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January 2017

Managing a crisis

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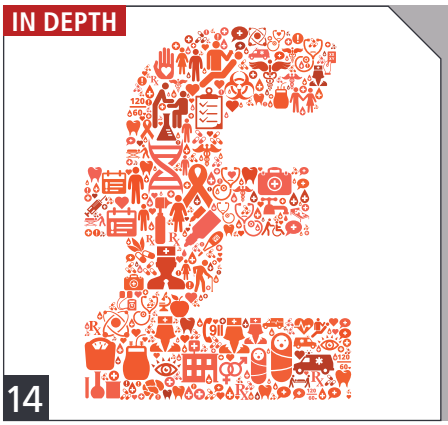

BDA
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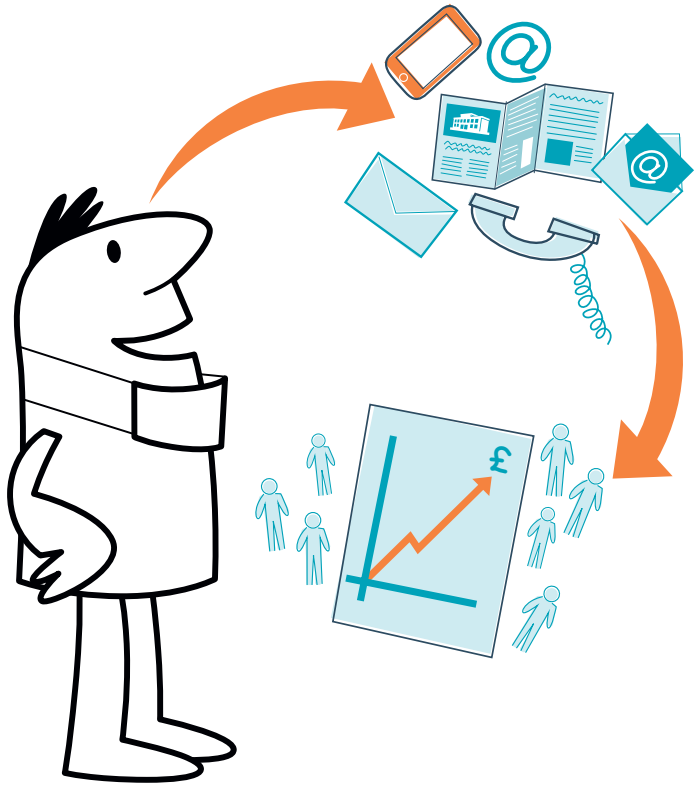
Does your patient marketing automatically **attract new patients** and **boost practice revenues?**



Let us show **you** how to do it

The fifth immutable law of practice performance is automating your patient communications, setting targets and monitoring your return on investment; ensuring time and money is spent only on what works.

Research shows that 89% of practices say they want to improve their patient marketing, yet 96% say they do not have the tools to do so, with 23% admitting to not actually having a plan. This latest Whitepaper includes **market research** and **best practice advice** that will help you **plan and deliver patient communications** that will **attract new patients** and **boost your practice revenues**.

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COLUMN

The cost of government indifference to dentistry

Paul Blaylock, PEC member

Do you recall reading the dental section of the Five Year Forward View, the current plans for developing the NHS in England? No? That's probably because the dental section doesn't exist. This government indifference to dentistry has a hugely negative effect on dentists and patients alike.

Dental public health messaging is inadequate, and even the encouraging sugar tax plans have already been watered down. The current GDS dental contract is recognised as deeply flawed, with activity-based targets which restrict dentists' ability to provide preventative care, manage high needs patients, and take on new patients. However, Prototypes are sharing increasing concerns about meeting capitation and activity targets, which will lead to financial clawback.

Our patients deserve a truly preventative-focused contract which allows dentists to concentrate on delivering optimum care, without fear of the consequences of missing arbitrary targets. The government must engage with the BDA to get contract reform correct. It is unacceptable that nearly 50,000 children per year require general anaesthesia for dental extractions, at a cost to the NHS of £35 million annually, which would be much better spent on prevention.

Alongside struggling contract reform, £170 million of government funding has been slashed from England's annual dental budget since 2010. This failure to invest has contributed to many areas of the country being unable to meet patient demand for NHS dentistry. Half of adults and one third of children fail to see an NHS dentist at least once every two years, so we are nowhere near universal access to NHS dentistry. Anyone who relies on the NHS 111 service to find a dentist will be sadly disappointed with the lack of appointments available in some areas, and there is a need to commission more unscheduled dental care capacity.

Patients are suffering as they fail to receive dental care they need, and pressure is building across the NHS. Patients are also being driven away by NHS patient charges which have increased by 5% this year to partially plug the government funding shortfall. The Adult Dental Health Survey found that 1 in 5 adults have delayed treatment due to cost, and patient charges are due to rise a further 5% in April 2017.

An increasing number of patients are going elsewhere with their dental problems. Each year 130,000 patients go to accident and emergency departments in hospitals at a cost of £18 million. A further 600,000 patients go to their GPs at a cost of £26 million annually. These are rarely the best places for patients to receive the urgent care they require, and many acute problems could have been prevented. The additional cost to the NHS from them not being seen regularly in practice is staggering.

The perceived cost savings from a lack of dental investment by government seem rather short sighted. The government must take notice before it is too late.

New figures show morale crisis threatens future of NHS dentistry

The BDA has reacted to new government figures showing that morale problems have left half of primary care dentists who treat NHS patients thinking about leaving general dentistry.

The report Dental Working Hours – Motivation Analysis collected survey responses from more than 6,000 self-employed primary care dentists across the UK.

The findings show that morale has fallen since 2012/13 across the UK nations.

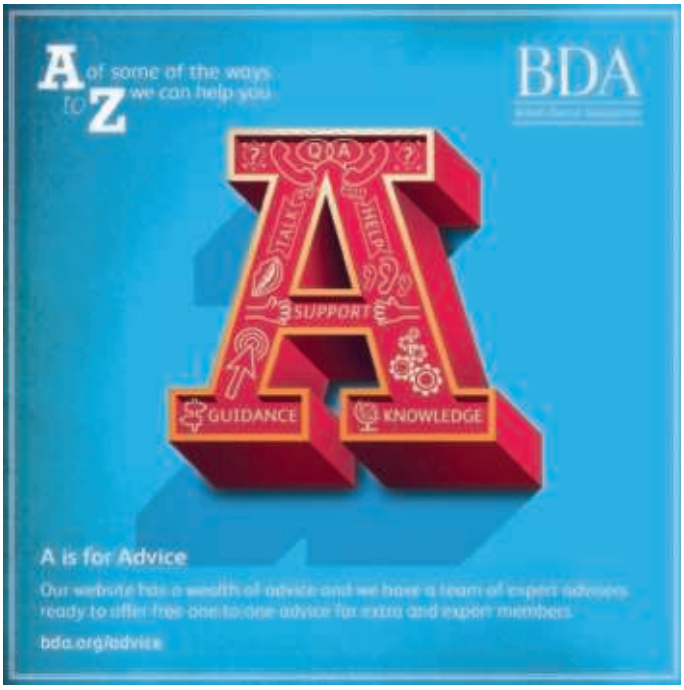
Taxable earnings for NHS dentists have fallen 35% in the last decade, while the costs of compliance have been estimated to have increased by over 1000%. The widely discredited target driven NHS contract introduced in 2006 in England and Wales is still in operation, with no clear dates for rollout of a replacement.

The BDA is currently engaged in a research project on burnout within the dental profession and dentists' well-being at work.

The BDA's Chair of General Dental Practice, Henrik Overgaard-Nielsen, said: 'A wholly avoidable crisis of morale has left half of all NHS dentists looking for the exit, and puts the future of the service in jeopardy.

'In every part of the UK we are seeing the same story. A collapse in earnings without parallel in the public sector, oppressive regulation, and contracts that fail both colleagues and patients are all taking their toll.

'Ministers can't pretend this problem will just go away of its own accord. We are already seeing access problems in certain areas. The government cannot delay needed reform until we get to the point where queues start appearing outside NHS practices.'



BDA considering legal action over patient charge deductions

The BDA has announced it is planning to mount a legal challenge on behalf of NHS General Dental Practitioners over NHS England's approach to deductions from patient charge revenue.

Since September the BDA has been canvasing its membership on the problems they have been facing with NHS systems. The deductions from patient charge revenue for over-performance and performance ruled non-contributory has emerged as a major theme.

The BDA has now taken senior legal advice, and is asking GDPs who feel they have been affected to come forward to form the basis of a potential High Court challenge.

BDA Vice Chair Eddie Crouch said: 'NHS England's heavy handed approach to patient charge revenue means many dentists suffer financial losses simply for providing their patients with needed care. So we have taken legal advice about the legitimacy of their approach, and our lawyers say there is a strong case to be made.

'So we are now reaching out to all practitioners who have lost out on income they have legitimately earned. We need individuals who are prepared to have their cases argued in court, in order to establish the principles which may subsequently form the basis of challenges which could be worth many millions of pounds.

'We've already been able to secure concessions from NHS England for the manifold failures by Capita on performer lists our members highlighted. Over 500 foundation dentists who faced having to stop working at the start of December, can now continue. Claims that would have fallen foul of the two-month rule due to slow performer attachments are now being permitted.

'We're making progress, but there is so much more we can do. I urge all BDA members to raise this issue with colleagues, and encourage them to share their experiences.'

