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July 2017

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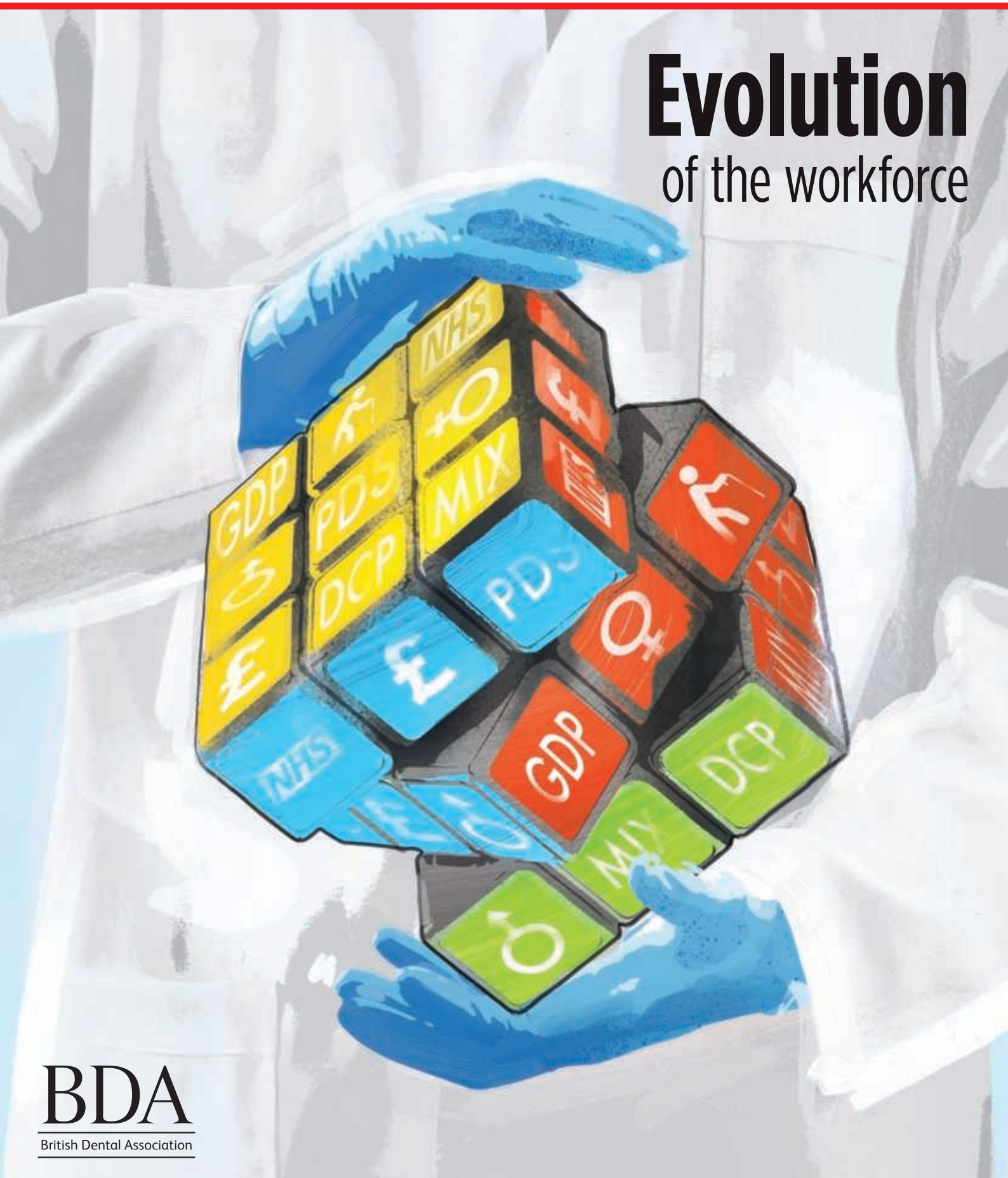
of the workforce



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JULY 2017

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Contract reform and clawback take centre stage at LDC

Twenty-six topics were debated at the Local Dental Committees Annual Conference in Birmingham (8-9 June), which was attended by 161 LDC representatives and 27 from the BDA's General Dental Practice Committee (GDPC).

Motions on contract reform and clawback took centre stage with prototype practice owners testifying that changes needed to be made to the business model to make contract reform workable.

© Sam Edwards / Getty Images Plus

97% of representatives voted in favour of a motion from Durham and Darlington LDC calling on the contract reform team to find a new way of measuring activity and for more time to deliver care. A motion form North Yorkshire LDC calling for the suspension of the current prototypes because they are unworkable was narrowly defeated.

GDPC Chair Henrik Overgaard-Nielson outlined the work of the committee in the last year. He noted the frustrations felt by dentists after six years of testing a reformed contract but warned that if they walked away from the process, dentists would be left with nothing but the discredited UDA system.

'We have to work for a better system and I will have to be carried away from the table before giving up', Henrik said.

A motion from Birmingham LDC calling for an end to engaging with the DDRB process until the Treasury's constraints on public pay are lifted was supported by just over 57% of delegates and will now be considered by the GDPC.

There was unanimous support for a motion on regulation from Northamptonshire LDC to remove the multiple layers of legislation and red tape on dental practices and replace this with a single method of inspection. Delegates also voted heavily in favour of a motion calling for no confidence vote in Capita's ability to process performer applications in a timely manner.

A Question Time style debate, with a panel of five dentists, prompted lively discussions on a wide range of issues including what could make dentistry more attractive to young dentists, and what happens to the money claw backed from dental practices. CDO for England Dr Sara Hurley estimated this to be as much as £95 million, and said it went back to other areas of primary care – mainly optics, and general medical practice but not dentistry.

Representatives heard a presentation from Claire Stevens, a Consultant in Paediatric Dentistry in Manchester, about the importance of seeing children by the age of one to reduce the number one cause of children being admitted to hospital.

Conference also sent out a strong message of support for targeted fluoridation to be considered by local authorities in the 13 areas in the Starting Well scheme; these have been identified as having the worst child dental health in England. There was overwhelming support (93.8%) for such a motion raised by East Riding of Yorkshire LDC.

The conference concluded with a presentation from Professor Nairn Wilson on the innovations in dentistry that could auger well for the future of dentistry in spite difficult times.

Vijay Sudra was voted as Chair Elect for the LDC Annual Conference 2019. ◆

Private dental practices in Wales – have you registered with HIW?

Private dentists working in Wales are reminded that their practices must be registered with Healthcare Inspectorate Wales to provide dental care, following changes to the regulations earlier this year.

The HIW has suggested to the BDA that some dental teams appear to be unaware that the regulations for private practices have changed, and that from 1 April 2018, all private practices must be registered with HIW to continue practising.

HIW advises that the process of registering may take some time (due to staff requiring DBS checks) so it encourages all practices to register as soon as possible.

