promotion out into the community at large', Dr Carter said. 'For many years all children had to have an annual examination by the school dentist but this was actually found to increase inequalities since patients in the system tended to receive more treatment and those not attending would not follow through with suggested treatment. This whole issue demonstrates the huge value of oral health promotion and taking the message out into the community where all can access the information in a non-threatening way.

'With oral health promotion teams being disbanded it may be down to the profession using vehicles such as National Smile Month to reach out to the community by taking the message of good oral health out to schools, universities, employers and shopping malls. Being creative on shoestring budgets is something we see all the time.'

Until there comes a time when dentistry overcomes barriers to care, nothing will change. A&E departments will get more crowded with children (and adults) seeking care for financial reasons. CDS will continue to operate on their outer limits until money is invested – both in recruitment, training and resources. Primary care services will suffer from a lack of signposting to the right care. If one thing happens, another will follow. And that needs to happen sooner rather than later. ◆

REGISTER FREE TO BE AMONG THE FIRST TO SEE WHAT'S NEW

WWW.DENTALSHOWCASE.COM

HEADLINE SPONSOR Oral-B

REGISTRATION SPONSOR Colgate

ORGANISERS GEORGE WARMAN PUBLICATIONS LTD

MA EXHIBITIONS

DENTAL SHOWCASE

Putting innovation into practice

19-21 OCTOBER 2017

NEC BIRMINGHAM

Building confidence

Bob Hughes,
CEO of the
Forton Group

I'm sure I'm not the only one who loves the Hollywood movie trope of the 'inspirational ra ra speech' given by the hero at their darkest hour.

Think of *Independence Day* where the President sends out the last few troops to take on the alien force. Or perhaps the moment in Henry V (Olivier or Brannagh – you choose) where he delivers the St Crispin's Day speech prior the Battle of Agincourt. Or you might admire the chickens who inspire Fowler to fly the plane as they escape in Chicken Run.

My personal favourite is in the West Wing, where Jed Bartlett (the US President figure) delivers a superb speech to demolish them at a time you think he's going to cave in.

We love these moments, we feel inspired by them, we wish we had that talent. Because there's a quality about those inspirational speeches that is genuinely moving.

Regular readers will recall that the model of leadership I describe has four clusters. So far we've covered the need for the leader to do some thinking, to come up with a good idea – a vision for success – and then to get people involved in delivering that vision.

So, now you have a team, and they all bought into your big idea, so surely that is enough?

Well, perhaps not; after all, we're only human. We can all succumb to self-doubt. If our task is especially challenging, we may question our own ability to deliver.

Even everyday familiar tasks may cause us to doubt our own abilities. Or when we think we're OK, we may look at the rest of the team and be concerned that someone else is struggling. It's part of the role of the leader to build confidence in the team, to reassure, to encourage. To bring focus back.

Imagine the leader who casts doubt on the future prospects or, worse, on the ability of the team to deliver. As I said above, the team has the potential to question itself – the last thing the team needs is the boss doing it too.

Another bad habit is to support the team, but then to suggest the organisation itself will never deliver. You might get the team to trust you more in the term, but this is divisive.

Even if a lack of confidence is not expressed overtly, it can leak out through behaviour. For example, the leader who constantly changes their mind or shifts direction 180 degrees when it gets tough. Or the boss who avoids making difficult decisions altogether. All these can point to a lack of confidence. And the team will pick up on it like a dog smells fear.

Here's a tip: every so often, stop and check: 'Do have I have information now?' Challenge yourself: 'What's stopping me taking this decision now?'

There is a school of thought that says it is more important to make any decision at the right time than to make the right decision too late. I'm not entirely convinced by that, but I do believe you have to communicate a good reason for delay.

Good leaders remain resolute when challenged. They'll make good quality decisions in a timely way, and will clearly justify and explain as appropriate. They take on the difficult conversations and the delicate issues.

I recall making someone redundant who, although quite capable, was hugely disruptive to the whole team through their behaviour and attitude. After he had gone, at least three of his former bosses came up to me to say what a good decision I had made. They all had seen this pattern of behaviour over the years, but their response had always been to pass him on to another boss who refused to bite the bullet.

Leaders who display the 'building confidence' behaviour as a real strength will very publicly demonstrate their support and confidence in the project, the team, or the organisation. Their words are positive statements that build excitement, enthusiasm and pride in the team. And they'll take personal responsibility for building the confidence of people around them.

I heard a great story from a former school-level rugby player. His team were about to play against a much better team. His coach took him to one side and told him that he was the one person who had the key to victory. The whole team depended on him and he could do it, he could guide them home. He felt filled with pride and excitement and the team did indeed go on to win a famous victory.

Years later, at a reunion, he mentioned this speech – he'd been too embarrassed at the time to tell his team mates how highly the coach thought of him. It turned out every other member of the team had had the same speech and the same personal attention, which had led them all to outperform on the day.

A little devious? Perhaps. Manipulative? Maybe. Yet what a powerful impact it had.