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

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BOOK REVIEW

Happy at work?

Unlocking happiness at work
Jennifer Moss
Kogan Page, 2016
ISBN: 978-0-7494-7807-0
£14.99

The sub-title of this book reads 'How a data-driven happiness strategy fuels purpose, passion and performance'. But the 'data-driven' phrase is somewhat ambiguous as it would be more accurate to describe this as evidence-based since author and happiness expert Jennifer Moss ensures that her arguments are scrupulously and frequently substantiated by real-life examples. The rationale for her methodological approach is outlined in fellow happiness expert Shawn Achor's foreword where he states: 'using data has allowed us to get past the mental or intellectual barriers that people can have. People who believe that happiness is soft are prejudiced.'

Happiness can be a major driver in terms of positive thinking, improved productivity and job satisfaction. Building communities, resulting in friendships within the workplace, is a significant factor but also will serve to prevent negative feelings of isolation which can be serious health risk factors.

Another practical route to happiness at work is to develop positive habits that stick, and Moss provides a model for this in the form of the acronym PERSIST (make your habit Practical, Repeatable, Incremental and Targeted). Happiness can also extend to the overarching ethics of a business and Moss explains that corporate social responsibility has moved on a stage to what is now known as 'conscious capitalism', encompassing not merely actions that further some social good but also those taking a holistic approach to defining success, the metrics of which are, crucially, not all financial ones. Happiness can also be encountered in a happier approach to change, traditionally always an activity engendering potential distress. Change can be a stressor but will be successful if the participants learn to love new ways of behaving and new routines. Whilst not necessarily easy, it is possible and it does work.

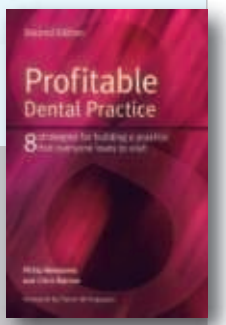
There is plenty of evidence given in this two hundred page paperback both within the chapters and also in a ten page appendix of references. But ultimately it's all about choices and as Moss concludes, 'if you want to be happy, be.'

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

BOOK REVIEW

Get in the black

Profitable dental practice – 8 strategies for building a practice that everyone loves to visit (2nd edition)
Philip Newsome and Chris Barrow
Radcliffe Publishing Ltd, 2014
£29.99
ISBN: 978-184619-777-2



Ten years after its first edition was published, this useful vade mecum for dental practice management has remained relatively unchanged. There are however a few tweaks scattered throughout the text but the most noticeable updates to its 2004 predecessor occur in the preliminary pages entitled 'Introduction: the changing face of dental practice.' Here the authors include references to newer legislation. This is also reflected in this chapter's reading list which contains some more recent references.

The overarching structure of the book however remains the same with successive eight chapters revealing eight strategies respectively. These cover a veritable panoply of actions designed to turbo-charge the management of the practice. First discussed is the need to construct a three-year vision and this is closely followed by the need to find time to plan. The third chapter stresses the importance of control of finances and the fourth chapter emphasises that an irresistible practice can only be realised by an irresistible team and therefore it's vital to lead a 'championship support team'. The next two strategies focus on the patient, specifically in terms of delivering world-class customer service and also refining one's selling skills , not – it should be emphasises – for profiteering purposes but rather in delivering five star services and helping your clients to purchase them.

Two concluding short chapters cover creating a low-cost marketing engine (with suggestions such as business networking and creating a new client welcome pack) and finally the importance of maintaining a healthy work-life balance. At the end of the book there is an appendix of self-assessment tools and a subject index. ◆

Presents from patients

In the build-up to the festive season, a Dental Defence Union (DDU) survey has revealed some of the more unusual presents patients have bought their dentist for Christmas.

Alongside chocolates and other edible gifts (87%) and alcohol (40%), one dental professional was given a pig's head, while others received a pheasant, a puzzle and homemade Christmas decorations.

DDU dento-legal adviser David Lauder said: 'General Dental Council guidance states that dental professionals must refuse any gifts, payment or hospitality if accepting them could affect, or could appear to affect, their professional judgment.

'It may be advisable to ensure the patient understands their dental care would not be affected in any way by the gift. You may sometimes want to keep a record of these conversations, any correspondence, and the reasons for accepting the gift, if you did so.' ◆

GDC still has mountain to climb on Fitness to Practise

The GDC must not to be distracted from fixing its Fitness to Practise function, following the latest report from the Professional Standards Authority.

The report shows that while the GDC has shown improvement this year, it has failed to meet standards 4, 8 and 10 on Fitness to Practise, with issues raised on the review and prioritisation of complaints, the quality of final decisions, and the secure retention of information on cases.

BDA research has found that many GDPs identify anxiety over complaints and Fitness to Practise as a common source of stress.

BDA Chair Mick Armstrong said: 'The General Dental Council has a mountain to climb to cast off its reputation as Britain's least effective and least efficient health regulator.

'This profession acknowledges signs of progress, but the GDC has no grounds for complacency. Today a dentist is still expected to pay more than any other healthcare professional for a regulator that still cannot provide an adequate fitness to practise function.

'There can be no room for distractions, pet projects or mission creep while the dental regulator remains incapable of delivering on its fundamental purpose.' ◆

©Peter Dazeley / Getty Images Plus

Navigating your way through a crisis

By David Westgarth,
Editor, *BDJ In Practice*

There are two types of accident; there are those waiting to happen, and there are those that, despite every effort, cannot be prevented. The latter often comes without warning and can be difficult to negotiate your way through.

Dig a little deeper and you often find the former of these issues relates to human intervention. Safety procedures not followed, paperwork filed in the wrong place, notes not up to standard – all of these examples have someone not doing something, or doing something incorrectly, right at the heart of the matter.

The same can be said when a crisis bestows itself upon a dental practice. It could be because someone drove through every red light in the practice, and it could be because someone smashed into you whilst parked on the street. Either way you look at it, it's how a practice responds that defines their future.

It's not all doom and gloom. Quite the opposite. Dentistry does dentistry very well. You just need to look at the latest Care Quality Commission (CQC) State of Care report, which shows dental services in England topping the league in providing high quality care. Community dental services were found to be offering the highest quality of care in the community services, with five services out of 29 (17%) achieving an outstanding rating and 20 (69%) achieving a rating of good. The quality of care for other three core community services was 70% of services being given a rating of good or outstanding.

Of the dental practices inspected in 2015/16, the CQC found that 90% complied with the regulator's five key tests: Are healthcare providers *safe, effective, caring, responsive* and *well-led*?

100% of inspected practices met the tests for 'caring' and treating people with compassion, kindness, dignity and respect; and 99% were found to be 'responsive' to their patients' needs and preferences and 'effective' in achieving good health outcomes.

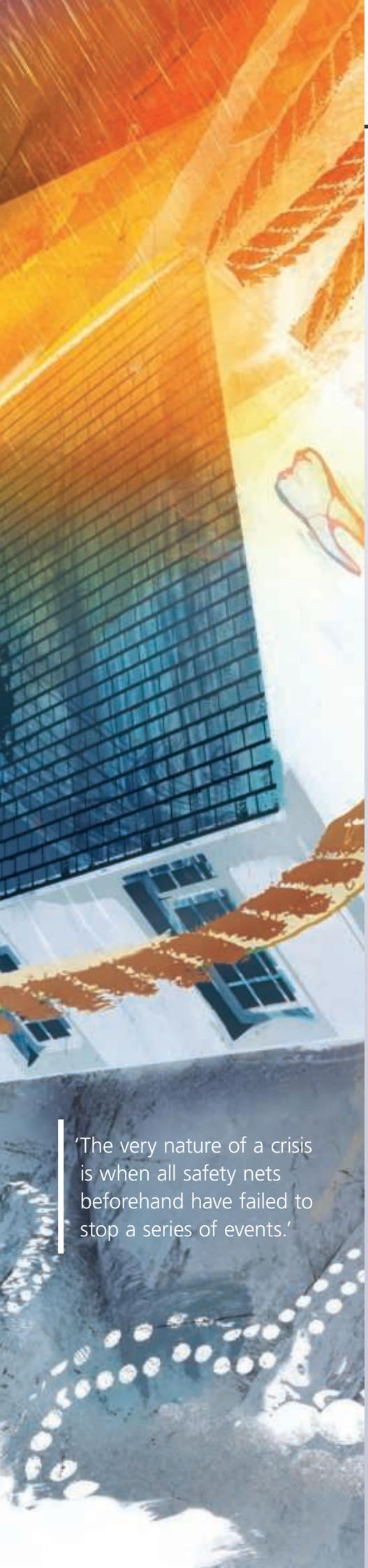
Community dental services were also found to be offering the highest quality of care of all the community services, with 86% achieving a rating of good or outstanding, compared with 70% for the other three core community services.

The regulator confirmed once again that dental practices, compared to other sectors, present a lower risk to patient safety. In April 2015, this low risk prompted the CQC to move to a model of inspecting just 10% of all practices each year.

But then again, the very nature of a crisis is when all safety nets beforehand have failed to stop a series of events.

So what happens next? What do you tell your patients? Do you even tell your patients? What do you tell your staff? What if the practice owner or manager is suspended? Who takes over? James Goldman, head of Employment and General Advice at the BDA, believes reassurance starts at home.