Earlier this year, BDA Wales succeeded in securing concessions on higher fees and curbing unnecessary red tape to the proposed amendments to the new Government regulations on private dentistry in Wales, helping to ensure single-handed practitioners were not onerously burdened by annual fees. ◆

BOOK REVIEW

Have a plan

How to write a business plan (5th edition)
Brian Finch
Kogan Page, 2016
ISBN: 978-0-7494-7569-7
£9.99

In a nutshell

With a Masters Degree in Business Administration from the London Business School, Brian Finch spent nearly twenty years in finance and business directorships before becoming an independent management consultant and author. His background has afforded him considerable experience in preparing and delivering effective business plans. Amongst other titles, he also wrote the books *Effective financial management* and *Insolvency and financial distress: how to avoid it and survive it*. This fifth edition of *How to write a business plan* comprehensively covers a large area and deals with all aspects of compiling and executing a business plan. Finch employs plain language to impart the basic rudiments of the subject but in as much depth as possible.

Who is ideal for?

Although the book is one designed as a universal template for any prospective or existing business owner, this generality is actually a benefit since the underlying premise of running a successful business should undoubtedly be common to all. Therefore anyone starting out or wanting to expand their business needs to have clear guidance on how to set about their goal. It's clear that the author wants to instil confidence in the reader in order for them to realise their business ambitions and this he does with reassuring aplomb, for example, he stresses that if you don't ask for what you actually need you won't get it, so ensure everything is itemised within the plan.

Why you should read it

This easy to read and digest paperback is divided into fourteen chapters. These cover all the essential elements that contribute to writing a winning business plan. Finch starts by introducing the structure of the plan and its summary. He then discusses the background of the business and its market, looking specifically at competitors, customers and trends, market segmentation and pricing. The next stage is to explain the actual operation and management of the company. From there Finch focuses on the proposal itself with financial forecasts and key information such as the profit and loss account and balance sheet. Final chapters deal with risks, legal issues and confidentiality and even selling a business, which can be another reason for needing a business plan. ◆

For more about these book: www.bda.org/booknews

Dental professionals in Scotland get legal protection when apologising

On 19 June 2017, the complete Apologies (Scotland) Act 2016 comes into force in Scotland providing legal protection for dental professionals when apologising to patients. According to The Dental Defence Union (DDU), this makes it clear that an apology (outside of legal proceedings) is not an admission of liability.

In the new Act, an apology is defined as: '…any statement made by or on behalf of a person which indicates that the person is sorry about, or regrets, an act, omission or outcome and includes any part of the statement which contains an undertaking to look at the circumstances giving rise to the act, omission or outcome with a view to preventing a recurrence.'

Angela Harkins, DDU dento-legal adviser, said: 'Saying sorry to a patient when something has gone wrong is the right thing to do and is an ethical duty for dental professionals. The Apologies (Scotland) Act provides further reassurance to dental professionals that apologising is not an admission of legal liability. In the DDU's experience, a sincere and frank apology and explanation can help restore a patient's confidence following an error and help to rebuild trust. This is important for a patient's future healthcare and can help to avoid a complaint or litigation.'

Dental professionals have a professional duty of candour, set out in the General Dental Council's standards for the dental team which states that when dealing with complaints: 'You should offer an apology and a practical solution where appropriate.'

A legal duty of candour was also introduced for health and social care providers in Scotland under The Health (Tobacco, Nicotine etc. and Care) (Scotland) Act 2016 although it is due to be implemented on April 1st, 2018. It will mean that doctors, dentists and other health and social care staff in Scotland will have to inform patients and their families when a patient has, in the reasonable opinion of an uninvolved registered health professional, died or been unintentionally or unexpectedly mentally or physically harmed as a result of their care or treatment.

Although the Apologies Act does not apply to the legal duty of candour, the Health Act makes it clear that 'an apology or other step taken in accordance with the Duty of Candour…does not of itself amount to admission of negligence or breach of a statutory duty'.

©Monty Rakusen / Getty Images Plus

The GDC has published ethical guidance on the duty of candour which explains in more detail what constitutes an effective apology. However, dental professionals are advised to contact their defence organisation for specialised advice and support.

BDA general dental practice survey – share your experiences

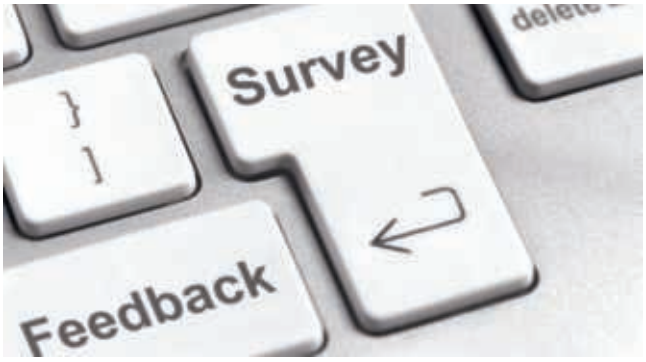
The BDA is calling on dentists to give their experience of working in general practice across the UK, to help inform our yearly submission to the Government's review body on dentists' pay.

Our survey aims to find out the state of dentists' morale, motivation, and job satisfaction, and we are particularly keen to find out more about the views and experiences of younger dentists and their career intentions over the next few years.

We have randomly selected a sample of BDA members working in general dental practice to participate in this survey. If you have been emailed an invitation to take part, please complete the survey and help us to be the collective voice of dentistry.

Please check your spam-related email folders, the subject line of the email is 'BDA Survey of General Dental Practitioners 2017'.

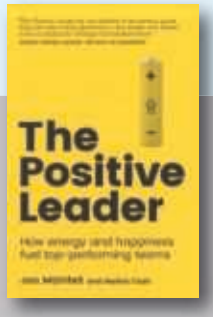
As a thank you for your time, we are offering participants the chance to enter into a prize draw to win a £100 Marks & Spencer voucher. Please be assured that your information will be anonymous and we will not pass your details on to any third parties. ◆



BOOK REVIEW

A positive leader

The positive leader – how energy and happiness fuel top-performing teams
Jan Mühlfeit and Melina Costi
Pearson, 2017
ISBN: 978-1-292-16615-5
£16.99



In a nutshell

Global strategist, executive coach and mentor Jan Mühlfeit is a former Chairman of Microsoft Europe and a veteran of the I.T industry having worked in it for 22 years. Currently 'entrepreneur in residence' at INSEAD and a coach for MBA students at Cambridge University, he strongly believes in taking a positive view in leading a work force. Hence the upbeat title of this book. He claims as a fact that happier employees are linked directly to a stronger bottom line and that this positivity-performance nexus has been confirmed in numerous studies. To consolidate his thesis, the book is divided into four main parts: Building strengths (positive people); Personal mission and ultimate vision (positive purpose); Energy management (positive process) and Success versus happiness (positive place). This whole joined-up strategy is encapsulated in what he refers to as 'The 4Ps of Positive Leadership'.

Who is ideal for?