The very best leaders find ways to encourage each of these leadership behaviours in others. They create systems or processes that help everyone to be better. For this behaviour, 'Building Confidence', one tactic would be to find ways to recognise achievements and reward success.

> 'Good leaders remain resolute when challenged. They'll make good quality decisions in a timely way, and will clearly justify and explain as appropriate.'

Some organisations create teams with this responsibility. In one organisation, we decided to create a monthly award, but with a difference. This was a small cash prize to allow the recipient to take their partner or best friend out for dinner. The rationale was that it's often the people who support the achievers who miss out and yet deserve some recognition. It also had the advantage of looking a bit different, so people noticed.

What we call 'rewards' don't have to be expensive. In fact, people love the really low value awards too. Then it becomes 'a bit of fun' without putting people on some kind of pedestal.

Sales teams are the exceptions here. Their competitive culture and perceived value of gadgets and bonuses is a very different mindset and should be addressed as part of the commercial and contractual benefits.

What I'm referring to here is rewards that encourage, recognise and build confidence.

Your role might be to build a winning mindset by getting the team to carry out tasks that may not be directly related to the project, but which will increase their capacity to succeed. So the leader has a lot of responsibility here for internal success.

There's another side to this too. The outside world looking in on the team may need reassurance. That can happen at many levels. People need to have confidence in the products they buy or use.

Sometimes, the smallest problems can get blown out of proportion – we all operate at an emotional level and tend to exaggerate the dangers when the spotlight has been shone on them. I'm writing this article on a plane. I have no real fear of flying, but if there had been any sort of incident in the news last week, it would be certain to be nagging at me at some level.

This kind of psychological interference can get in the way of success, and leadership is about spotting that 'interference' and neutralising it. It's an easy way to improve performance quickly.

There's a branch of thinking emerging called behavioural economics, which looks at why we behave in the often irrational ways that we do. One area covered shows how we are especially bad at assessing risk. In the US, a sample were asked if they would prefer to let their child go play in a friend's house if they knew there was a gun in that house, or if they knew there was a swimming pool. Most people were happier sending their child to the house with the pool, even though deaths in swimming pool accidents far outweigh accidental gun shootings.

Helping the team identify, and deal with, risk is another way to build their confidence.

So, the job of reassuring the public if a company's products have had some warnings issued is a tricky area and is often badly handled. It seems to be especially the case when government is involved. I still shudder at the memory of an MP forcing his child to eat a hamburger to reassure us all how safe beef was in the 1980s BSE crisis.

There are some great success stories and they usually are based on a leader who understands the world of their customers well enough to judge the correct response and be confident and reassuring in their delivery.

All of this, whether the need is for an internal or an external focus, requires sincerity and conviction. People will see through false bravado. Be genuine, be positive and you will build confidence

I hope you can see the value of this behaviour and can see opportunities to practise this. Next month, we'll be looking at how to influence others. ◆

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

The revolution in cosmetic treatment planning

Over the last 10 years, the demand for aesthetic dental procedures has significantly increased. This increase has largely been due to the influence of social media, advertising, dental publications and a more informed population. A recent survey by the American Academy of Cosmetic Dentistry (AACD) reported revenue from cosmetic dental procedures showed a four point increase in the top three tiers of the survey, to more than $1 million since 2013[1]. In 2009, increasing patient demand for information about cosmetic dental procedures inspired the launch of The Cosmetic Dentistry Guide, which is viewed by over 140,000 visitors a month[2]. So far, advancements in digital technology have been pivotal within the dental industry in facilitating clinical methods capable of meeting the rising demands for aesthetic perfection.

The process of treatment planning is a principle that every dentist learns in the early stages of professional training. **Alice Duke**, a final year dental student at the University of Leeds, spoke to *BDJ In Practice* about whether the current model needs a refresh.

Alice Duke
Dental student,
University of Leeds

Why is the treatment plan so important?

A well-constructed treatment plan is essential to achieving a successful clinical outcome and gaining informed patient consent. Presently, this process involves conveying a mass of complex dental information to a patient in such a way, that it is both understood and the patient has faith that the end result will be worth the investment

In many cases, this outdated procedure of gaining consent creates shortcomings in patients agreeing to and investing in cosmetic treatment; whether this be a course of anterior veneers or a complete smile transformation. With the number of practices offering cosmetic treatment rising, patients are spoilt for choice, yet often unwilling to pay the fee required for high-quality cosmetic dental treatment that they seek. In many instances, patients attend an initial consultation and upon receiving a quote for the intended treatment, proceed to search the market for a lower price. There

is need for practices to have an established protocol to motivate the patient to invest in cosmetic treatment.

Why does dentistry need that?

In light of recent advancements in dental technologies, such techniques seem rudimentary in approaching what could be a life changing course of treatment for a patient, with the ability to impact on both the aesthetic and psychological aspects of their character. Patients routinely seek treatment as they are unhappy with the way their teeth and/or smile appears, but are often unable to pinpoint the exact reasons as to why they are dissatisfied. This can be due to a variety of factors, which commonly extend beyond the obvious malalignment of teeth or discolouration.

