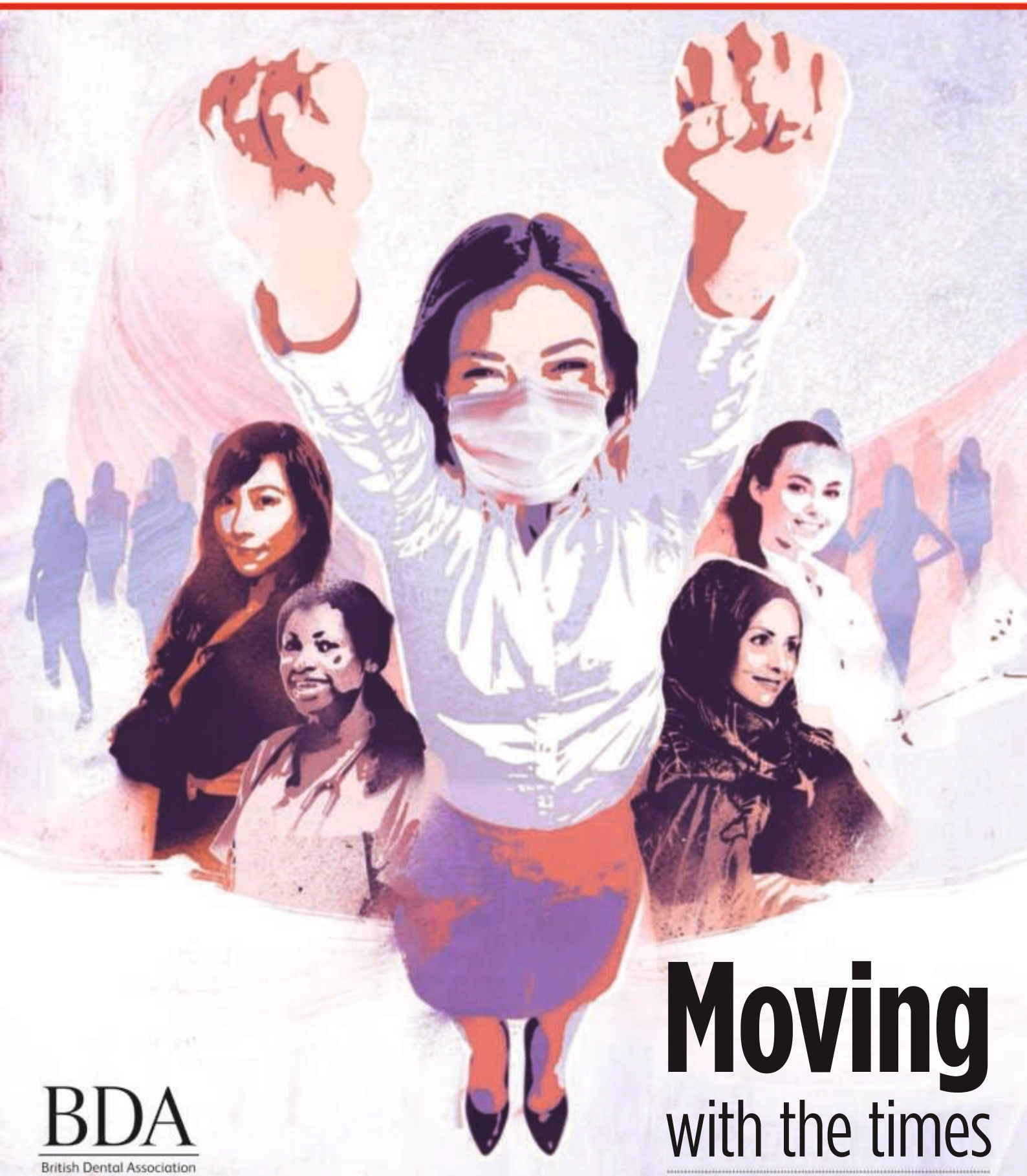
BDJ InPractice
February 2017



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A taxing issue

HMRCs new Making Tax Digital (MTD) scheme will present 'a severe headache' for the majority of dentists and be yet another cost that they will have to cover.

Alan Suggett, media officer of NASDAL (the National Association of Specialist Dental Accountants and Lawyers) and a partner in UNW LLP, explained: 'HMRC has been holding consultations on the Making Tax Digital scheme and these concluded on 7 November. The aims of the scheme appear to be laudable in terms of simplifying and making the tax system more efficient. However, the dental sector will face specific challenges. In short, it will create a severe headache for the majority of dentists.'

One of the key tenets of the scheme is the submission of quarterly updates to HMRC. This may not present much of an issue to most businesses as they are used to paying VAT on a quarterly basis and preparing monthly management accounts. However, dentists are not registered for VAT and even larger practices do not generally prepare monthly management accounts, or if they do, these don't represent a true picture of turnover as such and various adjustments are required at the year end.

Therefore, practice owners will often not have financially trained staff and normally use external accountants to prepare accounts. In the case of associates, almost all will rely on external accounting support. The current timetable set out for MTD is for it to commence on 6th April 2018.

Nick Ledingham, the Chairman of NASDAL sits on the ICAEW (Institute of Chartered Accountants in England and Wales) Healthcare Committee and has responsibility for dental matters. He has also been making representations on behalf of dentists through the ICAEW to HMRC to both delay the implementation of MTD, and also to increase the turnover limit of businesses which it will be affected by which at present is only £10,000 per annum. He added: 'NASDAL strongly supports the BDA stance on this matter as they have made representations to HMRC that because of the unique characteristics of the dental sector that it would be fairer to have an extra year to prepare.'

Paula Slinger, BDA Practice Management Consultant, said: 'Proposals for the imminent launch of HMRC's Making Tax Digital scheme mean self-employed dentists, including associates, will need to start preparing to meet the requirements.

'The days of giving your accountant a bag of invoices at the end of the year are numbered. It is always advisable to keep a tight grip on income and expenditure, but quarterly digital reporting will make it more important than ever to keep good records as you go along. Quarterly reports will need to be made using HMRC compatible software or apps. HMRC has suggested that free apps and software products will be available, but commercial software providers will also be able to discuss compatibility with the new requirements, any necessary updates and what features might be available to help you meet the new requirements.

'It might also be wise to attend, or send practice support staff, on courses and webinars relating to the new requirements. Contact your local HMRC to find out what free tax courses and webinars are available.

'Dentists who plan to rely on their accountant's help with the quarterly reports should make early enquires about what information will need to be shared with their accountant, in what format and within what timescales. It would also be wise to discuss the effect on future accountancy fees.' ◆

Notice: Private dentist registration (Scotland)

All fully private practices in Scotland (referred to as independent clinics) must now register with Health Improvement Scotland by 1 April 2017. It will be illegal not to register and failure to do so will mean the operating dentist will be reported to the Procurator Fiscal service for prosecution.

The application to register must be completed online though first it is important for you to get more information directly from the Independent Healthcare Enquiry line on hcis.clinicregulation@nhs.net or 0131 623 4342. Given the deadline make sure you do this in good time. There will be a substantial registration fee of £1,990.

This move will bring wholly private practices into the inspection regime and it is expected to closely mirror the Combined Practice Inspection process used for those practices with an NHS commitment. ◆

BSPD welcomes LGA statement

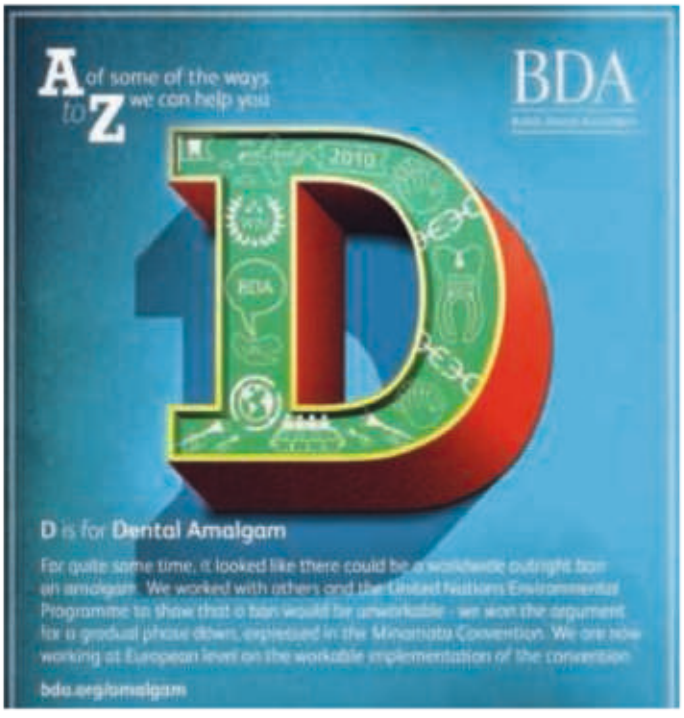
The attention drawn by the Local Government Association to the unacceptably high number of decay-related extractions in children as well as their call for Central Government to do more about excessive sugar consumption has been welcomed by the British Society of Paediatric Dentistry.

Spokesperson Claire Stevens said: 'I am one of the hospital-based paediatric dentists extracting children's teeth week in and week out, and the pressure is relentless. As soon, as I have finished in theatre, back at our clinic another 8 patients will have been added to our waiting list.

'I can be taking out all the baby teeth of a child as young as two or three in one procedure, at another appointment I am providing dentures for teenagers. This is sad, especially when we know that dental decay is a disease which is almost entirely preventable.

'What's required is the commissioning of evidence-based prevention outlined by Public Health England and this is the responsibility of local councils. We need oral health promotion programmes which meet the needs of local communities, including supervised tooth brushing in nurseries and fluoride varnish application programmes. This is the approach taken in Scotland where the number of hospital-based dental extractions has been dramatically reduced.

'In some areas of England, essential oral health promotion programmes are being squeezed due to lack of funds. Oral health education is vital at a time when there is over consumption of sweetened and sugary products. We would like to think that the LGA and the 370 local councils that it represents can maintain spending on evidence-based oral health promotion programmes in all areas where it's needed.'



LETTER

Pension problems

Sir, last year I reached 60 and it was financially prudent to start drawing my NHS Pension. In the preparation for that I had received forecasts about the 'Surviving Partner's Benefits' and noticed that a Civil Partner would receive £X while a Widow would receive £3X. Fortunately we had converted our Civil Partnership into a marriage the previous year and so I anticipated that, in keeping with the spirit of the Marriage (Same Sex Couples) Act 2013, my husband's benefits to be £3X. Wrong! The NHS pension scheme deems my husband to still be a Civil Partner.