'Staff will likely be curious and scared, so it is important to keep them informed of what has happened and what action the practice intends to take right from the outset. It's about managing expectations. It is better that they get correct information from the practice than spread unhelpful and inaccurate rumours.



'The very nature of a crisis is when all safety nets beforehand have failed to stop a series of events.'

Reassure staff that it should not affect them, but you should also warn staff that there may be local press interest in the story and that some reporters may not be as upfront as they would like. Don't say anything to anyone in public about this as it could lead to bad and unfair stories about the practice in the press.'

Replacing leadership

The difference between losing a member of staff and a leader in the practice has the potential to cause significant disruption. Losing a front-line worker – an associate, for example – may result in rescheduling patient appointments, disgruntled patients and even losing patients.

Losing a practice owner or a senior member of staff is another matter. CDO for England, Dr Sara Hurley, has often spoke of the need to develop leaders in dentistry. I asked Bob Hughes, regular *BDJ In Practice* columnist and CEO of the Forton Group, how leadership can be replaced.

'The easy answer is of course to plan ahead' he said. 'Well prepared organisations have succession plans in place, either for all senior positions or at least for the critical roles. If an organisation has a number of similar roles, they will often have a pool of potential successors matched to a group of suitable roles. These succession plans get reviewed regularly – at least annually and ideally quarterly. This is done at a senior level – either the board or a senior committee.

'The trap people often fall into, especially if the succession planning hasn't been done well, is to assume that you need to almost have cloned the leader. There's a huge assumption there that the only way to do that job is the way the current incumbent does it. The truth is more complex than that – we all have our own style of leadership, and two people with different approaches have the potential to be equally successful in the same role.

'Depending on the size of the organisation, another approach is take someone of the same seniority and move them sideways – their experience at working at that level may be more important than the experiences in that specific field

'Organisations need to address the 'Myth of the Hero Leader'. Just because the figurehead has gone, it doesn't mean you are doomed. If the person who left was very charismatic, you may believe it is going to be tough to replace them. However, on closer inspection, you may find the team contributed more to the success than you at first thought. Look at different ways of providing leadership – what would happen if you let the team lead themselves, with a nominal person to go to for support?

'There's an interesting trend in some organisations where the people choose their own leader – a trend I am watching with great interest.'

The very nature of a crisis however means someone can often be thrust into an unfamiliar position. So what kind of person does it take to make the role a success?

'Organisations in crisis do need a leader who can support them through that. Depending on the organisation, that might require emphasis externally or internally – do you need to reassure your workforce or the external stakeholders? Also, you need to know what caused the crisis – if the management team were the problem, then putting one of them into the role will be counterproductive. However, overall, the leaders who get parachuted in to save organisations are usually much less successful than those who rise up through the ranks.

'In any event though, I don't believe there is a single model of leadership or a single set of qualities that should prevail, and we need to watch out for the same biases that may lead us to appoint the classic turnround person or the crisis manager. One example is the leader Britain chose after the Second World War; we had the charismatic figure of Churchill during the war. You might have assumed he'd be the best pick for the peace – or certainly a leader with a *ra ra* style, visionary, optimistic, outgoing. In fact, Atlee took over and was very successful. He had none of those obvious qualities and yet proved very effective.

'One of the biggest misleading traits is charisma. There is no correlation between the charisma of the leader and success. There is, interestingly, a huge correlation between charisma and salary.

'What is becoming more apparent, partly as our awareness evolves and partly as the world of work changes so rapidly, is that emotional intelligence is much more important than intellectual intelligence. The emotionally intelligent leader is more self-aware, is able to manage their emotions more effectively, and hence have a greater understanding of the emotional tone around them, and be able to influence that. And when I say manage their emotions, I don't mean supress, I mean be at choice over their emotional responses. We fool ourselves that we make decisions on a logical, fact based, approach. The truth is we chose on emotions and then use the facts to justify our decision. Some attributes of an emotionally intelligent leader are empathy, resilience, adaptability and conscientiousness. For people

who are curious, it is possible to measure, and then develop, your emotional intelligence.'

Telling patients

Notifying patients when a dentist is struck off is not necessary under the NHS contract, but patients often ask to see a particular dentist. 'Clearly if a patient asks to see the struck off dentist the owner will have to consider what they think is best to tell the patient', James added. 'Whatever course of action, you should always take into account the GDC's Standards for the Dental Team and the professional duty of candour'.

The time where you might need to pro-actively notify individual patients in more detail is where the dentist has been struck off for patient safety or clinical issues. In such cases it could be covered by the statutory duty of candour – where a 'notifiable safety incident' occurs there are fairly strict rules to follow. What this would cover is fairly complex but in summary an incident which might result in:

- The patient's death; or
- Severe harm, moderate harm or prolonged psychological harm.

Examples of where the statutory (as opposed to the professional) duty of candour could be triggered are difficult to be precise on but could possibly include instances of overdose of midazolam during conscious sedation that has resulted in hospital admission and/or the use of paramedical services.

If the dentist is struck off for an incident that falls into one of the above and patients have not already been notified by the dentist then the practice owner must inform the patient (or the representative, in the case of a death) and provide an account, which to the best of their knowledge is true of all the facts known about the incident at that time.

'Although this scenario is usually reserved for the more serious issues, it is something the practice owner should be aware of', James said.

Tell staff what they can say if anyone asks them about the dentist being struck off. There may be people phoning the practice to ask about it, and people who phone up asking for appointments with the dentist. Make sure there is a simple, agreed response for the receptionist, and that someone is at hand to answer more difficult questions; or more difficult people. You should prepare a short, simple statement for the press; in case anyone calls. Depending on the problem that gave rise to the suspension, you may want to take some advice about what to say in any statement to the press.

> 'It is always best to think about possible responses and best-case/worst-case scenarios in advance than when under the pressure of an actual crisis.'

A strategy

Like all good businesses, regardless of the apparent risk, it's always good to have a plan in place. Chris Baker from Corona Design & Communication, discussed the need for dental practices to have something in place for if the worst happens.

'At the risk of being flippant, don't find yourself in a crisis without a crisis management plan in place', he said. 'It is absolutely vital for any business or practice – large or small – to have a plan in place. If you don't prepare then it is likely that you will incur greater damage. Your organisation needs a plan, a chain of command and the right people speaking to the various media.

'Once in the midst of the crisis, the first mistake is often that people react without adequate information. People have a tendency to shoot first and ask questions later. However, you do need to be quick to respond, be accurate and be consistent. It may be that you can release a 'holding statement' that allows people to know you are aware of the problem and are taking steps to deal with it.

'Even if you have a comprehensive plan in place, the crisis itself is the first step that you cannot take in advance. If you haven't prepared in advance, your reaction will be delayed by the time it takes you, your team and perhaps hastily hired consultants to run through pre-crisis steps. A spur-of-the-moment created crisis team is never as efficient as one planned and rehearsed in advance.'

The increased safeguarding responsibility – not just within dentistry – means for many people healthcare professionals are viewed as safe havens. This is why negative stories in the press concerning healthcare professionals – be it individual or business – may leave a lasting impression on patients. According to Chris, healthcare crisis management is likely to be related to human error which is traditionally perceived to have a high level of responsibility for the crisis (as opposed to say, a freak weather event). So does he think healthcare needs to tread more carefully during a crisis?

'Yes, absolutely. There's no doubt that healthcare crisis management does need to be better than other sectors to reassure the public. The public look upon healthcare professionals as safe and caring. Unlike many other sectors, healthcare does have the problem of sometimes being a 'life or death' situation and even if it doesn't always reach this magnitude, our health is important to us in the way that a faulty smartphone isn't. A healthcare related crisis is likely to impact upon public safety and not just the reputation of a multi-national.'

With reputations on the line, being clear in how to navigate through a crisis is a fundamental principle in retaining any semblance of reputation. To that effect, effective communication is what good crisis management is all about. The crisis management plan that you have in place should identify those persons involved in the communication and the audiences that they are communicating with.

'Time should be taken to appoint the right team members', Chris explained. 'Good written communicators may not be the right people to speak to radio and television. Those who are good in front of the camera may not have the right tone for social media.

'Monitoring and notification systems for all the channels and audiences that you are wishing to communicate with need to be set up. Again, this would be done before any crisis occurred. Consider, who are your audiences? Maintaining an informed workforce helps ensure that business continues to flow as smoothly as possible. It can also minimise any internal rumours. Externally, it is key that your patients, suppliers etc. hear about the situation from you and not a third party.

'Finally – and a really important point for me – be as honest and open as you can be. If you aren't, you are likely to add fuel to the flames as your audiences become annoyed with a perceived lack of transparency. The more you hide and the more you deny, the worse things will be if – inevitably – they come out in the wash.'

A critical component of any crisis management plan is the establishment of a

succession plan. It must be clearly outlined what the necessary steps are if a key member of staff becomes unable to perform their duties. This all goes back to a clear chain of command and the team having the right training to undertake their own duties and perhaps those of a colleague should it become necessary.

'It depends on the size of the practice how you should go about implementing a chain of succession', Bob said. 'Ask yourself if it is feasible to be growing leadership from within, or does your succession plan need to be broader – do you need to be looking at your network outside the practice and include external people in your plan?

'In any event, step one is to identify the roles that are critical. The ones that if that person left tomorrow, what would the impact be? Needless to say, the bigger the impact, the greater the need to plan. It's also important to look at the whole team - it's often the people behind the scenes we miss the most

'Of course, key to all this is having great leadership to ensure high levels of engagement and hence reduce the need to have to worry about people leaving in the first place.'