If the patient presents with significant plaque, you will have to weigh up what the patient wants in-line with what you are prepared to deliver. There isn't a 'one size fits all' rule here; if you feel their basic oral hygiene isn't up to scratch, you can send them away with some advice and invite them to return. Most patients would probably be motivated to return with their mouth in a better condition.

Understanding the patient's specific concerns regarding their smile are crucial to proposing a treatment plan that will result in an outcome where the patient's expectations are fully satisfied.

Communication is a 'soft skill' and is developed outside of clinical teaching. Why is it important – particularly for cosmetic work – the profession gets it right?

The reality of any cosmetic intervention is that compromise is an integral part of the treatment planning process. Setting realistic expectations with the patient before any treatment is instigated is critical to a successful outcome. Assessing patient risk factors and understanding any barriers to achieving optimal aesthetics, such as asymmetries and disharmonies, is the responsibility of the dentist. Such difficulties must be conveyed to the patient and the dental technician. With the number of GDC conduct cases relating to the failure in obtaining adequate patient consent showing a rapid annual increase, it is essential that a protocol exists whereby such limitations of treatment can be effectively communicated.

Dentistry finds itself in a relatively unique position. It is available through the NHS, yet patients are expected to pay for it at the outset. As a result, patients often have higher expectations, and the same applies for cosmetic work. Good communication allied with excellent technical work can – and do – help to deliver on those expectations.

How do you get around the issue?

You have to get patients invested in their treatment. That doesn't mean simply financial. Take Digital Smile Design for example. It is a concept created by Dr Christian Coachman at the Well Clinic, São Paulo that integrates digital photography, video and the presentation software of Apple Keynote/MS PowerPoint, to allow 3D smile evaluation. Patients will get excited about that.

It follows a systematic approach to diagnosis, treatment planning and case management, whereby the patient can be actively involved in the initial planning procedure of changing their smile. Working on the principle that the design of restorative treatment should be defined at an earlier stage of the treatment process, it can obtain consistently predictable aesthetic outcomes.

What are the main benefits?

Central to the concept is consideration of the face in motion and planning of the desired smile from a variety of dynamic perspectives. This principle extends beyond the standard guidelines integrated into conventional aesthetic treatment planning. A short video clip of the patient talking through their main concerns is recorded in addition to three baseline photographs, to capture the full range of lip positions at rest and in motion. The data is inserted into a slide presentation and digital manipulation of the images follows, including digital facebow, smile analysis, smile simulation, tooth proportion and white and pink aesthetic evaluation.

What benefits does it offer the patient?

Many patients have never had the opportunity to view themselves from another's perspective or on video, where speaking, smiling and every possible facial expression can be considered in relation to their teeth. Ultimately the Digital Smile Design protocol gathers all information necessary for the technician to develop a precise and useful 3D wax-up, considering the patient's individual facial features and emotional needs.

The sharing of information via email and *DropBox* results in enhanced multidisciplinary communication, whereby the entire treatment team can better identify the potential challenges of treatment, and by doing so keep the patient in the loop. Consequently, the time taken to complete treatment can be reduced, which obvious has a number of benefits.

The visual method of presenting information allows the patient to understand the multifactorial nature of oral-facial issues and see how treatment options are consequentially impacted. The issues to be addressed by the treatment plan can be superimposed over the patients' original photographs, allowing for better visualisation of the end result. Any feedback provided by the patient can be immediately modified on the virtual aesthetic treatment plan, ensuring a predictable clinical result for both the patient and the clinician. Consent to the initiation or continuation of their treatment can be more easily obtained, as the patient is ultimately more engaged with the treatment procedure, motivated to see it through, and can value the work that has been completed.

Will it catch on?

Over the next ten years as digital technologies become mainstay, there is every chance that systems such as Digital Smile Design will grow to become central in the delivery and planning of dental cosmetic procedures. It has the capacity to enhance diagnostic ability, improve multidisciplinary communication, provide medicolegal coverage for clinicians, and deliver information in a way that advances patient education.

As a consequence, barriers to gaining informed consent can be overcome, the uptake of cosmetic dental treatment increased and the number of patients left dissatisfied after treatment reduced. Ultimately, every patient is an individual so every smile is distinctly different. As dental professionals anything we can embrace to recognise and develop this is welcome. ◆

1. American Academy of Cosmetic Dentistry. 2015. Cosmetic dentistry: State of the industry survey 2015. [Online]. Available online at: www.aacd.com/proxy/files/Publications%20and%20Resources/AACD%20State%20of%20the%20Cosmetic%20Dentistry%20Industry%202015.pdf (accessed March 2017).
2. Bajaj, A. 2009. Product news: New cosmetic dentistry guide. *Br Dent J* **207:** 182.

Restriction clauses

By James Goldman
the Practice Support team's Special Adviser (Legal). James trained as a barrister and advises practices on partnerships, associate contracts and employment law.