There are complex legal arguments around this subject, just as there are for the pension benefits of surviving partners of female workers under the NHS, but with the equalisation of pension age there should also be equalisation of benefits. To do otherwise would be to discriminate pension benefits on the grounds of both gender and sexuality.

Yesterday I raised this matter with my MP (Alan Whitehead – Southampton Test), who had supported the Act, and he was dismayed at the discrepancy between the spirit in which the Act was written and how it is being interpreted and implemented by the NHS Pension Scheme. He will be raising this matter in Parliament as a written question.

In the meantime, I would like to hear from other members of our profession who have had the same experience so that I can forward that to my MP, in order to strengthen his case, as well as urging them to raise the matter with their own MP. It would also be fruitful for other gay and lesbian members of our profession to check their own predicted 'surviving partner's benefits' as they will probably discover the same problem. The problem will not affect them directly but is comforting to know that one's affairs will be in the best shape for one's surviving partner.

I would be grateful if you could publish my e-address, clivemarks@bedfordplacedentist.co.uk, so that interested parties can contact me.

C. Marks, Southampton.

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New contact details

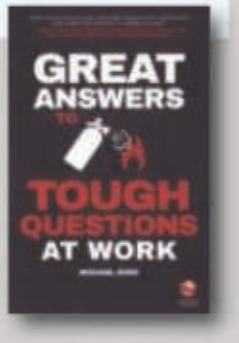
We now have one email address for Extra and Expert members wishing to seek advice from the BDA.

Gone are the multiple email addresses, which have been replaced by one single point of contact. So if you wish to contact a member of the advisory team via email, please do so by contacting advice.enquiries@bda.org.

BOOK REVIEW

Great answers to tough questions at work

Michael Dodd
Capstone, 2016
ISBN: 978-0-857-08639-6
£12.99



Communications guru Michael Dodd knows about the challenges of difficult questions at work and has written an excellent book on the subject.

He reveals that the phenomenon of the bruising verbal encounter is so common that the French have an expression for it, 'L'espirit d'escalier', loosely translated as 'staircase wit'. But the workplace interrogation can occur at any level, from staff meeting to boardroom. So it's essential to be prepared and equally important to be able diffuse a potentially tricky situation. Dodd suggests that one effective solution is the use of storytelling. Ronald Reagan was able to harness the power of positive oration in explaining the 1986 Challenger disaster to the American people, which, in his words allowed the astronauts to 'touch the face of God', thus in some small way mitigating the tragedy.

But stories should also be functional for them to work and Dodd advocates the use of TRUTH, comprising the elements a story needs in order to make an impact, thus: Topical, Relevant, Unusual, Trouble and Human. One example would be where a company has helped an individual in trouble. Planning in advance is always useful and again there's an acronym for this, AMEN which stands for Audience, Messages, Examples and Negatives (be very prepared for even the toughest negative question).

Dodd then cites to two 'golden formulas' dealing with how to structure an answer and later, what to say when something goes seriously wrong. He also refers to motivational speaker Tony Alessandra when looking at different personality types: Directors, Thinkers, Socialisers and Relaters, and how to approach each of them.

The second section of the book is devoted to using these new found tools. Answers to potential clients' question such as: 'what do you do?' are dealt with using the first golden formula, for example, 'I'm an accountant helping clients make more profit' but then the trick is to 'dangle' (or hook) the enquirer with a 'for instance...'. The inevitable pricing question ('how can you possibly justify your high cost?') should invoke a snappy 'that's easy, I'm offering high value that will...'). An accident at work might involve another acronym CARE (Concern, Action, Reassurance, Example) where response to a situation involves genuine empathy, some real information, some reassurance and an example ('we've only had one other serious injury such as this in the past 12 years'). The final chapters deal with answers for job interviews, talking to the boss, events, meetings, the media and public 'grillings'. So there seems to be an answer for just about everything here. ◆

ADDENDUM

The value of collaboration

In the December 2016 issue of *BDJ In Practice* we published the above titled piece based on an interview with two colleagues involved in a child health project in North Manchester. Regrettably the proof amendments from the interviewees did not reach the editorial office in time to be incorporated in the published article. If readers would like to read the piece again, with the amendments incorporated, we will be pleased to send a copy of the text on request by email to the editor, at david.westgarth@bda.org ◆

Dentists treating the most vulnerable failed by Stormont

The British Dental Association (BDA) has lambasted the Northern Ireland Government for backtracking on an agreement to modernise the contracts of community dentists, who serve the most vulnerable patients.

The Community Dental Service in Northern Ireland provides dental care for people of all ages including children and adults with learning disabilities, patients with health problems, phobias, and those unable to leave their homes.

©iStockPhoto

They are the only health service workers in the UK not to have had their terms and conditions modernised since the 1980s.

In March 2016 an overwhelming majority of dentists voted in an official ballot to support an agreement reached between the BDA and Stormont on a new contract, following seven years of negotiation. While funding was set aside by the Department of Health in early 2016, and allocated to local trusts, the Department of Finance has since claimed no agreement has been reached.

The BDA has been able to push officials to unlock money for needed training, but it is now calling on ministers to honour the agreement, and finally bring these contracts into the 21st century.

Grainne Quinn, Chair of the BDA's Northern Ireland Salaried Dentists Committee, said: 'These community dentists are the only health professionals left in the UK working under contracts drafted three decades ago. Last year we reached an agreement to bring their terms and conditions into the 21st century, but ever since ministers and officials have been stalling.

'It has been very frustrating for these dedicated professionals who are serving the most vulnerable people in Northern Ireland. It means they have spent a year not even knowing how much leave they are entitled to, unclear if a promise of nearly two years of backdated pay increases will ever materialise, or when this situation will be resolved.

'It's an absurd situation. For 12 months the money set aside has been sitting in trusts' bank accounts gaining interest while officials in Stormont squabble amongst themselves over whether an agreement was even reached.

'All we are asking for is for ministers to honour an agreement negotiated in good faith and implement the agreed terms and conditions as soon as possible'.

GDPs prepared to have their case considered are invited to complete this online form: https://www.surveymonkey.co.uk/r/CWGPCF6

BOOK REVIEW

Successful time management (4th edition)
Patrick Forsyth
Kogan Page, 2016
ISBN: 978-0-7494-7581-9
£9.99

The phrase 'time management is not an option' is repeated more than once in this relatively short paperback (in itself a time-saver). Patrick Forsyth is a successful management consultant who has authored over 50 business books and writes regularly for business journals. Rapidly cutting to the chase, he stresses the need for self-organisation as a key to time management. Time management also involves being aware of time wasting. Procrastination being the 'thief of time', Forsyth identifies three key 'time thieves' cautioning against being gulled into them: don't put of difficult things, don't put off things you don't like doing and finally, beware of your favourite tasks. Similarly, five remedies are presented for the inevitable interruptions that occur in daily life, the simplest being a 'Do Not Disturb' sign.

Following a short discussion about the pros and cons of email and some etiquette in using this potentially time-wasting mode of communication, the next chapter deals with 'first things first', identifying Pareto's law (the 80/20 rule) as a cautionary example. This means that 20 per cent of one's work time contributes to 80 per cent of what is necessary to succeed in the job. Therefore more concentrating on the big issues is paramount. The author makes two more major points in the final two chapters. First, dealing with paperwork needs to be controlled, for example, he advises that correspondence should be as brief as possible.

The final aspect Forsyth covers is potentially the most hazardous. This is about dealing with people. He discloses here what might be the most time-saving phrase in the language. So when asked by someone 'I'm not sure how to proceed with this, would you like to check it' he advises the magic response: 'What do you think you should do?' They may not know but in pressing them to make some suggestions the manager can then ask them which solution is the best, and with them arriving at the best answer, the final command will be 'that's fine'. So although there isn't a blueprint for successful time management, there are always ways and means, and an hour spent with this book won't be time wasted.

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

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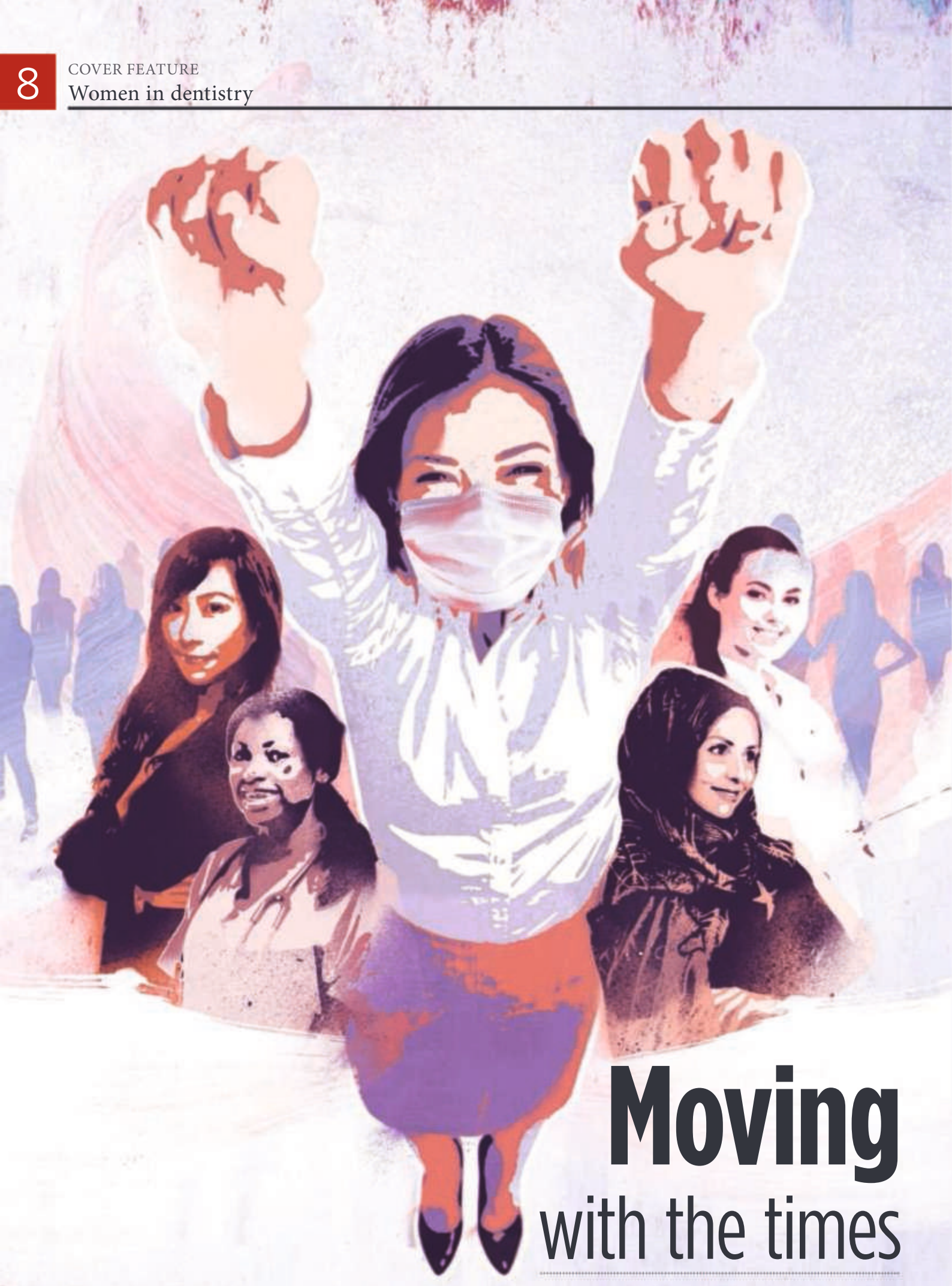