According to Chris, the key is in the foresight.

'Anticipating these things – through succession plans for instance – could go a long way towards getting you in a good place to address immediate concerns. With thanks to Donald Rumsfeld, there are known unknowns and unknown unknowns. One needs to anticipate what might go wrong. If you and your appointed crisis management team regularly consider this (I would recommend annually), it is quite likely that a number of potential crisis situations can be avoided, simply by modifying existing systems.

'It is always better to think about possible responses and best-case/worst-case scenarios in advance then when under the pressure of an actual crisis. Thinking clearly under pressure is significantly easier to do if you have thought about scenarios, outcomes and assigned responsibility beforehand.'

After it's all blown over

This is when an organisation needs to review what was done well, what was done badly and what could be done better next time whilst planning for 'next time' never to occur. At this point there is also likely to be a good deal of 'reputation repair' taking place and depending upon the nature of the crisis, this could go on for some time.

'Often during a crisis, organisations promise to provide additional information', Chris added. 'The crisis managers must deliver on those promises or risk losing the trust of audiences who want the information. You don't want to have to answer further questions from patients who you previously promised to keep informed.

'It's imperative you release regularly and timely updates on the recovery process, any corrective actions, and/or investigations of the crisis. The amount of follow-up communication required depends on the amount of information promised during the crisis and the length of time it takes to complete the recovery process. That might not happen overnight. Reputations take months and years to form and only minutes to destroy.'

A crisis isn't meant to be easy – that's the very nature of the beast. But with a little bit of planning and a splash of luck, you can come out of the other side in tact. ◆

Out of 967 dental care inspections conducted by the CQC:

- 100% of practices were found to be caring, where staff involve and treat people with compassion, kindness, dignity and respect
- 99% responsive, where services are organised so that they meet people's needs
- 91% well lead where leadership, management and governance of the organisation assures the delivery of high-quality person-centred care, supports learning and innovation, and promotes an open and fair culture
- 95% safe, where people are protected from abuse and avoidable harm
- 99% effective, where care, treatment and support achieves good outcomes, promotes a good quality of life and is based on the best available evidence
- 874 (90%) required no action, and just eight (1%) required enforcement action

Teamwork

Bob Hughes,
CEO of the Forton Group

As a leader, once you've created your vision and started to plan how to achieve this, you are going to need a group of people can help you deliver it. Of course, there are examples of solitary individuals making a difference in the world through individual contributions. However, especially in an increasingly complex and interconnected world, it is more usually the case that achievement happens because of a well-crafted team working together under the guidance of an effective leader.

I am writing this article from an apartment in New York. When I look up from the keyboard, I have a great view of the United Nations building overlooking the East River. We have the good fortune to be working with the UN, training a cadre of internal leadership coaches to support the organisation. I am struck by the great achievement of the world leaders raking through the ashes of the Second World War and finding the nugget of an idea that was crafted into the United Nations. Although flawed in many ways, few can doubt the scale of that achievement. Every day, teams of people made up from many disparate nations are working hard to find consensus and compromise in order to deliver on a truly global scale.

Last month, I wrote about empathy and the need to understand others, to see their viewpoint. This is an important prerequisite to the behaviour I want to address this month, which is teamwork. I'm sure we can all agree that teams that work well together are more likely to deliver than those that don't; I'm not saying you have to be bosom buddies with everybody you work with, but the natural common cause and the desire to achieve is a necessary part of an efficient team.

Great teams don't normally just emerge. They are built. Whilst every member of the team will contribute in some way to the success of the building of the team, the main responsibility lies on the shoulder of the leader. They are the focal point, the decision-maker on the team membership, the glue that holds the team together and the one who notices the creeks and wobbles

that inevitably happen and tries to keep them together.

The timing of my visit to New York has been interesting. It is a week since the election of Donald Trump as the 44th President of the United States. The news programmes are full of speculation and reporting on the makeup of his new government. The change in personnel at the top following the election of a new president is huge – around 4,000 political appointments have to be made in around two months. Here in the UK, there are a few dozen posts that change hands when a new Prime Minister is elected.

The first step in the USA is to create a transition team, a small core team who will be responsible for those appointments, as every other aspect of the handover as well. Some of the key posts, such as Secretary of State, are also decided now. Of course, what I'm seeing through the news is bound to exaggerate the difficulties because that is more newsworthy. However, it seems apparent that infighting amongst colleagues jockeying for key posts and settling old scores is taking priority over getting the best team. The vested interests of a small core are being satisfied at the expense of healing what is clearly a divided nation. In contrast, I remember reading with interest a book about Abraham Lincoln called *Team of Rivals*. When he stood for president there were four other runners for the nomination. When he was elected, he appointed all four of them to senior positions in his cabinet rather than just relying on his personal favourites.

Great leaders select the best people for the roles bearing in mind also their ability to work well together. That is different from all being the same – diverse teams achieve better results than a group of like-minded individuals. However, the leadership behaviour we describe here is teamwork is much more than just that initial team creation. The role of the leader is to continue to develop the team and encourage them to interact creatively.

I was once asked if I could do one thing in an organisation to improve its performance, what would that be? I said they should surgically remove the egos of the leaders. Just because you are the leader of the team doesn't mean that all the ideas must come from you.

The negative manifestation of this behaviour is seen in those leaders who close down the team members, stopping ideas and imposing their own. I was in a meeting once with one (short lived) boss who started by asking us what we thought. After about 20 minutes, he brought the discussion to close and told us all what we were going to do. This bore no resemblance to any of the things that we had been talking about; we could only conclude that he been on a course where he'd been told to canvas opinion, but must have left the course before they told him to seek consensus and compromise.

Our leadership model includes a principal we call 'Accept, Blend and Create'. It's based on the world of acting improvisation, where they talk about 'yes, and'. How often have you heard people, when a new idea is floated, say 'yes, but…'? Or even 'no, but'. Using this principle, the leader's role is to accept what is being said, to blend it together and create something new and better than any one individual idea.

The leader's role is to manage the interaction and actively facilitate everyone's involvement. As a leader, you may be able to see patterns and connections that arise from the discussion. But if you don't see them you should encourage others to. The power of teams is unleashed when the combined minds work in harmony.

> 'Great leaders select the best people for the roles bearing in mind also their ability to work well together.'

Now, that's not easy, especially when the discussion is around something you're passionate about and indeed knowledgeable about. You have great ideas and are impatient to tell everyone your thoughts. That' great, but that's about your ego.

There are several ways you can self-manage here; it requires some discipline. One approach is to stop talking too much and invite everybody to participate, then sit back and listen. Truly listen, without prejudgement, without just listening to the voices that support your initial thinking. Keep an open mind – a beginner's mind. It's often the newcomer to the team who can provide a valuable perspective – how often have you heard someone ask 'Why do you do it that way?' It's easy to dismiss that voice, but next time, listen, and see if they are pointing to an established method that truly works, or merely a custom that has past it's sell by date.

It's also important to be sure everyone has a chance to contribute – in their own way and in their own time. Carl Jung talked about extraversion and introversion. He didn't mean it in the colloquial way we now use the terms introvert and extravert – it's more about where we get our energy from. Introverts draw energy from the inside and extraverts take it from external sources. An extravert will often think out loud – talking as they think. An introvert is more likely to compose the thinking in their head and only be willing to talk when they have it fully formed. Most groups of people will have someone in there who is the deep thinker, who won't talk as they think, who needs time and space to express their views; in a free for all they won't get heard.

Having an external facilitator can be even more useful – especially if you give them permission to shut you up!

Increasingly, leaders use a team coach, a role which is more than just a facilitator. The team coach will be effective in supporting he team to achieve their goal. However, they will also be concerned with the spirit of the team – how they are interacting and who they are evolving into as a team, not just what they are delivering. The team coach will support the team to learn and grow together, enabling them to repeat success through changing behaviour, resulting in repeated achievement, rather than just a one-off success.

When leaders fully involve the team, when they get shared ideas and concepts, created from the entire team, then several benefits ensue. Firstly, people feel involved and have a sense of ownership, shared responsibility for the way forward. When they feel that way, people tend to over deliver and do it sooner than you anticipated – because they see it as theirs too.

Secondly, the ideas created are usually more powerful and more creative. There is a myth that creativity and invention are often the product of the solitary genius. This is rarely the case – teams that are led well are more creative. There's a good book on this called *Myths of Creativity* by David Burkus.

Finally, it takes a huge load off the leader – you no longer have to feel responsible for being the driving force behind everything.

The great leaders know how to harness the power of not just one team, but interconnected, interacting teams. They strategize towards that, they create processes and systems that encourage co-operation. And they reward these behaviours, knowing these are the only way we can create sustainable ad tangibly better leadership. ◆

It's a pain in the neck

Dr James Tang, CES, MBA, BDS, LDS RCS GDP, NASM Corrective Exercise Specialist, is a Level 3 Personal Trainer, Sports Nutritionist and Level 3 Sports Massage Therapist, with special interest in postural dysfunction and lower back problems

We live in an age of inactivity and repetitive motions. This is particularly true for dental professionals. Dentists commonly experience musculoskeletal pain during the course of their careers. Pain occurs not only in their lower backs, but also their necks and shoulders. Such symptoms do not occur overnight; they develop almost imperceptibly at first. Then, they become increasingly obvious. You may not be suffering from these symptoms at present but prevention is always better than cure and the earlier you recognise the causative factors, the earlier you can start a prevention regime thus preventing the possibilities of long–term injuries.