The restriction clauses in associate contracts – that prevent associates working in a certain area or treating former patients after they leave the practice – can cause intense discussion. They may seem overly complicated or too harsh and, indeed, there are many ways in which post-termination restrictions can be badly drafted and, as a result, be difficult to enforce. Nevertheless, the law allows practices to protect their patient goodwill. Though, the law does not like practices imposing restrictions that go beyond what is necessary to protect the goodwill: the law does not like terms that unnecessarily prevent free competition.

In a sense, it should be easier to negotiate with a practice owner about post-termination restrictions than other clauses because a practice owner, if they are properly advised, will not want to have restrictions that are too onerous and so unenforceable. It is in both parties' interests that the restrictions are reasonable.

Part of a contract

The restrictions need to be part of a larger agreement. Practice owners simply cannot get associates to agree to post-termination restrictions without anything in return. To be legally-binding contracts must have a number of obligations going between the parties; so restrictions should appear within a comprehensive contract and not as stand-alone terms.

Individuals

The goodwill being protected has to relate to identifiable people. Since the only patients who have goodwill towards an associate are patients the associate has treated, so the courts are likely only to enforce restrictions that prevent the associate from soliciting or treating patients from the practice that the associate has personally treated.

Geographical restrictions

Most restrictions cover a defined area in a radius from the practice. But the geographical restriction has to be reasonable. It is very difficult to work out what is going to be reasonable in any particular case. It will depend on the local population, the area in which most patients live, how many other practices are in the area, and other factors. In Wimpole Street, an area of central London renowned for private practices, a practice may get away with a restriction of no more than a few hundred yards; in a sparsely populated rural part of the country, restrictions of, say, five or even ten miles may be enforceable.

The restriction does not have to be a circle defined by a radius from the practice. There may be natural boundaries and major roads that present a better outline to the geographical area in which an associate cannot practice.

The courts want to know that the parties have seriously considered the nature of the restrictions and what is necessary to protect the practice's goodwill. It is vital that a practice owner gives careful thought the restrictions.

Associates should think about where they may want to work after an associateship. If the geographical restrictions are unreasonable, the associate can argue that a smaller or different area may make it more likely that the practice owner can enforce the restriction.

Make sense of it

Sometimes contractual clauses can be quite intricate, because they have to cover a range of scenarios and avoid ambiguity. Paradoxically this can make them harder to understand. If an associate does not understand a clause, it is sometimes best to clarify what it means. It is best not to assume that a lawyer drafted the contract and so it must be correct.

Tactically agree to a poor clause

Maybe an associate is better off with a bad clause – if a clause is too onerous to be reasonable, you could decide to agree to the terms in the hope that it is unlikely to be enforceable. Such a strategy is not without risks. But there is an argument to say that the practice owner wants the associate to be restricted from taking patients, and it is up to the practice owner to get the restriction right.

Ethics

Post-termination restrictions are a commercial matter for practice owner and associate to agree upon. Enforceability is a legal matter. Generally there is no ethical issue over competing for patients. However, if an associate copies patient data, such as their contact details from practice records this could infringe data protection law. It is best not to misuse practice data, patient data from given to the practice so they could be treated at that practice not at any future practice.

Feelings

Overall goodwill is nothing more than a positive feeling that patients have towards a particular practice or dentist. If a patient has treated a patient a number of times, and is pleased with their care, the patient will have goodwill and that goodwill has a financial value, because the patient will come back. It is understandable for practice owners to want some level of protection for the patient base they have built up, so it is best for both parties to recognise this and agree a clause with reasonable but not excessive restriction as part of the associate contract. ◆

Relocation location location

by Sarah Cook
an NHS Adviser in the BDA's Business Team. Sarah advises members on all aspects of NHS dental regulations and agreements.

The need or wish to relocate your practice may arise for a variety of reasons. For example your lease may not be renewed by your landlord or you might not be able to agree new terms. Or you may be planning to expand or refurbish and feel that new premises would be more practical. However, there are many considerations if you want or need to move premises and you must think them all through.

Patient base

You will need to think carefully how the relocation will affect your patients, the benefits you can highlight to them and how you will communicate these. At the most basic your patients may have chosen you initially due to location being convenient for them, so any move, regardless of the personal goodwill you inspire, could make you less convenient for them.

Map where your patients live and consider the transport routes they would need to take to get to you. Do some market research amongst your patients and on the wider demand in the area where you plan to relocate (NHS practices in England and Wales need to provide the commissioners with evidence of your consultation with your patient group in relation to any proposed move). There are many market research firms that can help you set up and run focus groups for you so you can get professional input and analysis. Also look at the characteristics of the population you will serve and their oral health needs, a lot of demographic data is available freely from your local authority or the census.

Plan how you will promote your new practice location to current patients (and potential new patients). Your message may want to highlight the practice facilities, how to get there and the continuity of care that you will offer with the familiar practice team.

NHS Contract considerations

NHS contracts in England and Wales are location specific, there will be a clause in your contract which sets out the address of the premises to be used for the provision of services. This means that a written variation notice is required to provide the service from another address which has to be agreed and signed by NHS England or the local Health Board. There is no automatic right for this to be approved and consent can be withheld by the commissioners. It's vital to seek agreement before moving, otherwise it could constitute a breach and possible termination of the contract.