Moving with the times

By David Westgarth,
Editor, *BDJ In Practice*

'The practice of the woman dentist of the near future will be confined to dealing with patients of her own sex and children.' BDJ, 1914

When the founding fathers of the BDA established the Association in 1880, it was very much a man's world. Like many of the groups established at the time the predominance of male practitioners reflected the social realities of the time. Thirty years before the suffragettes were to win women the vote, the idea of anything approaching parity or equality of access was unimaginable.

Contrast that world with where we are now. It is likely that by 2020 the number of women working as dentists will outstrip the number of men. Of the four nations of the UK, three of them have women as their Chief Dental Officers. In areas of research, clinical leadership and education, women are well represented.

The sea change that we see in the shape of the profession is the result of a battery changes in attitudes, social reform and legislation. Laws and rules to ensure fair and equal treatment have opened the gates to opportunities that would have shocked our Victorian founders. And women haven't just taken those opportunities, they have embraced them and deployed them to create a fundamental shift in the dynamic. So as we approach the tipping point, perhaps it is timely to reflect. Has the playing field been so flattened that we are truly in a place where fairness prevails and the treatment of individuals is the completely the same?

Having ironed out many of the irrational differences through legislation, the one remaining fundamental difference between the sexes is the physical act of childbirth. As of 2017 it is still the medical reality that only women can bear children (although with advancing medical technologies – who knows what will happen in the future!). That simple fact means that whatever we do to even up the opportunities the actual course of life is different for men and women. Additionally, there are the academic studies which show that behaviourally and attitudinally the two genders approach things in different ways.

So the question is – have we done enough? In less than 150 years, society in general and the liberal professions in particular have seen change in the shape of opportunity and enablement. But it could be argued that this is merely the beginning of the real embedding of equality. The vestiges of maleness that reflect the profession's origins abound. Subtly and invisibly it may be the case that the way things are arranged and the way things are done are designed in ways that somehow match the expectations of men and deter women.

The recent round of BDA PEC elections with an open free vote moved our governance board a step further away from being gender representative, now leaving us with fourteen men and one woman. The GDPC as the committee that represents the interests of general practitioners (the sizeable proportion of whom are now female) is disproportionately populated by men.

These may, of course, be features not relating directly to gender but to age. It may be that, in the main, these representative positions only become doable at a certain life stage and despite the shift, not enough women have reached that life stage yet.

But it's not a simply waiting on women stepping up. It requires an understanding of the roads the next generation of dental leaders will follow, and ensuring we, as a profession can identify, support and encourage them all.

This is not a problem unique to dentistry. Despite Frances O'Grady's presence at the helm of the TUC, most trade unions leaderships remain male dominated. It's a butterfly effect, where a first visit by a young member to a local club or committee can inadvertently effectively shut down the pipeline of female talent.

The UK picture

Times have certainly moved on from the opening quote, taken from a piece published in the *BDJ* in 1914. We've set foot on the moon. The Internet happened. Virtual reality headsets are an actual thing. A lot has happened since year dot, so why isn't equality on that list?

That's not a question I am qualified to answer, but I am entitled to ask.

Perhaps it isn't one I – nor many writers across the country – should still be asking. It is 2017 after all. Not 1917, 2017. Is equality now just taken as a given? Take money, for example. In 1970 we had the Equal Pay Act, yet on Thursday 11 November 2016, dubbed Equal Pay Day, women started working for free due to the discrepancies in average salaries earned by women and men in the UK.

The average female worker in the UK earns 13.9% less than her male counterpart – based on the mean average for full time employees. That translates to 86.1 pence for every £1 a man earns. It means that, relative to men, women are essentially not paid a penny for the remaining 50 days of the year.

Equal pay and the gender pay gap are intertwined and make up a fraction of the perceived imbalance between XX and XY. Take a step back from pay, and even the distribution of jobs makes for interesting reading.

The number of women working in NHS dentistry is steadily rising. In 2014/15 in England, the number of female dentists stood at 11,285, a 3.1% increase on the previous year, and a 44.2% increase on 2006/07[1].

The under 35 and the 35-44 age groups have a greater number of female dentists working than male dentists. In the under 35 age group, 57% of the workforce are female and in the 35-44 age group, 51% are female.

> 'And women haven't just taken those opportunities, they have embraced them and deployed them to create a fundamental shift in the dynamic'

This pattern is also being repeated across the devolved nations. In Northern Ireland, the General Dental Service workforce is becoming increasingly female; 52% in 2015[2]. In Scotland, female NHS general dental practitioners numbers are also rising, in 1995 less than 30% of GDPs were female, but in 2013, almost 47% were female[3].

Statistics in Wales reveal[4] almost 60% of NHS dentists were male, although amongst younger dentists (and dental undergraduates) the gender ratio is now closer to 50:50. Community dental services in Wales are dominated by females, with 67% working in the service.

So what do these statistics mean? This changing demographic of the dental workforce is raising issues around working patterns, practice models, professional incomes, specialty training and practice and leadership.

In a BDA survey[5] of dentists working as associates in England, females report lower monthly incomes than their male

counterparts. One in ten women report monthly gross earnings of £6,000-£7,999 compared to one in four men on the same income bracket. Women are more likely to be earning in the lower bracket of £2,000-£3,999, 25% report to be in this bracket, compared to 14% of male respondents.

Leadership and ownership

It's often said leadership and senior elected positions are male dominated. There's truth in that but where posts are openly recruited we already see a difference. Even taking into account the wide-ranging differences in the workforce across the UK, dentistry doesn't do too badly. The English, Welsh and Scottish Chief Dental Officers are female. Many Presidents of the various professional and trade associations are also female.

Leadership can often translate to ownership. So how do the numbers stack up there?

Interestingly the leadership paradigm in the upper echelons of dentistry does not appear to translate to practice level. Practice ownership did not seem to be an overriding ambition of many women dentists, with only 27% of non-practice owners saying that they would like to. Of those who said 'no', the reasons given were that they weren't business minded or were simply happy in their current situation, as well as that owning a practice would not fit in with their family and spouse or partner's job. Many also mentioned that the paperwork, responsibility and commitment were just 'too much hassle'.[6]

Previous research has revealed only 32% of women dentists surveyed[7] owned a dental practice, stating that the benefits were being able to dictate their own working hours and working environment, allowing them to run the practice how they chose and to build their own team. More recent research supports this, showing that women manage practices very differently.[6]

> 'One in ten women report monthly gross earnings of £6,000-£7,999 compared to one in four men on the same income bracket. Women are more likely to be earning in the lower bracket of £2,000-£3,999, 25% report to be in this bracket, compared to 14% of male respondents'

Perhaps this is changing as, even over the last year, there seems to have been a slow increase in females purchasing partnership with females. According to data from Frank Taylor & Associates, 14% of all of practice purchases in 2015 were to women, and over 24% of all purchases were to partnerships of men and women (either work or life partners). Last year nearly 19% of all purchases were to women, and nearly 30% to partnerships, thereby seeing a steady decrease of the solely male buyers.

Which begs the question, what do women want from their job in dentistry?

The survey revealed that women are more likely to be working part-time, as 54% said they worked 30 hours or less. Compare that to their male counterparts, where just 27% of men work part-time. This may go some way to explaining the lower reported incomes, but there are possibly other factors at work under the current NHS contract that may negatively impact on female dentists' earning potential. Among associate dentists, women are more likely to work at just one practice (79.9%) compared to men (74%). Men are more likely than women to work in two, three, four and five or more practices. Perhaps this can be explained by nothing other than timing. Research[8] has identified that as women progress through postgraduate education in dentistry, specialisation, involvement in research, and positions at the senior level, the gender gap is telling. Specialist education often conflicts with child-bearing years. Among postgraduate students without children, 67% were women; but among postgraduate students with children, the percentages were reversed, with 65% of them men. This difference suggests that having children significantly affected these women's decision to pursue postgraduate education, which results in a reduced number of female dental specialists.

Dr Sarveen Mann, Principal Dentist at the Fulham Dentist, spoke to *BDJ In Practice* about her team – an all-female practice.

'Patients have always viewed us as a professional, friendly and caring team. This is more to do with the service we offer, the effort we all put in individually and as a team to ensure patients are treated to the highest standards rather than the fact that we are an all-female practice.

'That's not to say we have not had new patients deliberately seek us out as they wanted a female dentist. That has happened on a number of occasions. The perception is that we are gentler and less mercenary!'

So does an all-female team pose different dynamics compared to an all-male team? 'I don't think working in a same sex team is problematic at all from a management perspective', Dr Mann said. 'As long as you take the time to look after your staff, it's exactly the same. I understand the female side of life from hormones to having babies, so I can put this to use when typical female issues arise. We discuss problems and give each other support when needed whilst not losing sight of the fact that we have a job to do and to do it well.'

Leaders of tomorrow

What it all means is open to interpretation. There is no black and white. We can make assumptions and projections based on the developments of the previous decade. It hasn't served the banks too badly, although that is open to interpretation.

Could we be looking at a 50/50 split by 2020? Could we be looking at a largely part time workforce, given the above statistics? Who would fill the leadership void? Could we be facing a scenario where part time staff become leaders and take on leadership roles?