Why is neck pain common amongst dentists?

Dentistry is well known to be a stressful job; dentists are constantly under a tremendous amount of time, administrative and financial pressure. The situation is worsened with the burden of detailed record keeping, increase in patients' expectations and the likelihood of complaints. When you are stressed, you automatically tense up in the shoulder and neck region. Whenever you tense up, you extend the cervical portion of the spinal column forward. If you are depressed, you hold your head down and become too relaxed in this area. These positions can cause muscle imbalances ultimately leading to musculoskeletal neck pain or even spinal disc problems.

Causes of musculoskeletal neck pain

The main culprit relates to the operative position of the dentist's head. The human head is, on average, 8–10% of our total body weight.

Maintaining the 'natural' cervical lordosis is important but unfortunately, in an effort to achieve a direct line of vision into the oral cavity, dentists are often required to lean forward. Forward head postures are therefore common among dental professionals because it is only possible to perform dentistry in a 'neutral' position if one carries out treatment using a surgical microscope.

In neutral position, the spine is supported mostly by the vertebrae resting on top of one another. By holding the head and neck in an unbalanced forward position in order to gain better visibility during treatment, the spine increasingly depends on muscles and ligaments to maintain an upright position. For examples, the upper trapezius and erector spinae must contract constantly to support the weight of the head in the forward posture. This results in development of trigger points in these muscles leading to predictable referral pain patterns – such as the tension neck syndrome characterised by headaches and chronic pain in the neck.

Practical advice on how to reduce the risks of neck pain

If it is not possible for you to provide dental care in a balanced posture, what can you do to minimise the damaging effects of prolonged torque resistance?

Improvement of your work postures

Firstly, it is important to get to know your habitual head posture (start by watching yourself in front of a mirror or even videoing yourself) at work in particular and probably outside work. Correct it consciously in your everyday routine until the proper posture feels 'normal' by learning to transform your harmful habitual postural patterns into healthy ones. You can do this by consciously thinking about your posture and by applying your new knowledge until the new posture

and movement patterns become established as a norm.

Improvement of work ergonomics

Furthermore, regarding work ergonomics, selection of a good operator's chair can help you to maintain a neutral spine whilst you sit. But it is still advisable to avoid prolonged sitting which can lead to tightening of your hip flexor group of muscles and weakening of your glutes due to reciprocal inhibition. The gluteal muscles are important for pelvic stabilisation and their weakness can lead to synergetic dominance of the synergist muscles of the back predisposing to lower back pain.

It is also advisable to adjust the operative position to a comfortable level because if your chair is too low and the patient's chair is too high, this causes you to elevate your shoulders. Alternately, if your chair is too high and the patient's chair is too low, you'll have to flex your neck excessively, both scenarios could lead to neck pain.

Always try to maintain an upright posture, maintaining the nature thoracic kyphotic and lumbar lordodic curves. For instance, by positioning your chair closer to the patient, you can minimise forward bending over the patient's head. Your head can be as heavy as a bowling ball, and when you lean and flex your head forward, you force your neck extensor muscles to work excessively to hold up the weight of your head. It is also important to position the light beam so you don't have to strain your neck excessively when you look into the patient's mouth. Position your instrument tray close to you so that you do not have to overextend yourself to reach for your handpieces or instruments, thus putting excessive stress on your back, shoulders, and arms.

Alternate work positions between sitting, standing, and side of patient. Switching positions allows certain muscles to relax while shifting the stress onto other muscles.

Furthermore, it is advisable to take frequent breaks, especially if you have to sit for a prolonged period of time, even if it is only for short period of time, to get up and move around or even do simple exercises such as retracting your scapulae as you await anaesthesia, setting of materials, etc.

Lifestyle changes

Choosing supportive cervical pillows is very important since we spend about a third of the time of the day sleeping. This time can be used to help your neck posture with the proper neck pillow support. Pillows that are too soft and too large can cause problems. To support your neck, your head should rest on a small, hard pillow. Furthermore, to avoid neck and back pain, it is important to select a good mattress that supports your body, is elastic at every point and does not sink in under the pelvis, shoulder or head.

> 'You may not be suffering from these symptoms at present but prevention is always better than cure'

Practical advices for dentists with neck pain and forward head posture

Exercises are important because inter–vertebral discs contain no blood supplies and they derive their nutrition by diffusion caused by compression and decompression. The longer you sit or stand without moving or changing your posture, the worse this is for the disks.

At this point, it is important to emphasise that you should properly warm up your entire body prior to any exercise and stretches – this ensures that all your muscles, joints, tendons and ligaments you want to train are well–supplied with blood and adequately prepared. A warmed–up muscle is more 'elastic' and a loosened joint (one that is adequately lubricated with synovial fluids) are able to handle more stress and are less susceptible to injuries. It cannot be over emphasised that corrective exercises should be performed in a pain–free range of motion. If you experience pain when performing these exercises you must consult your exercise professional, doctor or physiotherapist.

Strengthening exercise for the deep neck flexors:

- Since weaknesses of the deep neck flexors is commonly associated with neck pain (similar to weakness of the transversus abdominis is commonly associated with lower back pain), there are a number exercises that can be done to re–activate these tiny muscles. It is important to be aware that it is the forward head posture that contributes to deep neck flexor weakness. For this reason, apart from doing strengthening exercises for the deep neck flexors, it is imperative to develop good postural habits for the normal function of the neck and shoulder girdles
- Neck flexors can be activated by simple head nodding motions (chin–tucks), i.e. by moving the chin closer to the thyroid cartilage ('Adam's apple'). This can improve both the strength and endurance of these deep muscles which can improve your posture, the biomechanics of your neck, shoulders and upper limbs
- Teaching points of chin tuck: Stand against a wall so the retraction of the head is just until it touches the wall. Hold this while breathing normally for 10 seconds and repeat this 12–15 times.

Corrective exercises for hyperkyphosis

Dental professionals with hyperkyphotic posture should avoid doing exercises that cause further tightening of your pectorals, such as chest presses, press ups and biking. Hyperkyphosis is due to muscle imbalances – tightness of the pectoral – so these muscles need to be stretched. The weakened back muscles (middle trapezius and rhomboids) need to be strengthened.

Examples of strengthening exercises for the middle trapezius and rhomboids:

- **Single–arm dumbbell rows** – Holding a dumbbell in your right hand, place your left hand and left knee on a bench. Hold the weight with your arm straight. Use your upper–back muscles to pull the dumbbell up and back toward your hip. Pause, and then slowly lower the weight. Pull the weight up so your elbow passes your torso.
- **Reverse fly** – using a set of lightweight dumbbells. Sit on the end of a weight bench with your back straight and your core muscles engaged. Lean forward, bringing your chest over your knees. Lift both arms to shoulder level, squeezing the shoulder blades together. Lower your arms down on either side of your body. When performing this exercise make sure that your elbows are slightly bent and you do not raise your arms higher than shoulder level. ◆

That would be an acumen-ical matter

Dr Alun Rees BDS looks at what the newly qualified dentist needs to consider from a business perspective...

A newly qualified dentist emerges, like any fledgling, into a world that is full of challenges to their survival. Their university education has been focused on giving them a scientific base and the skills to apply that knowledge for the benefit of their patients. What new graduates are missing, and always have been, is the understanding of the model, particularly the business model, into which they will be expected to fit, to contribute and from which they will make a living.

Students are taught communication skills and the importance of gaining informed consent. Nobody has told them that in addition to explaining the positive outcomes and risks of treatment they will also have to justify to the patient their financial investment. They have no training in how they should handle objections based purely on price.

Frequently a new dentist who is coming to terms with applying clinical skills will delegate or abdicate dealing with the money issue. That is understandable in the early days, but for many it becomes a habit where they are happy to take payment but avoid examining from where the money comes. The consequence of this is an associate who does not understand the fundamentals of the business of dentistry.

Yet money has almost always been involved. The system was completely private before the NHS and even then it took only three years for the government to introduce charges for dental and ophthalmic care.

In my frequent conversations with dentists young and old, most wish they had known something about the way a dental business runs before they were involved. Some training in basic business skills should be part of the undergraduate dental curriculum and not from a purely 'NHS' mindset. Knowledge of finances, sales, marketing, strategic planning, team work and business systems would only be of benefit to those taking their first steps on their career.

For some reason there is often a reluctance from practice principals or owners to share the nuts and bolts of management, especially the financial ones. Most people learn these things the hard way or not at all.

The expansion of dental undergraduate places has led to a rise in the number of associates. The problems with finding Foundation Year places have been well documented but that doesn't seem to have spread to associate posts yet. It seems that an enthusiastic, hard working person with good people skills will always find a job, especially if they are willing to travel.

One change is the fall in income. With the continuing application of austerity from the UK government leading to a fall in real practice incomes, owners are having to tighten their belts. I know of practices where an associate who might have been paid 50% of a UDA value of £20 in 2006 is now earning 35% of a UDA value of £25. In some this is essential for survival; in others they are exploiting the junior dentist.

The fallout from the increased numbers has yet to be felt fully as those at the end of their careers take advantage of the increase in practice values and sell up. This practice price inflation means that new owners are deeper in debt and therefore can ill afford to pay associates well. The knock on here is that associates with a lower income find it harder to save.