Practices that receive a Scottish Dental Access Initiative grant need to check that their planned new location complies with the terms for the grant.

Premises

You need proper planning consent for your new premises. Class D1 planning permission is required for England, Wales and Northern Ireland. Class 2 is required in Scotland. Check with your local authority whether you need to apply for planning permission for a change of use.

It is also important to ensure that any new premises are fit for purpose. You may need to refurbish them, install equipment and make sure they meet health and safety requirements such as HTM 01-05. The premises must also be approved by local quality standards regimes – the CQC in England, Combined Practice Inspection in Scotland (or Healthcare Improvement Scotland if you are wholly private), Healthcare Inspectorate Wales (HIW) and the RQIA in Northern Ireland.

Make sure you can shift the contracts with your utility suppliers or that you can terminate them without penalty. You need to check notice periods for doing so and whether there are any penalty payments for early termination.

Accessibility

If moving to new premises you will required to make sure they are compatible with the Equality Act. As a dentist you have a duty to make reasonable adjustments to ensure that disabled people can access your services. This could involve the following: ramps, handrails, wide doors for wheelchairs, low reception counters, a disabled toilet and hearing loops. A disability access audit, carried out by a properly qualified surveyor, can assist you with advice on the steps that should be taken.

Tenure of premises

Consider whether you are going to buy the premises as a freeholder or lease it. If you are going to lease your premises it is crucial to secure a tenancy that protects this asset in the long term while providing the flexibility to expand, modify or move elsewhere if business needs change. The duration of a lease for commercial premises tends to be around 10 to 20 years. It is essential to take independent legal advice from a solicitor on the terms of the lease and any restrictions it may contain.

Staff

Consult with staff to seek their views on the proposed move. Their place of work will be defined in their employment contracts. So they may need to agree to a move. If they would encounter great difficulties in getting to or from the new premises they may be able to object.

Finances

Moving will be a costly process. Work out the cost and effect of your move on your cash-flow. You need to research any change to premises costs, building and equipment costs and staff costs. And factor in any potential changes to income from your patient base. You may also need top approach your bank or other lender to help with the costs. ◆

Electronic Appointment Reminders

By Sabina Mirza
a Practice Management Consultant in the BDA Practice Support Team. Sabina trained as a solicitor and advises general dental practitioners on associate contracts and a wide range of employment and other law.

Electronic communication is fast becoming the most commonplace method for accessing and sharing information – the regulator OFCOM report that 93% of adults have a mobile phone and that on average each one sends or receives 107 text messages a month.[1] But should voicemail, email and text messaging for practices to inform patients of their appointments? This type of communication is far quicker and efficient. Though, whilst there are obvious benefits of utilising electronic messaging you need to be mindful of the potential risks arising from data protection and patient confidentiality obligations.

Patient consent

Get formal consent from your patients before contacting them by voicemail, text or email. Just because they have given mobile phone number or email address do not assume this means they agree to you sending an appointment reminder by this means. You need to specifically ask about this and record their agreement.

Data protection laws set out your legal obligations in terms of collecting and using patient data. Generally, a telephone number or email address provided by a patient for one purpose cannot be used to process their data for a different purpose. To ensure the processing is fair and lawful the practice must actively inform patients that you plan to use their number or email to send out appointment reminders. The patients should be asked if they are happy to receive an appointment reminder in this way. You can do this when registering them with the practice and re-check it at subsequent appointments. The patient can then freely decide whether they agree based on their personal circumstances and their preferences.

Patients should also be given clear information on how they can withdraw consent. A template Electronic privacy – patient notice is available in BDA Expert Solutions.

Clearly record the patient's preference on the front page of their file to ensure appointment reminders are not sent by staff in error. Patients who consent should be asked at regular intervals, if they are happy to continue to receive messages from the practice and to confirm there are no changes to their contact details. This is particularly important when sending text messages as mobile phones are regularly replaced and old numbers reassigned. It is a data protection requirement to keep records up to date so always double check and remind patients of the importance of telling you of any changes to their contact details.

Communication security

Another data protection requirement is to ensure the messaging system in place is secure. Think about the reliability issues relating to electronic communication which are beyond the control of the practice. Understand the technical specifications of the system and have a rigorous service level agreement with your internet service provider or mobile network in which they commit to complying with proper e-security safeguards.

Also keep a record of the reminders sent and their content. Texts or emails to patients are a professional communication and you may need to prove what information was sent and when. Therefore keep a record of the date, time and content of any messages sent to a patient.

Account

Practices should have a dedicated email account or mobile phone for contacting patients. Make sure it is accessible by only those staff required to send the appointment reminders or other communications to patients. Messages should not be sent from staff's personally owned mobile phones or personal email accounts, due to the potential for these to be accessed by the staff member's family or friends.