One practice owner told *BDJ In Practice*

about a situation whereby the practice manager left on maternity leave and two of the senior nurses applied for a job share of the role. It wasn't successful, based on the very nature of a part-time manager. 'For continuity – both for staff and patients – I felt it was more appropriate to have one person in the role', she told *BDJ In Practice*. 'Of course you can do the books or the wages from home. I often do that so I can concentrate without being distracted, but the day-to-day management of a practice in my view isn't something you can do part time.

'What happens if there's a disagreement with a patient on their day off? What happens if a patient sees one manager one day and the other manager the following day? Where's the service delivery continuity there?

'The issue we may face with the workforce changing is a significantly more balanced one, but fewer and fewer women in leadership roles. It's not something that can be helped, and it's not due to any gender bias. It may just happen as a result of circumstance.'

> 'Perhaps more pertinently, where will the leaders of tomorrow come from, and what will they look like?'

Does this mean owners and managers will now have to decide between singularity or full time hours? The number of associates continues to rise, giving more credence to the notion of practices compromising of several people doing the same job.

And, of course, ever-evolving employment laws may only add to the pick 'n' mix. Shared parental leave is a significant development. This allows parents to share statutory maternity leave or adoption leave. Employees on maternity or adoption leave can break their absence from work into separate blocks and to share some of the leave with their spouse or partner. Potentially, eligible parents, in the first year of a child's birth or adoption, will be able to dip in and out of their job, taking time off to provide care for the child.

Up to 50 weeks of outstanding statutory maternity leave or adoption leave could be available for shared parental leave. The actual amount of shared parental leave available depends on how much maternity or adoption leave is taken, so any week or weeks taken reduces the shared parental leave available by a corresponding amount.

It is the mother's initial choice over whether to opt for shared parental leave, but once that choice has been made, the couple must agree when they should take leave. They may take time off either at the same time or consecutively. Shared parental leave must be taken by the child's first birthday and any unused leave at that date would be lost.

Parents have to provide written notification of when they intend to take leave. Employees can make up to three different requests and could ask for more than one block of leave within each request. If they only request a single block of leave within their request, then the employer has got to agree to that request and has no flexibility. If your employee uses the notice asking for two separate leave requests which involves returning to work part way through, you have some discretion in how you treat it. You can refuse the employee's request but would then have to renegotiate a different pattern of leave that works both for you and the employee.

Dr Mann added: 'The introduction of employment laws, such as shared parental leave, is a huge positive step for dentistry. I fully believe women could benefit from a better balance between working and looking after children with their partner's support, and this will enable that balance.

'It would also be easier to return to dentistry after a shorter career break, which is preferable as it is quite easy to lose confidence if you have been out of the profession for a while, especially with dentistry changing as rapidly as it does. If you are off for nine or 12 months through maternity leave, the way our profession evolves there's every chance it could be alien to you on your return.

'The very nature of career breaks, shared parental leave and part-time staff will mean an inevitable shift in the workforce. In my opinion, this will be a great thing for dentistry. It seems the small general dental practices will be a thing of the past with dentistry becoming more speciality-focused in the next 10-15 years.

'Yes this means more study initially – and that isn't always something women pursue – but ultimately it would allow women more flexibility with part time work to cover the potentially longer hours in multi surgery clinics, for example. Women may then be able to better juggle the demands of childcare alongside part time work, something I – and many other female dentists I know – have struggled with. Times are changing, and they are only going to improve things.'

Will small teams doing lots of work be replaced by large teams with lighter workloads? Will this help to reduce stress in the profession? Perhaps more pertinently, where will the leaders of tomorrow come from, and what will they look like? Hopefully by the time we have passenger space crafts to the moon, we'll know.

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To read about the first female dentist in the UK, go to **www.bda.org/library/history/womenindentistry**

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Cultural Intelligence – How intelligent are you?

In the first of two articles, **Dr Janine Brooks MBE** discusses the value, the definition and the necessity of cultural intelligence.

I was recently thinking about the diversity in dentistry and how dental professionals, as both leaders and clinicians working with patients and colleagues, need to be constantly expanding our cultural intelligence.

Culture means so many different things and it probably means different things to each and every one of us. Culture can be big, as in the culture of a particular country or it can be small; the culture of a family. It can be age or gender related, specific to an organisation or geographic area. It is definitely dynamic and constantly re-shaping. Culture is complex and rarely is there a 'handbook' to guide you. Culture includes rules, both written and unwritten. Culture is powerful and affects all aspects of our life, home and work. We may not be fully aware how intrinsic our culture is to us, or how important it is. That is, until our cultures and the values they encapsulate are challenged or offended. Only then does the potential for conflict arise. Emotions become engaged, relationships strained and stereotypes rise to the surface. We are all part of many different cultures. Let me give you an example of the different cultures I find myself in:

- Female
- Older
- Village dweller
- English
- White
- Dentist
- My family.

Within each of the above groups, there are sub cultures, for example when I worked with patients I was a community dentist, my dental culture was different to that of a general practitioner. I was part of a Trust and we had a different culture to those of colleagues who worked in other Trusts. Very often our cultural make up is set early, we are born into particular families who live in certain places and our racial group is determined then. Other aspects of our culture are acquired, often as a result of the influence of our parents, family and friends. Some come later in life, such as the culture of our profession or work environment. Some cultures we can join or leave, others are more intrinsic and difficult to detach from ourselves.

What about intelligence? I believe that we have the potential to grow our intelligence. Some have an advantage in seemingly being more intelligent than others, but we can all expand on the genetic gift the random selection of birth gave us.

Socrates reportedly said 'I know that I am intelligent, because I know that I know nothing.' For centuries, philosophers have tried to pinpoint the true measure of intelligence. Intelligence is about knowing and our ability to acquire, store and utilise knowledge. Some people can do this more quickly and efficiently than others. The French psychologist, Alfred Binet developed tests for intelligence in the early 1900s, the Binet-Simon Scale. The intelligence quotient (IQ) has dominated our sense of personal worth since that time. IQ proves our ability to grasp new concepts fast and demonstrate to ourselves and others that we are on top of facts, systems and arguments. This aspect of intelligence underpins examination success and entry into further training, for example dental school. In our society, IQ clearly matters, however for leaders and those who wish to progress in our multi-cultural world it is just the start. We need more than simple intelligence. Bringing together culture and intelligence gives us cultural intelligence.

The dental profession working in the UK in 2016 is hugely culturally diverse. You may be surprised to know that there are dental professionals working in the UK from more than 37 different countries, from Australia to Iceland to Peru to Venezuela.

Work undertaken by the Dental Schools Council shows that 44% of dental students report themselves to be of Black and Minority Ethnic (BME) cultures. Dentistry is reported to have a higher proportion of BME students than any other university course in the UK at the current time. Of course this is only part of the picture of cultural diversity in dentistry, BME as a definition refers to individuals from non-white descent, cultural diversity embraces all cultures. It could be said that some of the most tricky cultural issues arise across Europe. In addition, it is relatively easy to get hung up on the obvious cultural diversity of skin tone completely missing the more subtle issues that cause individuals to struggle to understand each other.

Add to that the diversity of our patients who have been born in countries outside the UK and who have grown up in different cultures. The history of Britain is one of movement of individuals. For over 10,000 years people have moved into and out of Britain. Throughout recorded history the island has consisted of multiple cultural groups and identities. Some have even referred to the British people as 'mongrels'. It may have been meant unkindly, but I view that as a tremendous strength. For all that, it probably wasn't until after the Second World War when large scale immigration and our modern rich diversity of culture began to really take off.

'The dental profession working in the UK in 2016 is hugely culturally diverse. You may be surprised to know that there are dental professionals working in the UK from more than 37 different countries, from Australia to Iceland to Peru to Venezuela.'

London remains the most diverse city in Britain by far. The 2011 census showed that White Britons now account for less than half (almost 45%) of London's population for the first time, and more than one in three London residents is foreign-born. I believe this diversity is a cause for celebration, however it can also be a cause for confusion, misunderstanding and potential strife. If the celebration side of the balance is to predominate, then we need to build and keep building our cultural intelligence.

What is it?

Cultural intelligence is the ability to cross the divides that exist between people and allow us to thrive in multiple cultures. As noted above the potential divides that exist between people today include sectors, organisations, generations and all people who are different from us. Each and every one of us is a mixed bag of culture, some aspects of our culture we share with many other people, some we share with just a few. Before we can begin to understand other cultures we need to understand our own. We need to know what our culture means to us and the multiple sub-cultures we belong to. Being fully aware of what makes us who we are, and how our culture influences the way we work with other people is the starting point. So, how well do you know you?

How does cultural intelligence impact on the dental workplace?

As I have hinted there are a number of ways in which a better understanding of cultural intelligence can impact on the dental workplace:

- Impact on work place interactions – the dental workforce is diverse, this can lead to misunderstanding, miscommunication and conflict between members of the team. The more we grow our cultural intelligence, the more we understand each other and why we act and react in the ways we do. It is rare for the seemingly difficult behaviours we observe to be deliberate and conscious. Sadly, if we do not take time to understand

and interpret, problems can escalate and become entrenched. This is not good for staff and it isn't good for patients. No one likes to work in a toxic environment

- Leadership differs across cultures – it is not surprising that in the UK we utilise leadership behaviours and methods that are espoused, learnt and modelled in the UK. It should also come as no surprise that leadership styles differ across the world. Some styles are more autocratic, some more democratic, some are task orientated, some are feelings orientated. Some behaviours are derived from cultures that value individualistic approaches, others value community/family approaches. As a leader in dentistry (and most dentists are), understanding this and working with the differences rather than only using one style of working will help you to be a more effective leader
- Individual personality will interact with cultural style – I outlined some of my own cultural groupings earlier, however I won't be exactly like everyone else in my cultural groups. We are individuals with personalities that are influenced by experience and knowledge and we are unique.

We bring that uniqueness to our cultural underpinning. The key is don't expect all community dentists to be the same, don't expect all white, female community dentists to be the same. The key is seek out the individual not the stereotype. Try to bin stereotypes when you are trying to develop your cultural intelligence.

> 'Conflicts within the dental team undermine team working and ultimately patient care. Importantly working in an atmosphere of misunderstanding is bad for us as individuals.'

Vital for dentistry

Cultures can sometimes clash, often unintentionally and from ignorance. If the issues that caused the clash remain unknown misunderstanding can grow into real and deep conflict. Conflicts within the dental team undermine team working and ultimately patient care. Importantly working in an atmosphere of misunderstanding is bad for us as individuals. Toxic environments affect our ability to work to our best ability and make us feel demotivated and ultimately can lead to ill health. Culture clashes with patients seriously undermine patient care and can impact badly on their well-being. Serious culture clashes with patients can lead to complaints. Cultural Intelligence helps to minimise misunderstandings and conflict. When there are clashes it helps us to recognise them early and helps us to solve the clash.