This four point approach is aimed at anyone seeking the knowledge to become an inspirational leader and is essentially a 'how to' guide for busy managers. The book therefore targets strengths, not weaknesses and inspires the reader to have a dream about where they want their organisation to go. It places emphasis on managing energy rather than time and most importantly it places happiness before success. As Deepak Chopra, author of The Soul Of Leadership, states, it is 'the perfect guide that can help unlock greatness in any leader who wishes to be a catalyst for change and transformation'.

Why you should read it

Mühlfeit tackles his project systematically, beginning in part one by getting down to the very basics. He asks the reader to determine who they are, by dint of examining their self-awareness, EQ or Emotional Intelligence and strengths. This leads on, quite logically to a discussion concerning the development of team strengths. Part two (the 'why' or purpose) looks at the existential question of your own being and investigating the leader's own personal mission, values and passion. He illustrates this using Maslow's famous pyramidal hierarchy of needs as a metaphor for developing inspirational needs. In part three he covers energy and in particular burnout and stress and how to become a Chief Energy Officer. The final part deals with the pursuit of happiness. This is clearly the icing on the cake in terms of positive leadership and achieving one's full potential. He describes this in altruistic terms of helping others to help yourself and maintaining a truly positive outlook. ◆

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All in a day's work

At this year's *International Dental Show* in Cologne, I attended a press conference that discussed the fourth industrial revolution; technology. And that got me thinking. How has technology changed the world we live in today?

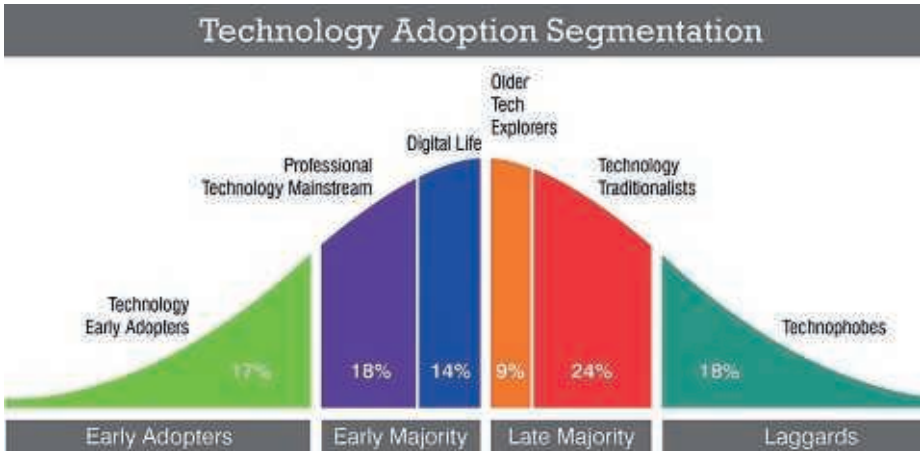
by David Westgarth,
Editor, *BDJ In Practice*

When I was younger, if I wanted to talk to one of my friends I'd have to pick up the telephone and call them. If we wanted to move our TV it was a three man job, given the size and weight of them. If we wanted to use email (heaven forbid), you had to unplug your telephone and pop in your dial-up internet (I won't call it broadband).

In a relatively short space of time, the analogue era has disappeared and is now replaced by the digital one. For many areas of the profession, the era ushered in remarkable technology to aide and assist new ways of working. The 'digital workflow' became part of the lingo. CAD/CAM is firmly entrenched in many practices. But, like everything, it soon changed. What we considered at the time was quick is now viewed as rather pedestrian.

Step forward the concept of 'single day dentistry'. No longer do patients have to wait weeks or months to have their dental work completed. As the name suggests, it can now be done in a single day. I spoke to Dr Alison Simpson, Director at Trinity Dental, to find out what the phrase really means.

'Digital technology was introduced and available within the profession 30 years ago' Dr Simpson said. '15 years ago the early adopters embraced the advanced technology and introduced it to their patients. CAD/CAM (computer aided design/computer aided manufacturing) has since advanced making it easier to implement in an established dental clinic.'



Everett Rogers, *Diffusion of Innovations*

Besides the time and cost savings to your practice and to your patient, CAD/CAM enables one single appointment from diagnosis to placing the restoration. I asked Dr Simpson whether single day dentistry was the start of the digital revolution, or the crystallising of that process.

'Even though the digital revolution was introduced 30 years ago, it is still the minority that are using this technology as so many are holding back' she said. 'In the last five or six years there have been more clinicians embracing the single day dentistry idea and I have witnessed confidence in the concept, and as a result it is growing.'

Confidence

Perhaps the profession's confidence in technology that delivers single day dentistry dates back to 2015, when Henry Schein pledged $1.25 million to fund a groundbreaking new digital dental school in partnership with the American College of Prosthodontists Education Foundation (ACPEF) to fund a curriculum that taught computer-aided design and manufacturing (CAD/CAM) technology. But what does Dr Simpson think?

'It's an interesting one, because I have seen the idea embraced and I have seen others not so keen. I am fortunate to have a forward thinking dental team at my clinic (non-clinicians) who push ideas for new processes and research new equipment and procedures within the profession.

'When I have been on advanced digital courses everyone is enthusiastic and inspired and you can see they are ready to implement the concept immediately. However, when placed in a more general audience there is still a huge amount of cynicism and dismissive opinion through their lack of knowledge and inspiration.

'As a practitioner I have prided myself in developing an advanced forward thinking practice. I want to offer the best and most efficient service available to my patients. If I can maximise my own time whilst having content patients then I am meeting my own expectations. That's why I have embraced it.'

Progression

The problem with any new concept – particularly in a challenging economic environment – is having the confidence that it will be a success. After all, investment in the machines isn't a decision to be made on a whim. It is those who can identify any equipment is an investment rather than an outlay that, as Dr Simpson says, are the 'forward thinkers'.

> 'In the end, it is about instant gratification and results which people have come to expect in today's world. Everything is done at the touch of a button and instant. Dentistry has to join that concept and keep up.'

'As a progressive forward thinking practice, being able to offer our patients the latest technology fits well with our ethos', Dr Simpson said. 'We want to be able to offer our patients the most effective and advanced treatments whilst at the same time increasing our own efficiency and profitability in order to increase patient numbers. Advanced technology enables us to do this and sparks interest from prospective patients.

'Being able to treat a patient in a day reduces any number of costs. Lab costs, for example. But for me, it's the way in which technology can deliver results. We don't look at it from a patient's point of view, but to be able to see your restoration being made in the milling machine must be a huge selling point for you and your practice.

'Often restorations can be quite complex, and technology reduces the lottery of whether they will need to return or not. It's precise, and that helps me and my patients.

'From a different perspective, there are some patients that benefit from single day work for different reasons. As clinicians we need to adapt to lifestyle. Patients that are time poor have the benefit of completing their planned treatment in a single appointment with no stage for temporising and delaying the restoration.

'Digital impressions prove more comfortable and efficient than the analogue equivalent whilst giving the technician the opportunity to assess the preparation while the patient is still seated and having the time for changes to be made. It can also aide those who aren't massively comfortable with visits to the dentist.