Replies

Patient may respond to the message seeking other information, such as urgent clinical advice. Make it clear to them whether replies sent to the account you use will be monitored or not. Also if you start exchanging messages about their appointment you must be careful not to disclose sensitive information, unless you have got their clear consent to do so and you are sure of their identity. To better manage patient expectations, the reminder itself should provide other practice contact details such as a telephone number for the patient to call.

Appropriate message content

The practice should adopt a standardised message for sending appointment reminders. Keep it succinct, you only to remind the patient they have an appointment and its time. It is unnecessary for the message to include the nature of the appointment or any personal details. Whilst an appointment reminder may not be contain any sensitive information, the practice should bear in mind that a patient's phone or email account itself may not be secure. Set up a template for staff to use.

Carefully consider the timing. Many people rely on their electronic devices but with others phones switched off or emails not logged into for several days. Messages sent on the day may not be picked up in time. Appointment reminders should ideally be sent a few days before the appointment.

Further details on electronic communications are available at www.bda.org/advice in the 'Web and email security' section of BDA advice Protecting Personal Information.

Office of Communications, Fast Facts, cited 17 March 2017, available from www.ofcom.org.uk. ◆

Introducing version 2.0

Dedicated to offering ethical anterior alignment training and appliances, the IAS Academy is pleased to announce the launch of the ClearSmile Aligner 2.0.

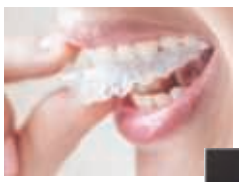
Building upon the existing excellence of the original ClearSmile Aligner appliance, the 2.0 offers a greater level of predictability and accuracy of movement for even better results.

There have been a number of changes made from the original design, all of which the Academy expects will facilitate a higher standard of anterior alignment training with quality outcomes that both patient and practitioner can be proud of.

The key benefits of the ClearSmile Aligner 2.0 include:

- Virtual digital planning for predictable outcomes
- Precise 3D manufacturing
- Exclusive stretch-resistant intelligent material
- Biomechanical indices for ideal staging
- Custom Force Drivers for individual tooth control.

For more information on upcoming IAS Academy training courses including the ClearSmile Aligner 2.0, please visit www.iasortho.com or call 0208 916 2024.



Fully equipped

If patients are motivated enough to clean their teeth for two minutes, twice a day, they're going to want to be rewarded with good oral health, particularly good gingival health. As well as the right technique, they also need to be using the right products. Just as you want your washing machine and detergent to work in harmony, so too do you want a toothbrush and toothpaste to give the best possible outcome.

Oral-B's Genius toothbrush works in synergy with Oral-B's Pro-Expert toothpaste. The Genius brush will almost certainly improve a patient's technique ensuring the user brushes for the right length of time, does not apply too much pressure and, most importantly, never misses a zone! There is no excuse for non-uniform brushing as real-time guidance is given to improve their technique.

Using the washing machine analogy, Oral-B's Pro-Expert is the 'Ariel' to its Genius power toothbrush. It's the inclusion of stabilised stannous fluoride that makes the difference. This powerful ingredient gives Oral-B's Pro-Expert toothpaste a long-lasting antimicrobial action as it inhibits antimicrobial growth as well as reducing the ability of bacteria to 'stick' to tooth and gum surfaces.

The inclusion of sodium hexametaphospate is also beneficial as it protects against calculus formation, as well as staining, thereby reducing a further cause of plaque retention on the roughened surface of the calculus. The combined force of these two plaque reducing agents, alongside the mechanical action of the Oral-B Genius help protect against gum problems.

Customised results

When providing specialist orthodontic treatments, you need specialist equipment. The Incognito Lite appliance system from 3M Oral Care has been designed in close cooperation with orthodontists, making it ideal for your practice.

With proven accuracy, the Incognito lingual bracket system can deliver the results for which you planned.

What's more, thanks to the way in which each bracket pad and body conforms to the patient's dental anatomy, patient comfort can be optimised – and with a large bonding area, good bond strength can easily be achieved.

For a fully customisable lingual bracket system, endorsed by more than 9,000 orthodontists across the globe, choose the Incognito Lite system today.

For more information call 0845 873 4066 or visit http://solutions.3m.co.uk/wps/portal/3M/en_GB/orthodontics_EU/Unitek/ or www.hiddenbraces.co.uk

Revive your business

'Forgotten' or unsold treatment plans could be costing your practice between £100,000 and £1.3 million. Effectively reviving them could therefore be a highly lucrative activity and now there's an easy way to do it.

Working with the experts from 7connections, you can make use of their series of reactivation emails designed to re-engage patients who have shown interest in particular treatments in the past. The team will help you communicate the right messages to the right people at the right time, enabling you to strengthen your patient relationships and ensure they come to you first when they are ready to proceed with treatment.

For more information about 7connections, please call 0203 095 7259 or email hello@7connections.com.

A bit of luxe

Directa AB proudly announces that the NEW Luxator Forte F32C Elevator is now available in the United Kingdom!