It's more than bridging national borders and developing our capability to operate globally. It's about crossing all kinds of cultural divides, learning to operate effectively in unfamiliar surroundings and finding a way to break down barriers that may well not be geographical at all.

Leaders with cultural intelligence

To be an effective leader in dentistry today, cultural intelligence needs to be an essential part of your skill set. The dimensions you can develop are:

- Take every opportunity to understand differences in people. Culturally intelligent leaders actively move towards difference, rather than shy away from it
- Where you find divides between people, build bridges. Culturally intelligent leaders know that bridges help everyone to move to each other, bridges allow flow both ways. This is much more effective than simply crossing a divide which only works one way
- We often like to be with people who are like us, you only have to look at conferences where people from the same organisation or the same professional group stick together. Culturally intelligent leaders go out of their way to seek out people who are not 'like them'. Next time you go to a conference, sit with people you don't know and seem different to you and find out more about them
- Always look outside your cultural group. Culturally intelligent leaders are fascinated and energised by different cultures.

Being tolerant of difference is good, it's a start, but culturally intelligent leaders make it their strength to go beyond tolerance towards real appreciation and understanding. ◆

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Counting the cost of government indifference

As the NHS reels from the latest winter crisis **Henrik Overgaard-Nielsen** reveals how failures in dental policy are putting the pressure on across the system.

Have you ever wondered how many patients are heading to A&E with dental problems? Well it turns out Health Ministers are not the ones to ask.

Thanks to the team at Newcastle University's Centre for Oral Health Research we now know that official figures could be under-estimating the number of attendees by a factor of 10.

This is more than trivia. Patients in dental pain should get the care they need at the right time, in the right place, and from the right people. And it's the view of Newcastle academics that the overwhelming majority of these patients would have been better off seeking help in primary care, particularly the significant number who have delayed treatment.

This also matters because of the strain it puts on our NHS. At this scale, we're looking at £18 million spent on problems that could have been managed at a fraction of the cost at high street dental practices.

But this is what you get when Ministers offer nothing resembling a strategy for oral health, short of cutting budgets and expecting patients to plug the funding gap through ever-increasing NHS charges. And medical colleagues, who are unequipped to deal with these dental problems, are left to pick up the pieces.

Dentistry does not sit in a neat silo in the NHS. The casual indifference from successive governments is now putting pressure on every part of the system, and is comes with a multimillion pound price tag. We shouldn't be looking at 600,000 people seeking help at the GP with dental problems every year, or indeed nearly 40,000 children lining up for multiple tooth extractions in our hospitals.

It's why we've written to England's Chief Dental Officer, Sara Hurley, to demand more emergency slots for dentistry. This could address her concerns about the need for a long-term solution to improve access to urgent dental care, as well as reducing unnecessary A&E and GP attendances. If adopted, our proposals would also have the benefit of providing a clear indication to NHS 111 which dental practices have the availability and capacity to treat patients who need urgent care.

It's why we will continue arguing that inflation-busting increases in patient charges are no substitute for adequate government investment. We simply shouldn't be giving patients on low incomes reasons to head to anyone other than a dentist when they have dental problems.

And it's why we remain committed to contract reform. For 10 years NHS dentists have laboured under a wretched system that places government targets ahead of patients. It's the factory model of care writ large.

We are the one part of the NHS where the mantra of 'prevention' could be easy to apply. We want to see genuinely patient-based contracts. We are asking for help to stop our patients piling the pressure on other parts of the health system. Sadly while there is real energy for change from our profession, government seems wilfully disinterested

On prevention we could be the exemplar of Simon Stevens' Five Year Forward View, if the powers that be would let us.

Ministers have a choice. They can start acknowledging dentistry is part of the health system. Or they can keep paying the price. ◆

A&E
135,000 patients with dental problems/year
Cost: £18 million /year

Newcastle University's three-year study revealed a systematic under-reporting of dental problems. Official stats suggest dental attenders could be as low as 14,000 per year. Evidence now points to a figure 10 times that – a conservative estimate of 135,000 or 0.7% of all A&E visits could be the result of dental problems - the lion's share related to toothache.

GPs
600,000 patients with dental problems/year
Cost: £26 million/year

We've shown 600,000 patients, over 11,000 a week, are heading to GPs for dental treatment every year. These appointments cost the NHS over £26 million a year.

Hospitals
160 multiple extractions on children/day
Cost: £35 million/year

There were 40,000 hospital operations to remove teeth in children and teenagers last year – the equivalent of more than 160 a day. The millions spent on child tooth extractions in hospitals have become emblematic of government failure on oral health.

Dental problems at A&E: why it matters

Charlotte Currie, Clinical Fellow in Oral Surgery at the Centre for Oral Health Research, School of Dental Sciences at Newcastle University, explains what led to their recent project investigating the number of patients attending hospitals for dental problems, and what we still need to discover to encourage patients to visit the dentist before they end up in A&E.

Just under 10% of the UK population reports experiencing current dental pain, and as dentists, we often see patients who are suffering with toothache, and have been for a while. The patients often delay seeing a dentist 'at all costs'.

Their 'toothache' pain is intense and affects their day-to-day life. However, they go on living with it, often for months. I've treated many of these patients and find their stories astonishing to hear.

I've listened to reports of patients extracting their own teeth, taking unintentional paracetamol overdoses, and being admitted to hospital with life threatening infections. Some patients also report that they try various other health care professionals first, before eventually visiting a dentist.

In addition, a large group of these patients are relying heavily on the emergency services for dental care, and attend on a regular basis, sometimes for the same problem over and over again.

Yet, despite these 'problem-orientated attenders' being well known to dentists and doctors, surprisingly little is really known about them: where do they seek help, why there, who are they, and why attend in this manner?

These unanswered questions, coupled with the impact the pain has on these patients' lives, prompted the start of our research project at Newcastle University.

Initially, we took a look at our local dental emergency services and found that around one-third of patients attending were regular problem-orientated attenders, and in addition 13% were coming back for the same problem.

We were aware that these patients also attended A&E departments, but were unsure as to the scale of this, leading us to examine the number of attendances at our local department. We were surprised to find the number of dental attendances at A&E as high as 0.7%, with the most common diagnoses being that of acute dental pain.

Startlingly, 10% of these attenders were repeat attenders for dental pain at A&E. In addition, from both of these studies the overwhelming majority of patients were men, in their 20's and 30's, and from the lower socio-demographic groups.

Commenting on our research in the Guardian, Barbara Ellen, suggests 'that dentistry could turn out to be another poverty indicator, with many of the poorest unable to afford to maintain basic dental health'. She believes that the poorest in society are too afraid to go to the dentist, not just because of the treatment, but because of the cost.

What isn't clear from the research we've done yet, is why these patients seek care in the way that they do, and other than emergency dentists and A&E departments, where else do they go and why?

Previous findings from our pain research team at Newcastle shows that incorrect care pathways within oral and facial pain can have huge direct and indirect economic impacts, which may be the case for these problem-orientated attenders.

Also, by delaying treatment for their dental pain, the success of potential treatment can be reduced and the potential for post-treatment complications such as persisting pain increased.

If we want to help these patients seek care from a dentist, and ideally attend for routine preventative dental care, we need to find the answer to these questions, so that we can improve both the care and experience for our patients and ensure NHS money is spent as wisely as possible.

Developing People

Bob Hughes,
CEO of the Forton Group

When I tell people about Harry Schroeder's model of high performance leadership, which includes the 12 leadership behaviours that my monthly articles are about, I am sometimes asked which one is most important. There is no one answer – depending on the leadership role, some may be more significant in that role than others.

However, if you asked me whether I had a favourite or not, then the answer is yes. My favourite is the subject of this month's article – developing people.

There are many different definitions of leadership. Here at The Forton Group, we say that leadership is about being personally successful whilst also enabling success in others. You will have your own definition about what 'personally successful' means – it might be expressed in financial or some other quantitative term, or it might be a qualitative success or simply about living every day to your best.

All that is true, and I would contend that true leadership is not just about personal success but is also about growing the leaders around you; bringing on the next generation.

I am involved as a Director of an organisation called *Engage for Success*. This arose from a request by government to look into what made people in some organisations

more engaged with their work than those in others. When people are engaged they want, and are able, to give their best each day, so that each day is a great day at work. When that happens, workplaces are thriving, growing and developing through the commitment, energy, and creativity of the people that work in them.

You've probably noticed this when you go into two different branches of the same organisation. There are two branches of my favourite sandwich bar near to each other in London that I use. In one of them, the staff seem to be more often talking with each other than attending to the customer and the standard and speed service is much lower. In the second, they are chatty and welcoming and I've even had the occasional free coffee from them. Yet they are both governed by the same employment practices and managed by the same rulebook. Guess which one gets most of my business.

The study also looked at the links between higher levels of engagement and key metrics such as performance, productivity, customer satisfaction, safety and well-being. There is a wealth of evidence that demonstrates the link between engagement and these metrics. The initial report, written by David McLeod and Nita Clarke, concluded that, whilst there is no single approach to engagement that will work in every organisation, there were four pillars that were common across engaged organisations. The most significant of these was having a manager who was engaging; they focus on their people, they give them scope, treating them as individuals, stretching them and coaching them to achieve success.

One question to ask yourself is how do you react when you notice one of your people underperforming or you see them making mistakes? If your instinctive reaction is to threaten or punish, then you may want to reconsider! As soon as there is a blame or a fear culture in an organisation, then creativity withers. Another one of my favourite questions is "Whose fault is it that we have a blame culture?"

> 'Both underperformance and mistakes are more likely to be attributable to a lack of understanding and the need for training or development.'

Both underperformance and mistakes are more likely to be attributable to a lack of understanding and the need for training or development. I have known managers who are reluctant to invest in their people for fear of them moving onto the competition. That may be true, but the price you pay is an uneducated and ignorant workforce; hardly a recipe for success. If, in addition to investing in them, you also ensure that they are fully engaged, then why would they leave?

There's a great quote: 'if you think education is expensive, try ignorance'.

(It's often attributed to Derek Bok from Harvard, but is more likely to have been said by a woman called Eppie Lederer, who wrote a column in the Washington Post under the pseudonym of Ann Landers.)

So, good leaders develop their people. But that doesn't just mean reaching for the training manual or googling the latest course. Of course, if training is the right approach, then use it. But there are many other ways that as a leader you can support the development of your people.