'In the end, it is about instant gratification and results which people have come to expect in today's world. Everything is done at the touch of a button and instant. Dentistry has to join that concept and keep up.'

What's next?

So how does dentistry keep up? What's the next step of the revolution?

'3D printing is becoming more and more advanced with prints of full arch prosthetics and it is exciting to see how this concept is developing' Dr Simpson added.

'Laser milling will be introduced for more accuracy as the CAD/CAM systems evolve which will bring greater time reduction but with better results.

'As technology advances at a rapid pace patients expect dentistry to move with it. There is a danger that if clinicians don't move at the same pace patients expectations will not be met. If the processes and systems are readily available and tried and tested it's important we all get on board and embrace it. So it is a case of keeping up with technological developments, developing the treatments in line with that technology whilst meeting patients' expectations.'

In a world where change is the only constant, it's difficult not to see technology advancing at a rapid rate. It's not beyond the realm of possibility to suggest single day dentistry – rather like dial up broadband – will soon be viewed as a thing of the past. 3D printing will certainly help to shape the future, but as was mentioned in the press conference, the future is now. ◆

Making it happen – an alternative view

Carol Groombridge,
MBA, BSc Hons, ACIB, Dip Sys Pract

Carol Groombridge has gained an excellent reputation as a highly skilled and professional dental business consultant throughout the UK over the past 10 years.

Carol's particular area of expertise is in the management of performance. She particularly enjoys working with practices ensuring that their business foundation is rock solid before helping them to grow knowing that the growth achieved is more sustainable. www.carolgroombridge.com

Developing an operational marketing plan to support your business plan is an essential but sadly often forgotten task. The majority of practices that I visit have a reactive, ad-hoc approach to marketing which kicks in when goals are not being achieved or when they receive a phone call about a reduced price advert in a magazine. A detailed, well thought through marketing plan ensures that you don't fall into these traps. It also enables your whole team to fully understand when and what activities are arranged to promote the practice and encourages them to become fully engaged in the delivery of those activities. Associate dentists are able to gain a much clearer picture and appreciate how their personal contribution to the delivery of the plan, and not just dentistry, will assist them in maximising their performance.

Your plan should not just detail the activities directly related to selling one treatment type or another it should also describe the practice approach to the experience that all patients should expect at all times. Your brand isn't just about your logo it's 'The way we do things around here'.

This article will cover a variety of often overlooked items that I have observed when visiting practices, together with some great hints and tips. Addressing them can make a huge difference to your patients' experience.

Exceed patient expectations

Your existing patients are your biggest source of new patients. However they need to have such an amazing experience at every single touch point of their journey through your practice that they tell the world about you. How confident are you that you and your team are doing absolutely everything possible to achieve that?

Walt Disney once said: *'Do what you do so well that they will want to see it again and bring their friends'*

Your relationship with your patients actually starts outside your front door. Take a walk along the road from your practice and walk back using the 'eyes of your patients'. By that I mean look, smell, hear and feel everything that they will experience.

How easy is it for patients to see and find your practice? Is the signage clear and clean? Could your front door do with a paint job? Are there weeds growing out of the garden or the gutter? Are the windows, window frames and doors clean? Does the handle on the door work efficiently or is it something you just haven't got around to getting fixed? Is there a cobweb lurking just inside your front door?

When you sit down in the waiting area are the seat covers clean and free of stains? Can you hear the drill going in a surgery? Is there a 'dentist' smell in the air? Is the carpet/flooring clean? Do the staff all look neat and tidy?

Refreshments, a good selection of magazines, relaxing music, not keeping patients waiting, having opening hours that meet your patients' needs and not just your needs and so on, all matter a good deal too. However these melt away into insignificance if other elements of the whole experience are not up to speed.

Consider carefully how you would treat your favourite 'A' lister should he/she come into the practice, then treat every single patient like that. Geoff Ramm, in his book '*Celebrity Service*', challenges your mind-set on that and gives some great examples.

Communicate well

Watch and listen to your team interacting with patients face to face and over the telephone. What is their body language like? Do they smile and look your patients in the eye whilst talking to them? Do dentists talk eye to eye with patients or to the backs of their heads?

Would you like to receive the letters/emails/texts that you send out to patients? Would they make you feel special and cared about? Review and amend them putting yourself in the patient's shoes.

Involve your associate dentists in much of this as a fresh pair of eyes and ears can often be more critical.

Review your social media activity and ensure that there is a maximum of 20% focused on sales. Your activity should major on raising your profile, building relationships and communicating to your audience what your brand stands for. Share and like posts about things that are happening in your area and perhaps the odd funny video. To show the human side of your practice will emphasise your caring friendly side. Use eye-catching images to support your posts. Remember that if your only posts are selling treatment then patients' perception will be that that is all you are interested in. Apply the same rule to newsletters that you may send out by email.

'Review your social media activity and ensure that there is a maximum of 20% focussed on sales. Your activity should major on raising your profile, building relationships and communicating to your audience what your brand stands for. Share and like posts about things that are happening in your area and perhaps the odd funny video.'

A regular dental health blog on your website circulated via social media can be a great way of reaching out to existing and potential new patients and will increase website activity.

Does your notice board look tired and unloved? Use the 'less is more' rule to encourage patients to read what is there and refresh the contents regularly and consider having a separate notice board for statutory notices.

Have 'communication' on your regular team meeting agenda and ask everyone to discuss what best practice they have observed and where improvements can be made. Ask them what is happening in the local area and tap into that.

Community work

Raise practice profile in your community in a number of different ways. It will take time to impact upon patient numbers but your aim should be to be the first dental practice name that rolls off the tongue of everyone in your community. Sponsor a local school football team, one that does well and has a good crowd at each match. Attend local wedding fayres, speak at WI meetings, sponsor a local festival and take a stand. Write a dental health column in your community newsletter. There will be loads of opportunities within your area that your whole team, including associate dentists, can become involved in.

What do your patients really think?

Respond to reviews about your practice remembering they will be read by those who are considering becoming your patients; a good response to a poor review can make a huge difference in their perception of your practice.

Undertake a comprehensive patient survey and consider not just asking how satisfied patients are but also how well you meet their expectations. Measuring the gap between their expectations and level of satisfaction can often be very surprising.

It's not cheeky to ask your patients to refer to you friends and family, if they have had a fantastic experience and received great dentistry your patients will be delighted to do so. Make it a habit and give them a card to make it easy.

It doesn't matter whether you are a private, a fully NHS or a mixed practice, good marketing starts with having a great foundation of patient experience. It costs very little to implement; time to get it right is your biggest investment. The whole team has a part to play including associate dentists, so ensure that you highlight what you expect from prospective staff in recruitment interviews and if it doesn't sit easily with them then maybe they are not for you.