The Luxator Forte Elevator differs from Luxator periotomes with its black handle, making it easily recognizable. The stainless steel blade is thicker and has a slightly different design of the tip, allowing it to be used for elevation of the tooth, after cutting of the periodontal ligaments with a Luxator Periotome has been performed. The world acclaimed, ergonomic handle of the Luxator instruments stays the same.

The development of the Luxator Forte F32C initiated from dentists desires of using a slightly curved instruments for their elevation. The curved blade will increase choice and improve accessibility for controlled and safer tooth elevation.

Find more product information at www.directadental.com/products/Luxator/Luxator-forte-elevator

Peace of mind

Chances are most dentists will only purchase one or two dental treatment centres in their professional life, so will want the reassurance that their investment is protected for as long as possible under the manufacturer's warranty policy. Belmont offers free extended warranties on its equipment. All chairs and operating lights are covered for five years, and all x-ray units for two. They do this because they are completely confident in the quality of their equipment and from experience, know that failure within this time scale is almost unheard of.

To reassure practices even further, the company has also recently achieved an additional ISO standard, which entails further electrical safety checks being carried out. It also ensures that all products are totally traceable from the supply chain to the end user. This is not an industry standard, or one common to all manufacturers.

For more information call 020 7515 0333 or visit www.belmontdental.co.uk.

A chip off the block

PerioChip is attending the British Dental Conference and Exhibition 2017 (stand B38) with a dynamic new stand. Come and meet the dedicated team of experts who can show you why PerioChip is considered such a useful and clinically effective adjunct for long-term periodontal therapy.

Easy to use and convenient, PerioChip is a gelatine based, biodegradable insert designed specifically to treat periodontal pockets >5mm. It can be placed directly into pockets using nothing but tweezers after scaling and root planing (SRP) and gets straight to work. After just two hours, PerioChip creates a high concentration of Chlorhexidine within the gingival crevicular fluid (GCF). The GCF then acts as a natural reservoir that provides free circulation of the antiseptic throughout the pocket. The broad-spectrum antiseptic in this adjunct has proven to be clinically effective at eliminating 99% of subgingival periopathogenic bacteria after just seven to ten days.

Even more remarkable, PerioChip then continues working for up to 11 weeks – supressing the growth of bacterial flora in the periodontal pocket and helping the site to heal.

To try PerioChip in your practice visit PerioChip.com, call 0800 013 2333 or email team@periochip.co.uk

Associates: arm yourself with the right cover

Completing foundation training and becoming an associate is a rite of passage for every dentist. As exciting as it may be, however, there are a number of factors that need to be taken into consideration.

First and foremost there's a lot more at stake – more money, more responsibility and more to lose if something were to happen. Taking out income protection and medical indemnity insurance can help with this.

At insurance4dentists, there are a number of plans to choose from at competitive prices, all of which are explained to you in detail to ensure that you end up with cover that meets your unique needs.

With over 100 years of insurance experience, the team of top professionals are well placed to help associates arrange the necessary protection. What's more, the team handles virtually all the important aspects of the policy, so you can rest assured that the process is dealt with to the highest standard.

For more information please call 0845 345 5060 or 0754 DENTIST. Email info@4dentistsgroup.com or visit www.4dentistsgroup.com.

Innovative solutions

Dedicated to providing quality products that help to improve performance, Nuview is pleased to offer the Yirro-plus self-clearing dental mirror.

Available either as an automatic (PREMIUM) or manual (COMFORT) system, the Yirro-plus is one of the most innovative mirrors on the market.

So what is it about the Yirro-plus that makes it so unique?

First of all, the mirror surface boasts an ultra-reflective multi-layered coating that is repellent to grease and contamination. Secondly, the system uses controllable airflow so that the mirror never fogs and offers a clear image at all times.

Other benefits are that it requires no maintenance, is autoclavable and provides ergonomic comfort.

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

The first of its kind

Innovative dental software developers Welltime are excited to announce their latest helpful solution: the Dental Diary app.

With this easy-to-use and free to download app, you will be able to access your entire diary on your smartphone – whenever you need to. Synching with your practice's existing management software, the Dental Diary app will update automatically if appointments are made, changed or cancelled – allowing you to stay in complete control of your workload.

Featuring 24/7 access, Dental Diary will let you plan your time more effectively. Updating in real time, the app will let you know if your first appointment tomorrow has been cancelled, allowing you to plan your day quickly and simply. What's more, you'll also be able to access you team's diaries, too – meaning your entire practice will run more efficiently than ever.

The Dental Diary app from Welltime is available for download on Android and iPhone; take control of you diary and stay informed at all times.

For more information, contact the Welltime team on 07999 991 337, email sales@welltime.co.uk or visit the website at www.welltime.co.uk.

How do you prefer to work?

Whether you prefer to work with imaging sensors or plates, Carestream Dental offers a solution for you.

The RVG 6200 digital intraoral sensor features state-of-the-art image processing at the touch of a button. It provides a highly intuitive workflow for maximum efficiency, alongside straightforward installation and integration with most imaging and dental practice management software.