There is a learning and development model called the 70:20:10 model. It suggests that the lessons learned by successful managers come 70% from challenging assignments, 20% from developmental relationships and 10% from formal coursework. We can argue about exactly what these ratios are but my experience suggests it's roughly correct.

What we also know from research is that attending a training course without effective follow-up is a poor investment. That follow-up can take a number of forms. The opportunity to try out the new skills must be made available. The learning will be retained much more thoroughly and for a longer period of time, if the individual has coaching after the course, as they try to apply the skill.

As the manager, you may not be directly involved in, but you should certainly be supporting people when they try to develop themselves and acknowledging them when they do so. Chat with them, ask them how it is going, be curious, rather than judgemental. Ask questions that will help them discover for themselves. You should know how to be a coach like leader.

If it's appropriate, pass on the benefit of your wisdom. This can be one of the most tempting and often easiest routes to take. I would however urge some caution here. Just because something worked for you a few years ago with a different group of people in a different set of circumstances, there is no guarantee it'll work for the person in front of you. It's much better if they discover a solution for themselves, often as a result of the great questions you can ask them.

There is another great benefit that arises from asking questions and getting your people to come up with their own solutions. Firstly, they will have more ownership of the solution, precisely because it was theirs. Secondly, they will become more independent and less reliant upon you to come up with the solutions every time. And finally, they might come up with something you never even thought of.

So a coach approach to leadership has many payoffs that should make your life easier and your organisation more productive.

Another way of supporting your people to develop themselves is by acting as a mentor. Here is one brief distinction between coaching and mentoring:

- → A mentor knows how to answer many great questions from the Mentee and pass on their experience
- → A coach knows how to ask great questions so that the coachee can discover and learn for themselves.

Typically, a mentor will be somebody other than their boss, but this doesn't stop you acting in a mentor-like way with your people.

I was recently asked to deliver our Post Graduate Level 7 Certificate training in leadership, coaching and mentoring to a group of dental professionals. A great chance for me to explain our approach in this sector. They were people who wanted to move beyond their leadership roles within their practices, to coaching and mentoring other professionals. We had some great discussions about these distinctions, and how their many years of experience might support the profession. I think it's fair to say that we concluded by recognising that each of us has a unique combination of skills and experience to bring to conversations and that the coaching and mentoring roles are different – yet focused on the common goal of developing people and teams.

> 'The best managers take personal responsibility for the support and development of their people. They look out for assignments they can put people on, not necessarily a new full-time job, but some extra responsibility that will serve to develop that individual.'

I've had the good fortune to work for a number of excellent managers during my career all showing different qualities that made them so. I recall one occasion when, particularly infuriated by another department, I had written them a memo. This was in the days before email when we used to use actual pieces of paper. In my mind, it was perfect; there was just the right amount of criticism and vitriol blended with a positive way forward. I took it to my boss just to double check. He asked me if I felt better for having written it. Well, as it happens, I did, so I told him so. 'Great', he said as he screwed it up and threw it into the wastepaper bin.

The best managers take personal responsibility for the support and development of their people. They look out for assignments they can put people on, not necessarily a new full-time job, but some extra responsibility that will serve to develop that individual. It might be as simple as deputising for you at some senior meeting or it creating a small team of people to work on a strategic project that has significance for the organisation – and then trusting them to deliver something of value. Whatever option you choose though, be sure to follow up.

Back to being 'coach like a leader', you can give valuable support to your people as they are going through these experiences. Of course, all of this is time-consuming. But look at the payoff that this investment can bring. Or look at the cost of not doing it. There's another interesting statistic here. The number one reason why people quit their jobs is because of dissatisfaction with their immediate boss. Now think about the cost of recruiting a replacement and the time and effort you'd have to put in to train them up again.

As with all of these behaviours that I've been covering each month, the highest rated level of performance for this behaviour goes to those leaders who perpetuate the behaviour within the organisation.

I was talking to a learning and development manager in a large international bank recently and he was explaining how the CEO was taking time out to launch every course in a training programme they were putting together. Imagine the commitment that must be taking, and also imagine the impact that must be having on the thousands of people receiving the training.

So the best managers find a way to make this coach approach to developing your people the norm. They put systems and processes in place to train, encourage and reward this behaviour. We worked in one organisation where the board had invested in training a large proportion of their managers to equip them with 'leader as coach' skills.

This had a number of benefits. Firstly, they managed their people better, because they knew how to coach them. Secondly, they were encouraged to volunteer a couple of hours a month of their time to coach people from different parts of the organisation. Not only did this bring the immediate benefit of having a great internal coaching pool, but it also served to spread understanding across the organisation. Simply by having conversations with people outside their team, they inevitably learnt more about the frustrations and successes elsewhere. And, at the next employee engagement survey, the teams that were led by people who had been through the coach training course consistently scored higher levels of engagement than the teams of those who hadn't. ◆

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

Doing nothing

At the Dental Futures event in Northern Ireland, Chair of the BDA Northern Ireland Dental Practice Committee (NI DPC), **Peter Crooks**, discussed how dental practices view their future. One in ten said they would do nothing. They weren't making a decision.

Or were they? Were they making a conscious decision to do nothing, or were they simply floating along? *BDJ In Practice* talked to Peter to find out more.

Peter Crooks

Chair of the BDA Northern Ireland Dental Practice Committee (NI DPC)

There's a statistic that suggests every individual makes around 35,000 decisions every day. No. That isn't a typo.

The more you think about it, the more it sort of begins to make sense. Take this article, for instance. Every word is a decision. Every time I look up from the keyboard is a decision. You reading this is a decision. You still reading this is a decision. You get the picture.

In the world of ownership and management, it wouldn't be unrealistic to think that number is significantly higher. Management is about making decisions. They could be large ones, or they could be micro-management ones, but the key part is the act of making a decision.

Where has this idea of 'doing nothing' come from?

A BDA survey of GDPs in Northern Ireland asked them to think about their individual net income in the next 12 months and if they intended to take any of a number of actions in their personal practice. Perhaps unsurprisingly increasing private work topped the list, followed by providing less Health Service work and increasing private. The one that jumped out at me was the 9.6% who said they would do nothing.

This really struck me. The previous speaker, Stephen Tidman, said very clearly that dentistry in Northern Ireland is a cash strapped service. The reduction in net income in the five-year period 2008/9 to 2013/14 was 32.8%. That is a huge fall. If, as a practice owner, you're not going to do anything about that, I believe it's too risky a strategy not to do something. To that end, it has to be a conscious decision. If it is – and even if it isn't – you have to be prepared to take the consequences, because there will be some.

It's clear that many practice owners believe that 'I have always been working in this way' will be sufficient. But with a cash-strapped service, inflation and further cuts looming, it isn't going to work. It's not the correct reasoning. You'd end up doing the same amount of work for less. Be prepared for a change in lifestyle– privately and professionally. As long as you've thought it through and are not coasting, that will be OK.

Where will those who coast along end up?

It's hard to say. Doing nothing now will mean actively avoiding change later. Things like freezing staff pay, which is a risky business. You have to know that your staff are always aware of what's going on around them. If someone up the road needs a member of staff, they will know about it. In which case you're going to end up trying to recruit someone on lower pay, which could

be difficult. You'll end up losing out on money if they aren't replaced quickly. I find principals pay an increase to staff to keep them, even at their own expense.

Further down the road you may even have to reduce your associate's pay, and that means difficult conversations. Plenty of those have happened in Northern Ireland! These are only some of the consequences. So many owners are trying to run a tight ship as it is.

With 90% looking to increase private, 41% of at the expense of less Health Service work, is that a dangerous precedent to set?

It would be a definite problem for those who need the service, but access here is significantly better than it was some years ago. There has been a great increase in patients being seen year on year, which is positive, but with less money coming in it does put a strain on the service.

If dentists are trying to increase profitability rather than reduce overheads, increasing skillsets and providing additional services rather than replacing current ones is a better template for success. From an individual perspective it gives more strings to your bow, and if the practice pays for the courses, it benefits them – and ultimately the patient.

Take facial aesthetics, for instance. It's a huge market. I have two associates both of whom have done courses on Botox and fillers. They are additional services, provides them with incentives and new ideas, and increases income. The positives outweigh the negatives.

Stress is a big problem in our profession. If we're taking more on, isn't that going to increase the chances of stress being a factor?

I have lobbied the Health and Social Care Board and the executive committees about this, and I believe it is definitely an issue. However from my experience, doing other things in practice means new focus and interests, not necessarily stress. I've found that doing the same thing day in day out is more boring and potentially stress-inducing than learning new things!

If you take on family care dentistry privately, for example, yes it's an add-on rather than replacement, but it's nothing that you don't do already. Many dentists here might find it difficult to do that as we're quite wedded to the Health Service, but it's thinking outside the box that could really help.

What about associates who are stuck with low pay? They might be doing nothing through no fault of their own and the decision taken out of their hands

It does depend on circumstance. It's not owners being difficult, it's just how it is. There isn't an awful lot of money floating around. They are limited contractually and have no say over staff, but there are still opportunities for them to increase their skillset. It should be encouraged as it makes them more employable. That brings benefits to them as an individual and the practice they are working for.

You've discussed conscious changes. What other changes do you foresee?

Someone once said the only constant in life is change. The only problem is if you don't do anything the natural progression is down. You don't find circumstances improve if you do nothing. On top of that if we don't see an increase in funding and investment for the Health Service, that will cause many, many issues. Things are already overstretched as they are. Inflation is rising, inflation within the profession isn't immune to it, and wages aren't going up, I fear for the future.

On the other side of that I'd like to see people manage change and review business plans to accommodate these possibilities. I think they have to, and that's not just in Northern Ireland. The Department has many other priorities that we read about and hear about. Cancer care, mental health care have been thrust into the limelight again recently. Dentistry is our priority, but it is not going to be high up for the Department and the Minister, so we tend to suffer. We will continue to campaign to get it further up their priorities, as we know that it can release the pressure on other areas. Take hospital admissions for example. Increased funding for dentistry could free up beds that are being taken up by children requiring dental work, often extractions. Health Service provisions being reduced is the nightmare scenario, but I fear that might become the reality. To keep businesses afloat, you will need to make some decisions.

If, for example, you decide to open up on a Saturday morning and provide Health Service care, is that really the answer to the problem? Inflation and costs mean returns are going to be minimal – if at all. You're increasing work for no or little gain. I've heard of some cases where expenses for staff training will be cut, which isn't taking a long term view. It's a short term fix, but I don't believe that is the answer. That investment – or lack of – could be the difference between surviving and thriving.

Do you think these are these conscious, pro-active decisions or reactive ones?