A consequence of rising practice prices is the temptation for individuals to over borrow, either from banks who still see an NHS contract as a gold standard for stability or from family. The wisdom of the banks I doubt and business failures which were once very

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rare are on the increase. Another result of higher values means that sometimes the only people being able to afford to buy a practice are corporate bodies and the rise of these has brought about a fundamental change in the market for the young dentist.

Many younger dentists are biding their time and investing in their skills by further study. In the long term this is good for them, their patients and the profession. Unfortunately many of these skills are often applicable only in a private set up and it is difficult to use them if one is 'stuck' fulfilling UDA targets, and mixing NHS and private work leaves you open to potential complaints.

We have a two lane profession; the future will see private practices and NHS clinics. The profound effects of austerity continue and NHS dentistry, whilst being slightly sheltered, is no exception. Private dentistry has continued to grow throughout the lean years with millions of patients taking advantage of being able to have dental care that they want rather than need and that is not covered by the NHS. Intelligent, appropriate marketing together with diversification and great customer service have brought about a veritable revolution in high street dentistry.

The baby boomer generation is able to choose to have cosmetic work and their post-war, sugar-ravaged dentitions are now being maintained and enhanced with crowns, implants and smile makeovers. Who will provide for this generation over the next couple of decades as they live longer and become more of a challenge?

It's not all good news if you are not willing to embrace change. I still meet practice owners who were running profitable businesses three years ago but are finding that unless they work harder on, as well as in, their practices they struggle to make a living. Sadly many seek help after the problems have arisen.

There are a lot of rose-tinted spectacles or heads in the sand where owners refuse to acknowledge the problems that they are facing. As Pink Floyd sang, too many are 'hanging on in quiet desperation' hoping that the next 'new' contract will make things right again. It's not going to happen.

The next decade will see more dramatic changes. Finally, more will understand the message that, 'dentists should only do what only dentists can do' and delegate more of their clinical and administrative work. So the use of dental therapists and hygienists will continue and expand. The promise of the last thirty years that dentists will become true team leaders will come true.

'We have a two lane profession; the future will see private practices and NHS clinics. The profound effects of austerity continue and NHS dentistry, whilst being slightly sheltered, is no exception.'

This will have an influence on the market for associates who will have to prove their worth to practice owners and learn to work as a team member. They will also have to be prepared to commit to a career structure similar to other professions.

The elephant in the room, in the UK anyway, is the NHS. Clearly unsustainable in its present set up it has somehow survived in spite of erosion and undermining by successive governments. How long can practitioners keep going? Are we at a point where the only thing that does keep it afloat is the inflated value of the NHS contract?

The increase of specialisms or special interests will continue. Endodontics on multi-rooted teeth, implants and oral surgery will become beyond the scope of practice of many generalists.

I can see that, particularly in NHS practices, associates will become salaried. It is increasingly difficult to justify the claim of self-employment when you are contracted to produce a fixed amount of work in premises where you don't pay staff, own equipment or take significant risks.

The 'traditional' single handed practice is already an anachronism. The model of premises in converted houses with two or three surgeries will become less and less economic and there will be more polyclinics in specially adapted or purpose built buildings.

There is potential for a rise in small managed group practices, where the owners share a philosophy of practice and combine back office functions, marketing and the training of younger dentists. This is one way for the profession to fight back against the corporates but will need practice owners to be more businesslike in their dealings with each other. There is still far too much tendency for relationships to founder on ambition, control and ego.

The fall in caries rates for many means that the days of drill and fill should become a thing of the past. Prevention and periodontal care have languished under the current NHS contract. The number of children being admitted to hospital for multiple extractions under general anaesthetic is a disgrace. In the same way, the fact that there is no incentive for screening, treatment and monitoring of patients' periodontal condition reflects poorly on the profession. That the NHS contract cannot change and adapt to alterations in treatment patterns and needs is shameful but reflects the fact that dentistry is a minority interest to government and is only considered when it is a nuisance.

I would hope that at last dentistry will seek its place as a mainstream health provider. We know that the condition of the mouth can have an influence on many other diseases of the body; perhaps it is time to take the moral high ground and be proud of what benefits dentistry can bring and how important it is. I know of practices that routinely take blood pressure readings of their patients, who will investigate patients who may have signs of being pre-diabetic and of course look for signs and symptoms of manifestations of systemic diseases around the head and neck.

For those individuals who are willing to invest in themselves, who take the long view, behave with humility, and treat their patients as people whose oral and general health is of paramount importance, the future is still good and they will have long satisfying careers. If you think that it is an opportunity to get rich quick then you will be sorely disappointed. ◆

Alun graduated from Newcastle University and started his career as an oral surgery resident, before working as an associate in a range of practices. Building upon this solid foundation, Alun went on to launch two practices in the space of just 15 months, a challenge in the toughest economic conditions. Alun served as a media representative for both the BDA and BDHF and has featured on BBC2, Sky TV and various radio stations.

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Working for a corporate

There's no hiding the facts that, in terms of real pay, the graph is only heading in one direction. That's perhaps tempered by another irrevocable fact – there isn't any more money out there to ask for. Costs are higher, so everyone has less. Practice owners have less income, which means they have less to pay staff.

For associates then, it's a challenging environment. An already inflated group of workers trying to seek out the same job as potentially 10-15 others doesn't sound like everyone's cup of tea. With numbers expected to rise, corporates are becoming a significant career option for many. So what is it like to work for a corporate? *BDJ In Practice* asked mydentist Clinical Services Director **Steve Williams**.

Steve Williams
Clinical Services Director, mydentist

Hello Steve. What is your view about the individual relationship between a particular dentist and a particular patient or group of patients?

The relationship between patient and clinician is paramount to the delivery of first class dental care. There must be trust so that the patient knows that a particular course of treatment being prescribed is the right option. To achieve this level of trust clinicians must be honest and offer clear and accurate options to the patient. This is why 'honest' is one of our core brand values.

How important do you think the personal passion and commitment of individual dentists is?

We as a company are passionate about and committed to delivering the best dental health care and treatment to our 5.5 million patients. Clinicians with passion for their career and the drive to grow and develop are paramount to delivering the best care for their patients. Clinicians that join our business and have that passion and commitment will find that mydentist supports them to develop and grow through both the clinical team and access to training and development via the mydentist academy and our Learning Management System.

Do you see all dental performers as interchangeable?

Continuity of care by the same clinicians is key for driving successful patient relationships. However we also recognise the importance of skill mix within a practice, and whilst clinicians might

not be interchangeable, we feel that patients should have access to the correct treatment which is carried out by the appropriate clinician. Whether that is a GDP, Specialist, Hygienist, Therapist or an extended duties nurse. The important thing for us is that the clinician carrying out treatment is giving our patient the best treatment available.

How does mydentist deal with patient lists when particular practitioners move on?
Much like any other practice we would see that the clinician replacing the exiting practitioner would take on that list. Continuity of career is really important to us and ideally want the inbound clinician to take over the list so they can start building a relationship with the patients. This ensures that clinicians are busy from day 1 and in the vast majority of cases do not need to build a book which can take time.

How often do you find patients asking to see a specific, named dentist?
We do have patients that want to see the same dentist, and so this happens frequently across all 670 practices; the reasons are wide and varying. Ultimately I think it comes down to trust. People build a level of trust with their dentist, they become comfortable and know what to expect. This is certainly the case with anxious or nervous patients, where the clinician will take time to reassure and educate the patient to the point where they are relaxed and treatment becomes less daunting.

What skills do you think differentiate successful dentists from less successful dentists?
Skills are obviously important but I think in many cases it is just as much about attitude. Patients want treatment that is pain free, works the first time and can trust the individual. Clinicians that are passionate, driven and want to develop are more likely to be successful. Skills and techniques can be learned and improved, attitude is what motivates those people to attain those skills.

What makes patients like their dentist?
I think people respond well to clinicians that are honest, and speak to them in language they understand and take the time to ensure the patient understands what is happening and that they are comfortable with what is involved in treatment. Communication is vital to the relationship between clinician and patient; such small things can make all the difference. Something as small as removing a surgical mask when greeting and speaking to a patient can make a clinician seem more approachable and open.

How do you align the interests of the company with the interests of the dentists?
We have a number of ways we listen and receive feedback from all our dentists. From one to one meetings with both the practice managers and clinical team that are there to support, to annual clinician surveys. Also at a more local level peer review groups are organised alongside regional clinical panel meetings where new ideas or materials are tested. Generally a successful dentist will usually be aligned with company goals, as long as it is within the standards and regulations.

> 'Much like any other practice we would see that the clinician replacing the exiting practitioner would take on that list. Continuity of career is really important to us and ideally want the inbound clinician to take over the list so they can start building a relationship with the patients.'

How much control do dentists have over their working environments?
The majority of clinicians are self-employed and as such have access to a wide choice of materials and labs. Currently we have over 200 approved labs which are all DAMAS accredited. They have clinical freedom to provide the most appropriate treatment for the patients. The company does have policies in place which do need to be followed, to help maintain our high regulatory standards and these are in place to help protect both the individual clinician and the company.

How much room for negotiation do dentists at my dentist have with the company?
There are standard contracts in place and these follow the BDA guidelines to ensure we protect self-employed status. Negotiations can sound very formal and at mydentist we encourage open dialogue with both the operations and clinical teams. There will be certain things that we will not allow, especially if this could breach any regulations, however usually the pros and cons will be discussed before coming to any final decisions. We are always looking for new ideas which is why we commit to an annual survey from all our clinicians.