Open your eyes and your ears, put yourself in your patients' shoes and make it happen. ◆

The times they are changin'

By David Westgarth,
Editor, *BDJ In Practice*

In all walks of life it can be beneficial to take a step back and assess how you have got to where you stand at that moment in time. Students are encouraged to do so, mainly through reflective assessments and assignments. Like a chameleon, the necessity to change and adapt throughout any given point-to-point reference in time dictates whether you as an individual sink or swim.

The same can – and should – be said of the dental profession. Today's environment differs greatly from what practitioners faced on a daily basis a decade ago. Even five years ago the landscape was very different. There are probably many of you reading this who have uttered those immortal words 'in my day'. That may be the case, but everything is different now. The people, the work, the technology.

We've all heard about Professor Jimmy Steele's 'heavy metal generation', yet according to a report published by PricewaterhouseCooper, it's the new breed than will leave a long-lasting impression.

The millennial generation, born between 1980 and 2000 now entering employment in vast numbers, will undoubtedly shape the dental workforce for years to come. It probably isn't a leap to suggest they may even change how we work.

In the report, it states that '*Millennials matter because they are not only different from those that have gone before, they are also more numerous than any since the soon-to-retire 'baby boomer generation – millennials already form 25% of the workforce in the US and account for over half of the population in India. By 2020, millennials will form 50% of the global workforce.*'[1]

With changing patient demands, expectations and particularly increasing complexities, millennials are forecast to be significantly more valuable than their predecessors. This generation will work to support a significantly larger older generation as life expectancy increases. Patients are living longer and keeping their natural teeth for longer, and so there are likely to be some pretty complex dentitions seen by millennial practitioners.

So what does that 'millennial practitioner' look like? Cast your minds back to 1985, and the film *Weird Science*, where two high school nerds tried to create their perfect date by feeding various different ideas into a computer. If we did that with dentistry, what would we come out with? A full-time male associate, aged 28 who offers only NHS treatment? Would it be a 52 year old female, a part-time co-owner of their purely private practice?

Registrants by job role

Latest figures released by the GDC[2] indicate there are a total of 110,303 registrants. The breakdown of those roles by type is listed in Table 1.

Dentists still outweigh dental hygienists and therapists by a ratio of 4:1, however this has closed up throughout the last five years. So what does this mean for the workforce?

Previously CDO for England, Dr Sara Hurley, has stressed the importance of dental hygienists and dental therapists in the future planning of the dental workforce. Dr Hurley has argued that these types of registrants may be at the front line of prevention in the future.

Table 1 – Registrants by type

TYPE	Orthodontic therapist	Dentist	Dental therapist	Dental technician	Dental nurse	Dental Hygienist	Clinical Dental Technician
Total	536	40,287	2,958	6,249	57,579	7,007	363

A review of the results of the literature review commissioned by the GDC in 2012 published in 2013[3] – that included more than 100 research papers – concluded there was 'no evidence of significant issues of patient safety resulting from the clinical activity of DCPs'.

> 'With changing patient demands, expectations and particularly increasing complexities, millennials are forecast to be significantly more valuable than their predecessors.'

Contrast that with the opinions of dentists two years after direct access was introduced[4]. In total 53% disagreed with the GDC's decision regarding direct access for hygienists, and 59.1% felt the same regarding therapists. The research suggested concern was greatest in respect to diagnosis, treatment planning and restorations. Comments were predominantly negative and reflected concerns over patient safety, what was seen as hygienists' and therapists' inadequate training or expertise, the undermining of the dentist's role, service delivery, the reform being poorly planned, implemented or being a cost-cutting exercise.

Wherever you sit on the pros and cons of dental hygienists and dental therapists, there's one thing that is indisputable; all signs point to their presence within the dental profession growing. Skill mix is here to stay, and whether you embrace it or not could depend any future success you have.

Speaking of the future, any workforce is going to be shaped by the number of dental graduates coming through the system. The total number of dental students in 2015/16 was down 2.2% to 5,655 but up 17.4% on 2005/06, although continuing to fall from its peak of 5,918 in 2013/14. This was a trend reflected in the student intake, down 4.5% to 1,005, a continued fall from its peak of 1,278 in 2010/11.

Dental graduates continued the rising trend, although this is expected to come to an end following the peak in student intake in 2010/11 and interrupted in 2012/13, up 0.2% to 1,215.

With fewer undergraduate places in dentistry, but applications still up, will we get a higher standard of graduate?

Ownership for sale?

A subset of the job role discussion – and indeed the elephant in the room – revolves around practice owners. There is no doubt that practice owners are continuing to dwindle. The question is why, and the answer isn't as simple as 'the corporate market'.

Becoming a practice owner is increasingly difficult in this economic climate. A 2012 survey revealed 47.3% of practice owners setting up in the previous five years experienced difficulties compared to 19.4% of those who had become practice owners more than five years ago. Borrowing or raising capital was the most common barrier reported to setting up a practice, by 33% of those who had set up a practice less than five years ago. However, a 2012 Business trends survey showed that nine out of ten practice owners that applied for a bank loan or credit were successful in their application.

Falling UDA values, increased overheads, stress are all issues that could be pointed to, but the key aspect to this is the 35% fall in real term income over the last decade. Dr Henrik Overgaard-Nielsen, Chair of General Dental Practice Committee, has previously labelled this as 'without parallel in the public sector'. Could that be why 6.3% – 1,504 of the 23,947 dentists working in 2014/15 – either left the profession or did not perform any NHS activity during 2015/16?

Economist Stephen Tidman believes that regardless of the actual figures, the trajectory of practice owners is only heading in one direction.

> 'With fewer choosing a career in dentistry, yet more students are sticking the course out, will we get a higher standard of graduate?'

'There is no doubt in my mind that practice owners are a dwindling area of the profession', Stephen said. 'The traditional career structure that many dentists have grown up with and been immersed in has gone. In those days you simply got your list number and off you went. Prices of practices are artificially inflated due to corporate purchases. These days it's the bank of mum and dad or you're stuffed.'

NHS, mixed, or private?

Against the backdrop of the changing landscape in the type of registrants, the chance of becoming a practice owner are disappearing. So how does the current workforce – and indeed the workforce of the future – intend to make their money?