Definite reactions. The reaction is always to cut back, which is understandable, but savvy owners may increase funding for long-term sustainability.

They can also learn from corporates. The reaction to their increase in the market is certainly a mixed one, but they do have good ideas that keep and retain patients. Attractive websites, for instance, help the patient experience. One corporate has reported an 8.8% year-on-year increase in income due to more private care on offer. That's a pro-active decision that may have short-term consequences, but long term gains.

How will the new breed of dentists coming through the system who become practice owners view the current climate? Many current practice owners have navigated through highs and lows, whereas new ones are entering a challenging financial climate

The change I see is the increase in corporates rather than individuals buying practices. Corporates are now looking at buying corporates, they're looking at individual practices, and the end result is they are growing in number. Associates will be – and are – happy to be employees without the baggage of management, paperwork and box-ticking. They appear to be quite happy with that. I'm hearing of practices changing hands and often the purchaser is a corporate. They do keep tight control of costs.

Could there be an issue with the drive to keep costs down regarding quality? You don't want a situation where you're cutting corners at the expense of quality and ultimately patient safety

We certainly wouldn't expect quality to suffer. I bought a dental chair many years ago that wasn't all bells and whistles, but it wasn't of poor quality either. You have to be sensible with the decisions regarding purchases. Materials I don't skimp on – if I find something that I like and delivers results, I'll keep it, even if it's a bit more expensive than some others. There might be a temptation to buy cheaper materials but it shouldn't be at the expense of quality. Whatever decisions you make, always have the bigger picture in mind. ◆

Workplace pensions

by Daniel James DipPFS
Director of Client Services at Lloyd & Whyte

The automatic enrolment of employees into a Workplace Pension became law under the Pensions Act 2008. This made it compulsory for every employer in the UK to provide a pension scheme and contribute towards it for certain staff, to help more people save for retirement. While larger employers have been the first to comply, time is now running out for smaller businesses like dental practices.

Many of the practices we speak to are staging in the next 12 months and you might be too.

Obligations

The legislation places certain obligations on employers that you must meet in order to avoid heavy fines. These duties consist of:

- Categorising your workers to understand who is eligible
- Communicating regularly with your employees regarding their category, yours and their contributions and the ability to opt-out or opt-in should they desire
- Keep detailed records of all of your employee communications
- Manage payroll – ensure the correct contributions are payable
- Consider offering employees the benefit of salary exchange in order to increase their pension pot
- Pension scheme – In addition to the above, you also need to select a pension scheme that meets the auto-enrolment requirements. The scheme governance also needs to be reviewed every three years.

The staging dates for Workplace Pensions for small businesses are going to reach a peak over the coming months, which could make it very difficult to get any assistance. With so much to prepare in order to avoid being significantly fined, you probably feel like you should have started yesterday.

Small businesses are leaving it too late

It's understandable that with all the other things that come along with running your dental practice, it's easy to put workplace pensions on the back burner. The best place to start however is by finding out your staging date. This can be done by entering your PAYE reference on the pension regulators website. (http://www.thepensionsregulator.gov.uk/employers/staging-date).

How do I introduce a Workplace Pension into my practice?

In order to comply with the legislation you must:

- Choose a pension provider and a default investment strategy
- Automatically enrol every employee that's eligible
- Re-enrol your eligible employees that opt out every three years
- Communicate with all of your employees
- Make employer contributions to the pension scheme
- Deduct contributions from employees' wages and pay them into the pension scheme
- Maintain a complete audit trail that can be inspected by the Pensions Regulator at any time
- Ensure your solution meets all government standards
- Officially declare compliance to the Pensions Regulator within five months of your staging date and then every three years.

Getting some help

So you now know what you need to do but there is some legwork to introduce the scheme. You also need to understand a little bit about which pension scheme to choose. To make this process and your life easier, we've developed an exclusive start-to-finish service just for workplace pensions. We've partnered with specialist organisations Creative Auto Enrolment and AE Simplicity Limited to give you a complete auto-enrolment package exclusively available through your BDA membership.

Creative Auto Enrolment

Creative Auto Enrolment offers the only complete end-to-end solution in the market. Having already helped over 17,000 employers meet their obligations, their service is designed to be as simple as possible for you and your employees – so you can get on with what matters to you.

Guiding you through

We've also teamed up with AE Simplicity Ltd, a business founded by auto enrolment specialists with extensive experience in the world of workplace pensions.

Our partnership with AE Simplicity means they'll be on hand to deal with any queries during the set-up and installation of a scheme with Creative Auto Enrolment. Through experience, they understand the automated process doesn't come without wrinkles and needs human intervention. ◆

Dealing with clashes of personality

by Natalie Birchall
a Practice Management Consultant in the BDA Practice Support Team. Natalie advises general dental practitioners on associate contracts and a wide range of employment and other law.

Associates are in a special situation when it comes to other team members. Clinically they are the lead but they are not the employer or even the boss. It is important to recognise that all members of the dental team contribute to patient care in different ways. On a day-to-day basis associates will be responsible for leading the dental team during patient consultations and throughout the course of treatment. It is important that associates co-operate with other team members. Each role must be respected and valued. Associates should communicate effectively and share their skills and knowledge with other team members as necessary.

Personality clash

As in any team environment there are different types of personalities. This is a good thing in many ways because a variety of different talents and abilities will contribute to a more balanced workplace. But it can pose challenges too – different ideas or thoughts on how to approach certain issues will inevitably lead to conflict from time to time and I have often had calls for advice on how to manage team working issues in the practice.

Conflict can arise for many reasons. An associate may be frustrated if a particular team member is not pulling their weight or is failing to follow instructions. Not only will this cause an associate undue stress, it could also have a detrimental impact on patient care.

It can work both ways though. An associate may perceive a nurse or receptionist to be performing poorly but in fact it might be that the associate has unrealistic expectations. Perhaps the associate has a preferred method of working or a certain temperament that some team members have responded well to in the past but does not suit everyone. An associate's unwillingness to be flexible and adapt to the different personalities in the practice can lead to problems.

Similarly, we often hear of disagreements arising where, for example, a very experienced dental nurse who has been at the practice for a long time may criticise a new associate or disagree with their way of working. This can be very difficult to hear, but their point may be valid.

Look at yourself

First, any professional should give some thought as to whether they may have had some role to play in creating the tension. No one is perfect. If you think you might have been unreasonable at times or expected too much, perhaps a modification in behaviour or tone going forwards, for example, in how you give instructions to staff, may be all that is needed to resolve matters. Given the importance of harmonious working in practice, it is sometimes worth swallowing your pride to avoid a personality clash getting in the way of patient care.

If a change in manner does not work, or it is the other party that is the sole cause of the problem, then there are a number of things to consider. Is the other team member aware of the impact their behaviour is having on your working relationship? Sometimes individuals can be oblivious to the effects of their actions, particularly if they have been there a long time and the practice owner has never taken steps to deal with the behaviour.

Quick chat

A quick chat at a convenient time, perhaps at the end of a clinical session, to highlight any problems may be appropriate. You should not reprimand your colleague but try to resolve your concerns informally – if you can resolve things directly, but informally, without reporting them to the practice owner it will be much better for both of you.

Be specific about your concerns and avoid vague or accusatory comments like 'your work needs to improve' or 'your attitude is poor'. Instead, refer to one or two recent incidents and explain why you are concerned and give clear feedback on how you would like things to work differently in future. If this is the first time that you are having to raise this with the team member, it is important to ask them if they have any questions or concerns about things. It would be a good idea to ask them for feedback on if there is something you could do differently to help them. Keep the conversation light and always end on a positive note.

The employer

It is important to remember that an associate is not an employer of the staff. That is the practice owner, who has an employment contract with each staff member and who is responsible for conducting appraisals or any disciplinary issues. However, there is a contractual triangle of sorts here, since practice owners are contractually bound to provide their associate with appropriate support staff. If a difficult relationship is getting out of hand and informal attempts to resolve it have not worked, the practice owner or manager may need to become involved more formally. A mediated meeting between the practice owner, staff member and associate where each party puts forward their views and the practice owner seeks to identify a way forward may be a good first step. Ultimately if a formal performance management or disciplinary process is required, the practice owner will be responsible for that process. ◆

Information Governance Toolkit

by Juliet Irvine
Head of Operations for Advisory Service and also part of the BDA's NHS and Business Team where Juliet advises members on all aspects of NHS dental regulations and agreements

NHS practices in England have to re-complete the Information Governance Toolkit every year. With the deadline coming up on 31 March it is important that you do it in good-time as each year some practices find that there are niggles or snags that cause them problems when trying to complete it.

Yard stick

The Information Governance Toolkit is an online system – set up by the Department of Health – to enable organisations to assess whether they are handling confidential information properly. With lots of data in dental practices being sensitive it is important that you make sure you comply with the law and other official guidance. The toolkit is intended to help you see whether information is handled correctly and especially whether you and your team are taking proper steps to make sure it is protected from unauthorised access, loss, damage and destruction. Currently practices are only required to attain Level 2 compliance, however you must obtain at least Level 2 each year.

The system is also an important outcome that the Care Quality Commission (CQC) uses when identifying how well organisations are meeting their Fundamental Standards of quality and safety.

Review function

For those practices who achieved level 2 compliance last year, the task in hand for this year is a much simpler matter. Provided there have been no substantial changes to the practice or practice policies then the toolkit gives you the opportunity to simply review your evidence and publish the same evidence, on the basis nothing has changed. However, ensure you are on the correct version. For this year you should have moved onto version 14. But some practices (generally if you hit a snag in a previous year) may still be on an earlier version. If this is the case then your previous data and evidence of compliance may be wiped out when you try to renew. If you find that you are not on version 14 then contact NHS Digital on **0300 3034034** immediately.

On the toolkit work through each requirement in turn. Generally, for every requirement you must demonstrate compliance by uploading evidence under each sub-section. At the bottom of each of the requirements is a grey box setting showing '*Previous Level*', '*Current Level*', '*Target Level*' and '*Target Date*'. If you have completed to level 2 last year, you will now see there is an additional tab for '*Review*' in this grey box. Provided there have been no material changes in your practice relating to each requirement, all you need to do is reset the '*Target Date*' to 31 March 2017, and ensure the '*Target Level*' is set as 2. Then click in the '*Review*' box to tick it. Press Save and then continue to the next requirement. However, if there have been changes in the practice then you may need to upload new evidence.

Changes that should be evidenced with new documentary information are: new staff members, any change to your Information Governance lead, any substantial changes to how information is processed or kept for example.