What characteristics would encourage my dentist to pay higher rates to associates?
Rates of pay will depend on experience, but also the geographical location of the practice. This is something that should be discussed at an early stage as a higher rate may be payable in a more rural location if you are flexible on your location. We have also committed to paying any DDRB uplifts to our clinicians that achieve their contract during the year.

Is it ultimately a matter of 'take it or leave it'? The lowest value UDA rate wins the day?
Not at all. It is the mydentist belief that it is important to get the right clinician for a practice and not just a body to fill a chair. All prospective dentists will be interviewed by the clinical team to ensure they are suitable and if successful, undertake a full clinical induction in our purpose built academy. In many cases we would rather wait for the right clinician to be able to start than just get the first available dentist. In these instances we would ensure we have either cover from one of our Regional Employed Dentists or a Locum to ensure that patient access is not impacted, but we don't just take the cheapest or the first dentist that comes along. ◆

Do you work for mydentist?
Do you agree with these comments?
Get in touch with the editor

Andy White, mydentist Clinical Marketing Manager, will be speaking at the Associates Careers Day on Friday 24 February. To book your place please contact 020 7563 4590 or visit www.bda.org/associatesday

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Contacting staff during sickness absence

by James Goldman
the BDA Practice Support Team's Special Adviser (Legal). James trained as a barrister and advises dental practices on employment law issues and has represented practitioners in many Employment Tribunal disputes

Contacting sick employees

When an employee does not turn up it disrupts you, your staff and your patients – sickness absence is, sadly, often unavoidable but the employee has to give you a full picture of their situation. They should know to contact you promptly whenever they are ill but it is also fine for you to contact a sick employee as long as you do so reasonably and are not too intrusive. At BDA Practice Support we have sometimes come across a reticence to contact absent employees, wondering whether it breaks any employment law rules. But official guidance from Acas says 'keep in touch with the employee by phone while they are absent'[1] Of course managing sick or injured employees requires sensitivity so always think carefully about the need to contact them, how you do it and what you want to discuss with them.

Make sure they know

It is best to have a written procedure outlining what staff need to do when they are sick and how you will respond. They should know that they must phone in sick when absent and indicate how long they are likely to be away. As part of staff induction and later team meetings go through your practices' written 'sickness and absence policy' – it should give details of their responsibilities to contact the practice and tell them that you contact them to enquire about their absence if necessary.

Making the call

A telephone call to find out why an employee is not at work is reasonable. It is also your opportunity to find out as much information as you can about the employee's absence. Generally they should have called you but this must not be a reprimand – there may be perfectly good reasons why they have not called you. Perhaps your employee was at an emergency appointment at their doctor's surgery. However, where there does not appear to be a good reason for not calling, it should be investigated when they return to work and, if necessary, disciplinary action can be considered.

Keeping up to date

You need your employee to stay in contact when absence goes on for more than one day, so that you know how they are doing and when they are likely to be back. They should know from your policy that they need to phone in for each day of sickness, otherwise it is fair for you to chase them up again. Let them know, if you have to call that you need updates on their condition. Though, daily calls (by either employee or employer) may not be necessary if it is clear that the employee will need to be off for a while; perhaps they have a doctor's certificate and have been signed off work for one week. They would only have to phone in (or you call them) at the end of that week if they have not recovered and are unable to return to work.

Unreasonable contact

Beware, however, that contacting employees who are on sick leave can in some situations be unreasonable. You should avoid circumstances such as repeatedly calling an employee who you know will be absent for a set period, because it could amount to harassment. Sometimes, though there may be times when you need to talk to an absent employee about a work-related matter. This could be acceptable but you need to think whether they are the only person that can help you, the reason for their absence and whether the matter can wait until their return.

When an employee is absent through work-related stress great care needs to be taken. Any contact could aggravate the employee's condition or delay their recovery. When you first learn of their absence you should agree a protocol for staying in touch. This can vary from person to person and medical advice may be needed.

Coughs and colds

Sickness is as inevitable as taxes, you need to be prepared by having a proper framework for dealing with it, part of this is an obligation on staff to contact you but do not be afraid to contact them if you need to. Employment law is not designed to stop you handling situations but to enable you to handle them fairly, for further information. ◆

1. Advisory, Conciliation and Arbitration Service (Acas) *Managing attendance and employee turnover,* March 2014.

see BDA Advice Sickness absence at www.bda.org/advice

When contacting a sick employee it is legitimate to ask these questions:

- What is the nature of the illness and symptoms?
- When do you expect to return to work?
- How long have you been unwell for?
- Do you know what might have caused the illness?
- What are the effects of the illness on you?
- Are you taking any medication? If so, what effect has the medication had?
- Will you be seeing a doctor whilst away?

Renewing your lease

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

Business tenants in England Wales and Northern Ireland, generally have an automatic right to renew their lease at the end of its term. If your commercial lease is longer than six months (nine months in Northern Ireland) than the Landlord and Tenant Act 1954[1] in England and Wales, and from the Business Tenancies (Northern Ireland) Order 1996[2] provide a right to extend the lease – providing the proper procedures are followed. (Scottish law has a different basis, leases roll-on for an additional year unless either the landlord or tenant gives the other at least 40 days' notice to quit before the lease ends. Theoretically leases could roll-on indefinitely on this basis until formal notice is given.)

Business leases are contractual agreements with the clauses negotiated between and binding on the parties, up to the point of renewal. At that point the statutory rules provide a set procedure that can lead to renewal of the lease, unless the landlord has good grounds to object, as set out in the statute. The procedures involved are named after the sections of the Landlord and Tenant Act that give rise to these rights. However please note sometimes the original lease agreement excludes the right of renewal so check the terms of your agreement.

Requests for a new lease

For tenants to renew the lease they must serve a request on their landlord setting out the date for the commencement of the proposed new lease. Known as a Section 26 Notice, the tenant must give between six and 12 months' notice to the landlord before the new lease begins. The notice will state the tenant's proposed terms for the new lease, such as rent, length of term and whether the tenancy is to be of the whole of the existing premises. It must also state that it is an official notice under the Act (or Order in Northern Ireland). Once a tenant triggers the renewal process, the landlord can either accept the terms or has a two month period in which to dispute the grant of a new lease.

In some situations the landlord might get in first by serving a Section 25 Notice on the tenant. This must also be sent between six and 12 months' notice before the renewal date and will set out why the landlord does not wish to renew the lease or their proposals for new terms for the lease.

© Lepro/Getty Images Plus

The landlord's right to refuse

Your landlord can refuse to renew your lease if they have official grounds to do so. This could be if tenant is in breach of their obligations for example not paying the rent or carrying out repairs. Or the landlord may want to want to use the premises themselves (for their business or to live there), refurbish the premises or consolidate smaller sub-lettings within a building into a whole unit.

Applications to court

The matter could go to court if the parties cannot agree terms for a new lease or if the tenant disputes the reason given by the landlord to refuse to renew. Applications to court can only be made if an official Section 26 or 25 Notice has been sent to the other party. The county court (or Lands Tribunal in Northern Ireland) will consider the issues and decide whether to order the grant of a new tenancy – and the terms of that tenancy – or to accept the landlord's reasons and not order the grant of a new tenancy.

If a new lease is granted the Court will apply a market rent based on expert evidence, together with terms that preserve the party's general position. Commonly, the burden will be on a party seeking to depart from the existing terms to prove that the lease should be altered accordingly.

A tenant who changes their mind about a renewal and wishes to pull out of the process, may do so. However, depending on the stage reached, it will usually be necessary to give at least three months' notice to the landlord. If Court proceedings have begun, a tenant may also be obliged to pay the landlord's costs. ◆

1. 2&3 ELIZ. 2, chapter 56, Her Majesty's Stationery Office.
2. SI 1996/725 (N.I. 5), Her Majesty's Stationery Office.

Further information is available in BDA Advice Leases and licenses at www.bda.org/advice

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For more information about CB12 White and how it could benefit your patients, please visit www.cb12.co.uk.

Free CPD klaxon!

In April 2016 GSK, the manufacturer of Corsodyl, Poligrip, Sensodyne and Pronamel, launched four free certified CPD modules. Each provides 1.5 hours of verifiable CPD and so far over 2000 modules have been completed, meaning GSK has provided over 3000 hours of free, verifiable CPD to DHCP's across the country.

The modules focus on a range of topics including gum disease and the Basic Periodontal Examination (BPE) with Corsodyl and the impact of an ageing population, the effects of tooth loss and dentures for patients and the role of denture fixatives and cleansers with Poligrip. Sensodyne Repair & Protect and Pronamel focus on the impacts of dentine hypersensitivity and the mode of action of NovaMin and the impacts of erosive tooth wear and the Basic Erosive Wear Examination (BEWE) respectively.

All modules can be completed remotely at a pace that suits the user. There is a selection of multiple-choice questions at the end of each module and, upon answering the questions correctly, the user is issued a certificate for completing the CPD module.

GSK sees delivering quality education and CPD as a core part of its mission and strives to continuously meet the needs of DHCPs through online learning as well as face to face lectures.

Access to all modules, as well as information on GSK products, is available at www.gsk-dentalprofessionals.co.uk.

Unlock your practice's potential

Offering new and effective marketing opportunities for dental practices across the UK, Munroe Sutton will help you grow your patient base and fulfil your business' potential.