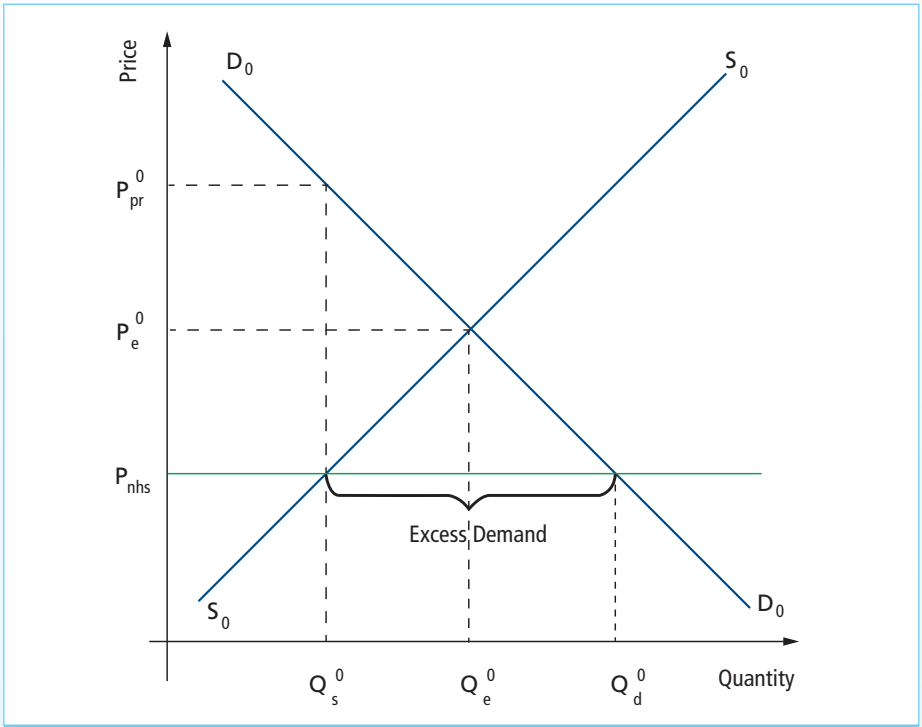


Figure 1 – Price theory applied to NHS dentistry. Courtesy of S. Tidman

In 2015/16 the number of NHS and mixed practices fell 3% to 8,956, down 18% on 2005/06: with those in England falling 3.5% to 7,179, down 20.6% on 2005/06; down 6.5% in Wales to 419, down 19% on 2005/06; up 0.6% in Scotland to 968, down 1.1% on 2005/06; and up 2.4% in Northern Ireland to 390, up 4.6% on 2005/06.

This gives a very clear indication of where the market is going. Furthermore the number of purely private practices is estimated at around 3,000, up around 44% on 2008/09. Is it little wonder practitioners are seeking the pot of private gold at the end of the rainbow?

'Whatever the situation surrounding NHS dentistry, as a practitioner you should ask yourself 'where will that guaranteed revenue come from?', Stephen said. 'There's £3.5bn out there spent on NHS dentistry every year. How will you even begin to replace this through work done purely privately, particularly in this financial climate?

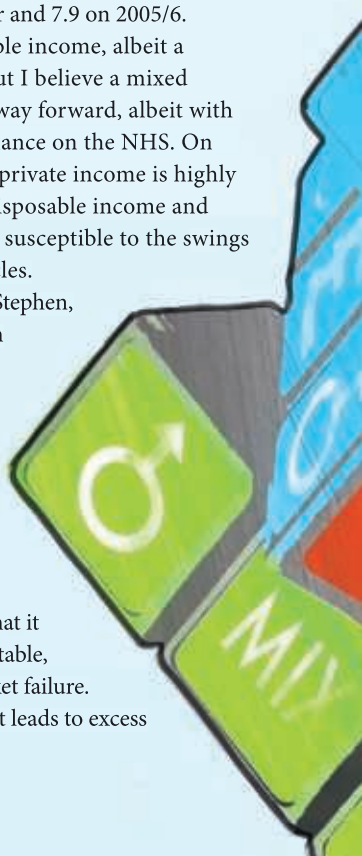
'There's a vulnerability in the private sector, with patients not always readily available. We struggle to get patients to attend check-ups through the NHS for £20. How do private practitioners expect there to be an endless supply of people willing to go private?

'The NHS is no longer a demand-led primary care service, but it is now a cash-limited service. There's a fixed budget to dip into, and that budget is a falling one.

'Perhaps of greatest concern in England, it is not just the fall in gross expenditure (including patient charge revenue [PCR]) in 2011/12 of 0.04% and 3.7% in 2013/14 but the falling proportion of government expenditure as PCR accounts for an increasing proportion of gross expenditure – 2015/16 26.5%, up 0.4 percentage points on the previous year and 7.9 on 2005/6.

'Yes it is a stable income, albeit a reducing one, but I believe a mixed portfolio is the way forward, albeit with a decreasing reliance on the NHS. On the other hand, private income is highly dependent on disposable income and therefore highly susceptible to the swings in economic cycles.

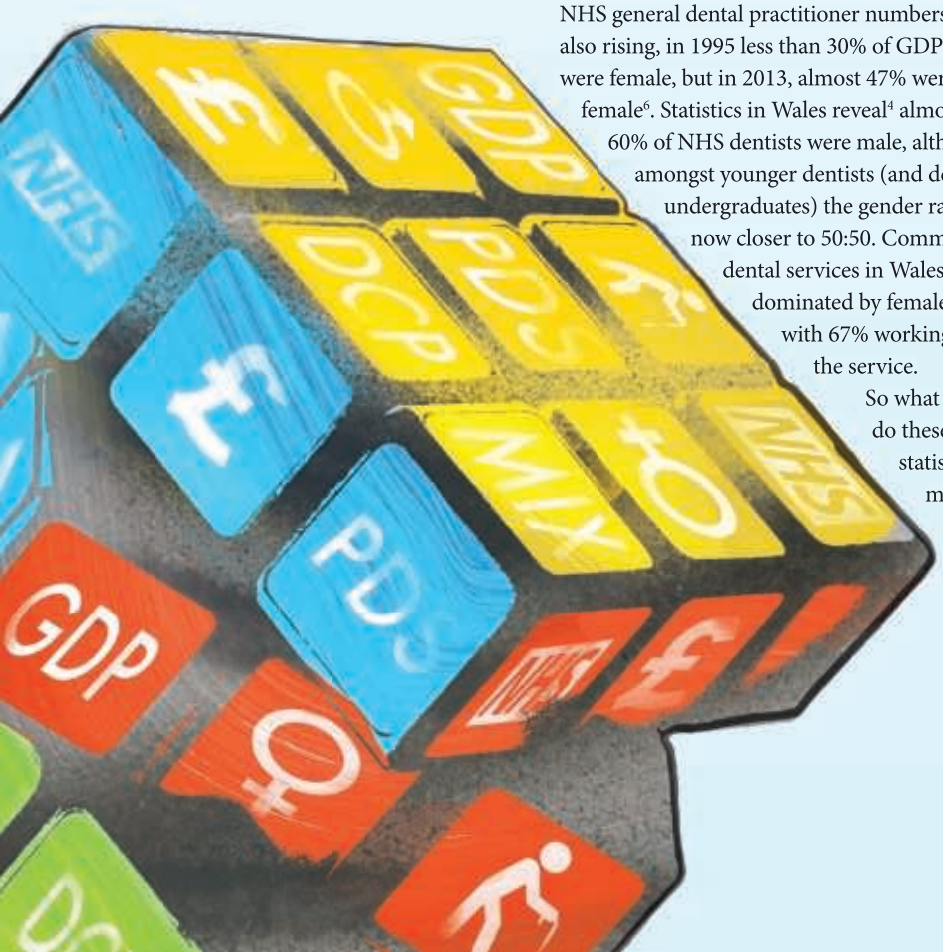
According to Stephen, the problem with a dental market like the UK's, characterised by government intervention setting price below market equilibrium, is that it is inherently unstable, and creates market failure. Fundamentally, it leads to excess



demand, making it difficult for the public to find an NHS dentist or forces them to obtain treatment privately. Basic price theory applied to dentistry in Figure 1 highlights the excess demand caused by the NHS setting patient charges below market equilibrium (P_e^0); the demand for dentistry is far greater than what is available. So what do patients do? They either queue or go privately at an artificially inflated price (P_{pr}^0).