Reviewing your assessment means you remain at Level 2 compliance for the forthcoming year. And generally, the review function means that your assessment can be completed much more quickly and efficiently without the need to upload documents this time around.

Staff training

Some evidence you need to show for compliance will be your staff's knowledge about data security and confidentiality issues. Previously you have been able to comply by getting staff members to use the Information Governance Toolkit Training Tool, however these webpages were taken down on 31 December 2016 and so are no longer available. Therefore if team members, say a new employee, require training in order to ensure compliance by 31 March 2017 you may need to look for alternative resources.

You can still rely on some of the Training Tool modules – if staff in the practice have undertaken one of the following modules in the last year: Introduction to IG, IG Refresher module, Beginners Guide to IG – then staff are not required to carry out any further training this year to be compliant. Also, whilst the new website is being constructed, if practices decide their staff require further training they can, in the interim, use the following Information Governance Toolkit documents as training material: The Work Book and The IG Essential PowerPoint. Both of these documents are available to download on the IG Tool website at www.igt.hscic.gov.uk ◆

Further information on re-completing the toolkit is available for BDA Extra and Expert members from the BDA Business Team on advice.enquiries@bda.org.

Aftermath of a negative appraisal

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

Negative feedback in staff appraisals is hard to give and hard to take. And what is more, studies have shown that employees do not respond well to having their flaws pointed out to them[1]. For some employees this may come as a complete surprise. It is not uncommon for some individuals to believe that they are performing very well at work even though this sentiment is not shared by colleagues and the employer. Or they may be resistant to change. An employee could leave the meeting upset and this is something you wish to avoid.

So, although appraisals are largely a positive tool to assist with the employee understanding how well they are performing at work, you need to take a measured approach if you anticipate giving feedback on poor performance. Remember, appraisals are not about telling your staff what to do or how to do it but about encouraging the best behaviour and a dedicated approach to doing their work. Here are seven points to help you turn negative feedback into positive outcomes.

Self-evaluation

Get the employee to think about it before the meeting. Ask them to fill out a self-assessment about their performance, work load and job satisfaction. An appraisal questionnaire provides structure to the appraisal meeting and allows both the appraiser and appraisee to consider any questions or issues before the meeting. It will help you prepare if you can see whether they have any concerns and whether they relate to the same issue as your concerns.

Objectivity

There is a difference between negativity, which merely belittles a person, and suggesting steps that can be taken to improve. You need to provide explanations why you find an aspect of their work to be unsatisfactory. Discuss this reason asking whether they recognise the situation. Look for viable solutions to help them address it.

Start positive

During an appraisal meeting the employer should ensure that they balance both the positive and negative feedback so the employee does not leave the meeting feeling too demotivated. It gives a bad impression to plough straight in with criticisms, better to start with a discussion of what they have done well or enjoyed about their work. You will also find that criticism has more weight if you have a general culture of reinforcing good behaviour by complimenting good work through the course of the working day.

However, contrary to the common perception, do not sandwich your critique with positive comments. This can sound as if the compliments are insincere and can confuse the message you are trying to convey.

When you need to move on from the positives, ask permission to give your concerns – perhaps along the lines of 'can I provide some feedback on how you are managing with the computer?' It warns them that you have something uncomfortable to say but also makes them more receptive as you are asking for their buy-in.

Be specific

You will only have negative feedback because of specific incidents that have caused you concern. Discuss actual events, providing as many details as possible and the reasons you find it unsatisfactory. Say how you have arrived at this view. This will help them relate to your concerns and they may be able to provide explanations for why it happened or be able to identify what could have helped them do better at the time.

Overcome obstacles

Offer solutions that can help resolve the problems. It is important that you clearly identify what you are looking for in their performance. Also consider the things that your employee says has prevented them from providing the standard of work that you wanted. Then discuss what can be done to resolve the situation and remove any obstacles to good performance.

Breathing space

Appraisals are also a valuable way to hear feedback from the employee about their job satisfaction and any training needs. It is a dialogue and the employer must demonstrate that they have listened to the employee's comments. Where difficult things have been said it may be necessary for both appraiser and appraise to digest them before coming to firm conclusions on the way forward. The appraiser should write up the performance review after the meeting but state that this is only a draft that the employee can comment upon before it is finalised and targets and an action plan is drawn up.

Action plan

The key aspect of an appraisal is to put in place a plan of action so that your employee can move forward. Not only will this be explaining standards of performance and setting targets for work in the coming year it must set out how the practice will help the employee achieve all of this. It may be that you need to provide mentoring to the employee, formal training, new equipment or dedicated time to accomplish a task. The aim of appraisals is also to retain staff. It is a two way dialogue designed to reinforce and strengthen the working relationship. ◆

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Take control

First there was Siri, then Hive, and more recently Amazon's Alexa. The digital age certainly is pervading your home life so it is perhaps not surprising that you can digitally take control of your surgery too. Tyscor Pulse, from Dürr Dental, ingeniously shows you the performance of your suction and compressor systems and is compatible with almost all Dürr suction and compressors units including the popular VSA 300s. Things such as current status, faults or maintenance messages, such as a prompt to change the filter, are immediately displayed on the monitor.

With Tyscor Pulse your practice equipment supply is always in view and can be accessed by engineers as well by you. The software will warn you if there is a malfunction, and will indicate whether the problem is something that can easily be rectified by a staff member or whether a service technician should be called.

If you can control your central heating from your phone and have a personal assistant called Alexa, who will perform various tasks for you and control various systems, shouldn't you have a little help at work too?

For more information on Tyscor Pulse visit www.duerrdental.com or call 01536 526749.

Bringing eye care back into healthcare

Dedicated to providing excellent patient care and dental treatment, Rodericks Dental is extending its services to bring eye care back into the healthcare setting.

It seems that too often these days, a visit to the opticians puts more emphasis on retail than healthcare. A trip to the opticians can feel more like shopping than tending to important eye conditions.

Rodericks is looking to change this by providing a combined healthcare solution for their valued dental patients that focuses more on their healthcare needs and giving advice on how to take care of their eyes.

The first Rodericks Dental Eye Care successful service was opened more than year ago from Buckingham House Dental Practice, with a second following last year in Luton House Dental and Eye Care. Providing the same patient-centred care the group has become known for in dentistry, Rodericks is excited to watch the service develop and open more eye care services in the coming months.

For more information visit www.rodericksdental.co.uk

Here to make your life easier

Carestream Dental strives to make your everyday life easier with each solution that it brings to the market.

Its latest offering is specifically for Denplan practices, who now benefit from a new integration between the CS R4+ practice management software and the Denplan/PreViser Patient Assessment (DEPPA) tool.

Without requiring a separate log in, you can view previous assessments or start new DEPPA examinations all from the clinical screens in R4+. For the latter, either the appropriate records will be automatically updated or new patient files will be created.

Patients can complete DEPPA questions on an easy-to-use Wacom tablet and receive a print out or an email copy of their examination (which is automatically recorded in the patient's communication tab).

This new integration is in addition to the previous benefits available to Denplan practices, such as automatic updates on Denplan patients, real-time review of fees paid and information on patients who have moved away but not updated their address at the practice or with Denplan.

To find out more about how to fully utilise your CSR4+ software for Denplan patients, contact the friendly team at Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk.

Buying your first practice management system

When buying your first Practice Management System (PMS) there are many potential routes to go down with suppliers both large and small, all wanting your business, so give yourself enough time to do your homework so you make the right decision. Your aim should be to 'buy' the system that you want and not just be 'sold a system' by a good salesman.

You can buy a PMS in various ways including ones that are Cloud based which work through web browsers and network based software running locally. Some turnkey suppliers also supply hardware which can be an advantage, otherwise you need to work with a separate hardware supplier and support service.

All the systems fulfil the same basic functions so it's the way it looks and how easy it is to understand that makes the real difference on a day to day basis so talk to other dentists about their systems and have a full demonstration from your chosen system suppliers. Then get quotes for the software and hardware with details of all other potential costs and ongoing maintenance charges so you can compare the total costs over three years.

Decide who you feel offers the best system and who you feel most comfortable to deal with – don't make it simply about cost – as you will be working with the company for many years a good working relationship is a key part of the ongoing partnership.

This information is taken from WYSdom's Buying Your First Practice Management System Guide. For further information visit www.wysdom.co.uk/getfile/6848.

Are you looking for verifiable CPD that will fit into your busy lifestyle?

A recent, pan-European study has revealed that as many as 41.9% of young adults suffer from dentine hypersensitivity.[1] Due to the often sporadic nature of the condition, patients may fail to mention it at the dental appointment. It therefore lies with the dental professional to identify this painful condition which can cause patients to avoid food and drink triggers they may otherwise enjoy and even neglect their oral hygiene.[2,3]

Discover the new interactive Sensodyne with NovaMin distance learner module. Through a series of short video clips and interactive activities, refresh your knowledge of this prevalent condition before learning more about Sensodyne's clinically proven innovation for dentine hypersensitivity treatment, Sensodyne Repair & Protect.

The module is free of charge, easy to use and available 24 hours a day. There's no time limit so you can complete the module whenever you like, in your own time and at your own pace. What's more, completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

Sensodyne Repair & Protect toothpaste with NovaMin builds a dynamic, hydroxyapatite-like layer over and within exposed dentine tubules.[4,8] It repairs your patients' dentine, to provide clinically proven sensitivity relief with twice daily brushing.[4,6] The robust NovaMin layer binds firmly to collagen in dentine,[6,9] and resists daily physical and chemical oral challenges,[4,6,8,10,11] helping to protect against future dentine hypersensitivity pain.

Visit www.gsk-dentalprofessionals.co.uk/pr to complete the module now.

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11. Wang Z *et al. J Dent* 2010; **38:** 400-410.

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Dentist to Dentist

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

East Anglia

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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

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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

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

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

DENTAL SPECIALISTS ST ALBANS

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

239826

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

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Q1: When did auto enrolment become law?

A Pensions Act 2006
B Pensions Act 2007
C Pensions Act 2008
D Pensions Act 2009

Q2: Which of these is not a way to turn negative feedback into a positive outcome?

A Objectivity
B Subjectivity
C Breathing space
D Action plan

Q3: What level compliance is required to comply with the Information Governance Toolkit?

A Level 2
B Level 3
C Level 4
D Level 5

Q4: How many female dentists were recorded in the UK in 2014/15?

A 12,185
B 11,285
C 11, 825
D 12, 815

Q5: In theory how many weeks are available for shared parental leave?

A Up to 40
B Up to 45
C Up to 50
D Up to 55

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