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With a friendly team of professionals on hand to support you and your staff whenever you may need it, Munroe Sutton could be the key to unlocking your practice's potential.

For more information please call 0808 234 3558 or visit www.munroesutton.co.uk.

Washing away worries

EndoWize is a new endodontic irrigant that gives dental practitioners greater confidence when performing root-canal procedures.

Irrigation solutions perform several important functions, not least of which is the washing, antimicrobial and biofilm elimination which is vital for the successful disinfection of the root canal space that works hand in hand with shaping of the canal.

However, the most commonly used irrigators, such as Sodium Hypochlorite, Chlorhexidine, EDTA and Hydrogen Peroxide, contain harsh chemicals which pose inherent risks to operators and patients.

This gives dentists a dilemma – use a potentially harmful solution or accept a lower chance of success.

EndoWize helps lubricate instruments, flushes debris, reduces smear layer and kills bacteria – but without the traditional risks. That's because it contains Hypochlorous (HOCl), a gentle biocide that is naturally produced by human white blood cells to phagocytose and destroy pathogens.

Extensive tests show HOCl to be non-irritating and non-sensitising. It is now widely used in a wide variety of applications, with independent testing proving the elimination of 99.9999% of pathogens, both *in vivo* and *in vitro*.

EndoWize is effective against the 460+ different types of bacteria commonly present in infected canals, including *e.faecalis* (commonly found in endodontic re-treatment cases). For all these reasons HOCI has been proposed as an endodontic irrigant for over 20 years. Naturally occurring HOCl is extremely unstable, however EndoWize's unique manufacturing process produces HOCl in an enhanced, stable form with a one year shelf life that is suitable for clinical applications. What's more, it's compatible with current endodontic materials, instruments and techniques.

For further info on distributors or technical info, please email enquiries@endowize.com or call 0333 335 0516.

Grow your business and acquire new patients

Practice management systems are traditionally seen as a means to store patient data, including details of treatments, medical histories and processing payments. As dentists begin to explore opportunities to grow their business, taking advantage of the rich data already present in your practice is the most cost effective marketing tool.

A built-in automated Recall Campaign Manager delivers improved recall effectiveness. Receptionists and practice managers find it challenging meeting the demands of a busy practice, as well as supporting marketing activities through carefully targeted messaging for recalls, reminders and acquiring new patients.

Recalls are often forgotten or sent only once in the hope the patient receives the message first time. Missed appointment patients are not contacted for re-booking and as a result end up in an 'idle' state with no activity in the practice. All of these issues lead to large lists of patients being registered but not being treated.

Understanding and reacting to the needs of patients is fundamental to proactive marketing. As a recognition of these issues, iSmile has a built-in Campaign Manager which can automatically generate up to three rounds of appointment reminders and up to eight rounds of recall reminders. Each message is set to be sent via any channel (SMS, email, letter or patient preference) and the message for each round of reminders can be customised. With all the activity happening automatically in the background it eases pressure on the practice managers and receptionists and ensures the practice knows the state of each registered patient.

The iSmile Patient Portal also captures patient feedback on their experience and includes a patient interest form. The feedback can then be analysed at the practice and interest specific campaigns can be setup.

Using a system that automates processing and relieves pressure from reception can result in double digit growth in practice revenues and significantly improve patient perceptions.

For more information about iSmile call 0845 468 1287, visit www.ismiledental.co.uk or email info@ismiledental.co.uk.

Partnership announced

Tipton Training – one of the UK's leading dental academies – has announced a new partnership with Healthcare Learning, a renowned online learning provider.

Healthcare Learning offer an online MSc in Restorative & Aesthetic Dentistry and which is affiliated with the University of Manchester. As part of this new partnership, Tipton Training is able to fast-track refer their alumni for Healthcare Learning's MSc programme. On referral by Tipton Training the application will be fast-tracked by Healthcare Learning for their MSc programme.

In addition to fast-track referral, Tipton Training alumni are also eligible for a cash discount on course fees and are granted exemption to Healthcare Learning's 12 residential days within the MSc programme.

The partnership allows Tipton Training delegates, to pursue an online MSc programme while using the exemption, to spend more time treating their patients in their own practices rather than attending residential days. This partnership adds to the existing career pathways to a Masters degree available to Tipton Training delegates and alumni. It further endorses Tipton Trainings reputation as a provider of high quality dental training.

For more information about Tipton training Training and their educational partnerships, please visit www.tiptontraining.co.uk or call +44 (0)161 348 7848 to book a place.

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Specialist Prosthodontists:
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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

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Specialist Periodontists:
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Specialist Orthodontist:
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283787

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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

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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

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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

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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

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72 Coombe Road,
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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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Business skills CPD

Q1: Under what circumstances should you actively notify patients a dentist has been suspended?

A If it is a regular patient

B If the patient's appointment is within 48 hours

C If it is due to patient safety or clinical issues

D You do not need to notify patients at all

Q2: What is the average weight of a human head?

A 8-10% of total body weight

B 10-14% of total body weight

C 15-20% of total body weight

D 21-25% of total body weight

Q3: Can you reprimand staff for not calling in sick before they are due to turn up for work?

A Yes

B It is at the discretion of the manager

C No

D Disciplinary action can be considered if a suitable reason has not been given

Q4: How much notice does the tenant need to give the landlord to renew their lease?

A 3-6 months

B 6-9 months

C 6-12 months

D 9-12 months

Q5: Which of these would constitute a tenant breaching their lease?

A Not paying their water bill

B Not paying their gas bill

C Not paying rent

D Not paying their TV license

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Need help?

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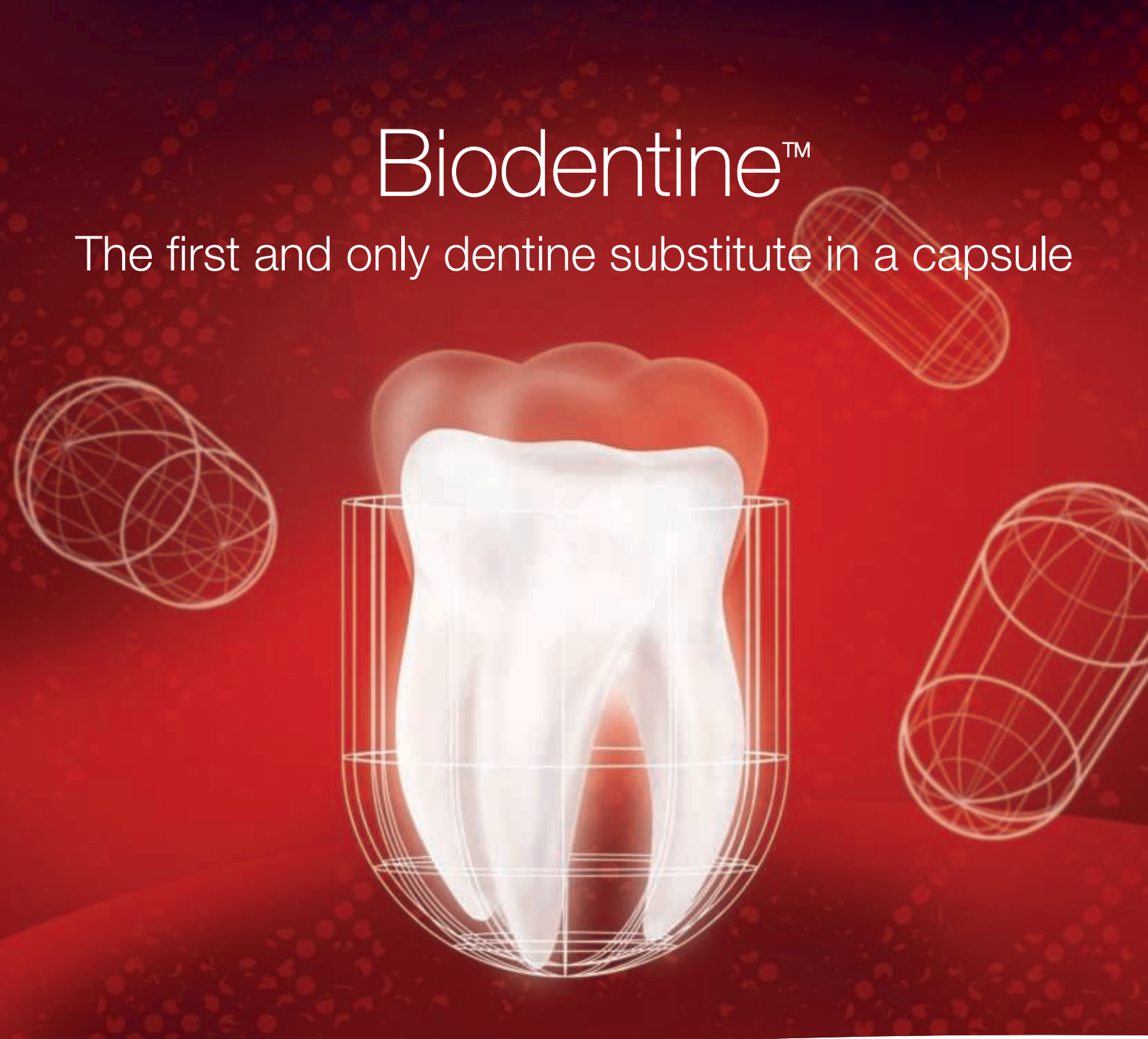

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