'I'm not advocating the NHS increases its price for dentistry', Stephen added. 'What I do think needs to change is the way we have dealt with the excess demand. More dentists is not the answer. Excess demand is not increased demand. What we have seen is lower earnings and ultimately lower service provision. If there are more of you, there's less of the pie to go around.

'Of course, when you're faced with this situation, it's not a surprise more and more practices are turning to private work, so take time to analyse what decision you are going to take without blindly thinking private will be the answer. The message is the grass isn't always greener on the other side, but remember this does not mean more money as gross earnings of private practitioners have generally been less than NHS practitioners. What it does offer is fewer patients but more time with the patient and therefore a better working environment.



Male or female?

At the recent Local Dental Committee meeting in Birmingham, it's not beyond a stretch to say the makeup of the committee members was very heavily weighted towards men. I'd go as far as saying there were roughly nine men to every female. Taking external factors into account, was that audience truly reflective of the gender balance in the profession?

> 'This changing demographic of the dental workforce is prompting new ways of working.'

The answer, quite simply, is no. Perhaps in 2005/06 when 63% of registered dentists were male you could understand it. Fast forward 12 years, and that figure is now 53%, and falling to such a degree that by 2020 it is likely the number of women working as dentists will outstrip the number of men.

In 2014/15 in England, the number of female dentists stood at 11,285, a 3.1% increase on the previous year, and a 44.2% increase on 2006/07[4]. This pattern is also being repeated across the devolved nations. In Northern Ireland, the General Dental Service workforce is becoming increasingly female; 52% in 2015[5]. In Scotland, female NHS general dental practitioner numbers are also rising, in 1995 less than 30% of GDPs were female, but in 2013, almost 47% were female[6]. Statistics in Wales reveal[4] almost 60% of NHS dentists were male, although amongst younger dentists (and dental undergraduates) the gender ratio is now closer to 50:50. Community dental services in Wales are dominated by females, with 67% working in the service.

So what do these statistics mean?

This changing demographic of the dental workforce is prompting new ways of working. Working patterns, practice models, professional incomes, specialty training and practice and leadership are all changing.

Interestingly the leadership paradigm in the upper echelons of dentistry does not appear to translate to practice level. Practice ownership did not seem to be an overriding ambition of many women dentists, with only 27% of non-practice owners saying that they would like to. Of those who said 'no', the reasons given were that they weren't business minded or were simply happy in their current situation, as well as that owning a practice would not fit in with their family and spouse or partner's job. Many also mentioned that the paperwork, responsibility and commitment were just 'too much hassle'.[7]

What we are seeing in dentistry is also reflected in student intake. In 2005/06, 56% of dental students were female. Now this figure stands at 64%.

You may be wondering why 56% of dental students were female in 2005/06, yet only 37% were registered dentists in the same year. Could the answer lie with dental care professions?

Possibly. Female dental care professionals outweigh their male colleagues significantly. Roughly 90% of all DCPs are female.

So, if there are more and more women entering the profession, surely the leaders of tomorrow will also be female?

Not so fast. While England, Scotland and Wales all have female Chief Dental Officers, statistics suggest leadership does not necessarily translate into ownership. It was recently put to this editor that females produce 50% less output than their male colleagues, so in theory it would take two female practitioners and/or owners to be as efficient as one male.

A challenging, thought-provoking and downright sexist claim perhaps, but if you look beyond the inflammatory phrasing and initial shock value, statistics show this may have some element of truth.

Research[8] suggests women are more likely to be working part-time, as 54% said they worked 30 hours or less. Compare that to their male counterparts, where just 27% of men work part-time. This may go some way to explaining the point the above comment alludes to. Among associate dentists, women are more likely to work at just one practice (79.9%) compared to men (74%). Men are more likely than women to work in multiple practices. If women are doing fewer hours, of course they will not see as many patients as their male colleagues.

There is little doubt that within a decade women will have eclipsed male registrants. What remains to be seen is how they will fit into the jigsaw. Part-time practice owners? Full time principal dentists? Some would argue part time leadership isn't a model that works, but if there are more women in the profession than men, and women are more likely to work part time, is it an eventuality? Only time will tell.

Does age matter?

There's a fabulous line in Pink Floyd's *Time*, which goes: '*The sun is the same in a relative way but you're older*'.

In a way, that's the story of dentistry. Dentistry will always be the same in a relative way, but things change and we grow older. Technological advances are rampant in the profession, and over the course of the years we have seen a number of new documents – think Child Protection and the Dental Team and HTM 01-05 – that either changed the way you worked or are part of everyday practice.

Since 2006-07 there has been an increase in the number of dentists across all age groups in England, with significant differences in the gender profile of each age group. In 2015/16 the under 35 and 35-44 age groups have a greater number of female dentists than male dentists.

In 2006/07, 51.8% of all dentists under 35 were female compared to 57.8% in 2015/16. In 2015/16, 75.4% of dentists who are aged 55 or over are male.[9]

The age distribution of dentists in Scotland has also significantly changed over the last decade. 2015 is quite different to the age distribution of dentists in 1995 reflecting the ageing of the dentists who remained in the workforce from 1995 and the inflow of younger dentists since 2005: in 1995 6% of GDS-PDS dentists were older than 55 compared to 11% in 2015.[10]

In Wales, approximately half (51%) of Wales' dentists are aged below 40, while around one quarter (27%) are aged 50 or above. Over half of Wales' dentists are male (57%). However, the gender distribution of younger and older dentists differs. While the gender distribution of dentists aged under 40 is broadly 50:50, there are a higher proportion of older male dentists.[11]

In Northern Ireland, while there has been a minimal increase in the number of dentists from 2012 to 2017, there has been significant increases in the number of practitioners 35 years of age and older. The biggest increase has seen practitioners between the ages of 50-54 (4.3%), while 30-34 year olds have gone the other way (4.8% decrease). Females outweigh their male colleagues until the ages of 45-49, when the ratio is almost 2:1.[12]

> 'Perhaps the eventual introduction of a new dental contract will be the asteroid in our profession and significantly change these projections.'

The mere fact that there are a large number of older dentists still working in practice may reflect the overall trend in population. Older patients will have established a rapport with certain professionals, so they may be reluctant to move on. They may simply be providing leadership to the influx of younger practitioners coming through their doors. That's a suggestion highlighted in the PwC report[1], which says millennials are comfortable working with older generations, and particularly value mentors.