What's more, the RVG 6200 is compatible with the innovative CS Adapt module, a set of user-defined image enhancement filters, enabling you to work in the way you want to.

For those who prefer imaging plates, the CS 7200 combines the benefits of film and digital workflows. With a compact and quiet design, it produces true resolution images of 17lp/mm with a wide exposure range and powerful processing for outstanding image clarity.

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

A shield never to be broken

The On1 restorative concept from Nobel Biocare is the first solution designed to preserve the natural shield created by soft tissue attachment after implant surgery.

The exciting system moves the restorative platform of Nobel Biocare's conical connection implants from bone level to tissue level. The On1 base is fitted straight after implant placement and is left in situ throughout the healing and restorative process, optimising soft tissue recovery for outstanding long-term results.

What's more, it offers complete restorative flexibility, as it's compatible with both screw- and cement-retained restorations. Special healing caps are also available to support the digital scanning workflow, ensuring you can continue to work in the way you want to.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com.

Getting hand hygiene right

With compliance clearly high for hand hygiene protocols among the dental profession, it's important that you are also using the most effective products for the very best results. The new Steri-7 Xtra Personal Care Range from Initial Medical has been proven to kill up to 99.9999% of bacteria, spores, fungi, yeasts and viruses, including C. difficile, Hepatitis C, influenza, MRSA and norovirus.

The high level Hand Rub and Wash are hypoallergenic and dermatologically tested to be kind on skin, making them ideal for frequent use. They have also been shown to remain active for up to three hours for long-term protection and total peace of mind.

Please visit www.initial.co.uk/medical or Tel: 0870 850 4045.

BDA
British Dental Association

MISSION IMPOSSIBLE

BDA CDS Group Annual Presidential and Scientific Meeting 2017

Cheltenham Racecourse

Programme highlights:

- Management of acute orofacial pain
- Oral surgery for the urgent care patient
- Mental Capacity Act – 10 years on
- Anxiety control in dentistry

Thursday 5 October – Friday 6 October 2017

I'd love to see you there!

Diana Gould
CDS Group President Elect

Sponsored by
HENRY SCHEIN® SPECIAL MARKETS

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

Dentist to Dentist

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

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

283787

Midlands

THE PRIORS DENTAL PRACTICE LTD

www.thepriorsdentalpractice.co.uk

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

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

Mr 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

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

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

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

South East

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

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

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

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

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

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

284695

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

If you wish to be included in these pages please contact Jamie Feek on 020 7843 4712 or Email jamie.feek@nature.com for a quote.

BRITISH DENTAL CONFERENCE & EXHIBITION 2017

25 - 27 May | Manchester

BDA
British Dental Association

Free passes for Extra and Expert members*

* Expert members receive two three-day tickets for DCPs

Claim your free passes now

0844 3819 769 **bda.org/conference**

In Practice CPD

Q1: According to OFCOM how many adults have a mobile phone?

A 73%
B 83%
C 93%
D 99%

Q2: What is considered appropriate message content?

A Time and date of their appointment
B The doctor they have
C Their address
D Cancellation policy

Q3: Where is class 2 planning permission required?

A Wales
B Scotland
C England
D Northern Ireland

Q4: Who deals with enforcing restriction clauses in contracts?

A Associates
B Practice owner
C Practice manager
D None – it is a legal matter

Q5: What was the cost of multiple teeth extraction in England in 2015/16?

A £11 million
B £14 million
C £17 million
D £20 million

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

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

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

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

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

Need help?

To access *BDJ In Practice* CPD online:

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

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

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

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

For support use: cpd.hub@bda.org

BDA
British Dental Association

Education for dental care professionals

Develop your skills with the BDA

NEW Essentials of decontamination

This online certificate course will cover all the essential information you need to know to enable you to understand and implement effective decontamination procedures within your practice.

SHORT COURSE CERTIFICATION

Course fee £70

5 hours verifiable CPD

bda.org/deconcourse

Dental radiography

This online course teaches you how to use x-rays safely and how to take common radiographs. It leads to the BDA Education Certificate in Dental Radiography - a nationally-recognised qualification that entitles you to take radiographs unsupervised.

ONLINE QUALIFICATION

Course fee £595
(+£124 exam fee)

40 hours verifiable CPD

bda.org/radcourse

Oral health education

This flexible, online course will help you learn the communication skills needed to educate your patients about their oral health.

ONLINE QUALIFICATION

Course fee £595
(+£124 exam fee)

40 hours verifiable CPD

bda.org/ohecourse

Not your average payment plan provider

We believe your patients are yours not ours. So, your payment plan should be branded as yours, not ours.

Keep control of your relationships with your patients and we'll take care of the admin.

Receive the support and training you're used to at a fraction of the cost.

Discounts are available for BDA members.

Lloyd & Whyte

What matters to you, matters to us

www.lloydwhyte.com/paymentplans

Lloyd & Whyte Ltd is authorised and regulated by the Financial Conduct Authority (FCA). The FCA do not regulate Payment Plans.

In proud partnership with

BDA