Conversely, 38% said older senior management do not relate to young workers, and 34% said their personal drive was intimidating to other generations. Certainly many associates have to have the drive and enthusiasm to succeed just to get their foot in the door.

What does all this mean?

All the statistics point to seismic changes in the dental workforce. As evolutionary processes go, there will always be tipping points where change becomes defined. There is a feeling that, particularly with the rapid advances in technology, that time is now.

So what does the prototype worker of the future look like? The majority of the work is still being carried out by dentists, but that is being eroded every year. More practitioners are performing private work, in part driven by the high returns garnered from new technology. More female practitioners working variable hours will be responsible for the work, given the sea change in gender balance. Those practitioners will either be at the start or very end of their career, given the flow of older dentists and younger dentists.

If only it was as easy as *Weird Science*. This worker and leader may not come to fruition. Perhaps the eventual introduction of a new dental contract will be the asteroid in our profession and significantly change these projections. Whatever happens, you can be sure of one thing; dentistry will continue to change. Like a chameleon, it will adapt to its environment. Why? Because it has to. ◆

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Help! I'm scared of the dentist

by Shaila Patel-Buxton,
General Dental Practitioner, BDS Mfgdp Lfhom (Dent)

At social gatherings and parties when I'm meeting new people, I hesitate for a fleeting moment before I share that I'm a dentist. I recall an experience of meeting someone who immediately went pale and started shaking at the mere mention of 'dentist'. I was newly qualified at the time, and hadn't seen such an exaggerated 'dental phobic' response before.

Almost half of UK adults have a fear of dentists and it's thought that 1 in 8 people are so scared of going to the dentist, they have dental phobia.[1] As dentists, we become aware that nervous patients come in all shapes and sizes, but we may not know the causes of such nervousness, the associated behaviour it leads to and how we can help the patient.

We can create empathy from a place of understanding, without upset or judgement of odd or challenging patient behaviour. This openness allows us to establish a better working relationship with nervous patients and improves the decision-making process.

We are guided by the patient as to whether we should attempt treatment, or whether the anxiety or phobia level is so high that a referral should be made for sedation or specialist clinic in line with GDC guidelines: *'You should manage patients' dental pain and anxiety appropriately.'*[2]

In my experience, real transformation takes place when a patient learns to overcome their fears and phobia. As their oral health improves, so does overall confidence and wellbeing, creating enhanced quality of life which is hugely rewarding to see.

Fear or anxiety?

'Fight or flight' is a fear response describing our behaviour when we are threatened – we either stay around and fight, or escape danger. But we also have other responses to a threat. We might freeze, become hypervigilant, yell or scream rather than get physical or flee.[3]

In popular psychology, 'fear' concepts are commonly used. Fear of the unknown, fear of flying or fear of failure, yet these are experienced as the emotion of anxiety.[4]

Anxiety is a general state of distress that is longer lasting than fear and produces symptoms that could be physical, psychological or a combination.[4,5] Sometimes patients become fearful of experiencing anxiety itself because it's so exhausting.

Anxiety seems to take three main forms and patients may experience more than one type:[5]

- **Generalised anxiety disorder (GAD)**, where symptoms are present most of the time.[6]
- **Panic attacks** are unpredictable, sudden and intense attacks of anxiety. The feelings are strong and come on suddenly, reaching a peak in 10 minutes or less. Patients may also feel that they are going to die, lose control, choke or be short of breath.
- **Phobia** is when patients feel really frightened of something that is not actually dangerous and which most people do not find troublesome. The nearer they get to the thing that makes them anxious, the more anxious they get and so they tend to avoid it. Away from it they feel fine.

Common concerns associated with dental phobias are loss of control especially of personal space, being ridiculed or 'told off', and the possibility of feeling pain during treatment. In the 2009 Adult Dental Health Survey, more women than men had extreme dental anxiety.[1]

Signs and symptoms

The level of anxiety a patient can present with may vary from mild symptoms to an extreme phobia. We might notice one or a combination of anxiety symptoms the patient is not always aware of. Sweating, trembling, pacing, feeling faint or dizzy, muscle tension, choking sensation, dry mouth or difficulty opening mouth are physical symptoms. Obvious emotional symptoms could be a glum face, tears and crying, whilst anger is often projected outwards as passive-aggression or general irritability. We may notice an Intellectual response of the mind - asking lots of questions, looking for answers, expressing a need to feel safe and assured. There may be an exaggerated response to minor surprises or to being startled, such as a sudden noise.

What causes anxiety?

Genes

Some of us seem to be born a bit anxious – research suggests that it could be inherited through our genes. This idea was explored in the 2005 BBC Horizon documentary '*Ghost*

in your genes', featuring emeritus Professor Marcus Pembrey of Paediatric Genetics at (UCL) University College London who said:

'At the heart of this new field [of epigenetics] is a simple but contentious idea — that genes have a 'memory.' That the lives of your grandparents — the air they breathed, the food they ate, even the things they saw — can directly affect you, decades later, despite your never experiencing these things yourself.'

Trauma

Some circumstances are so upsetting and threatening that the anxiety they cause can go on long after the event. These are often life-threatening situations like car crashes, train crashes or fires. If this happens, patients can feel nervous for months or years after the event, even if they weren't physically harmed. This is part of post-traumatic stress disorder**.** It can also happen in patients who have been neglected or abused in childhood; or persistently mistreated as an adult.

Psychology and memories

Some patients start to believe that the physical symptoms of mild anxiety are symptoms of serious physical disease. This makes them worry more, so the symptoms get worse, so they worry more... and so on.

Bad memories of childhood dental treatment, such as painful fillings or the smell of the equipment used to administer general anaesthetic can cause dental phobia.

'I can remember having to have a tooth extracted as an 8-year-old (maybe!) and having this black rubber funnel thing put over my mouth to knock me out….it was horrible. So, I would only go to the dentist when really needed during my teens or when my mum made me. As I became an adult I could make my own decisions, so decided not to go at all.'

Sometimes shared negative dentist stories e.g. from parents and grandparents transfer anxiety to their children, almost like a habit that has been unconsciously copied such as nail biting.

Drugs

Street drugs like amphetamines, LSD or Ecstasy don't help. Caffeine in coffee can be enough to make some patients feel over anxious!

Mental and physical health problems

Many mental health problems can increase patients' anxiety. About half the people with depression get panic attacks at some point. Anxiety can also be a symptom of a medical conditions like hyperthyroidism, certain cancers, cardiac and lung disease.[7]

The nervous patient journey

Anxious and dental phobic patients are looking for a dentist and a dental team they can learn to trust and be comfortable with. They will examine our verbal and non-verbal communication such as eye contact and body language, to look for signs of reassurance.

Establish good rapport by welcoming patients with care and empathy, while putting your preconceptions aside[8]. Take the time to observe and assess demeanour and disposition – are they relaxed or displaying any signs of anxiety or phobia?

Patients may initially be upset and tearful, angry or ask lots of questions, so communication is key. Ask open questions to encourage patients to share their story and show you are interested in them. Ask about their fears and triggers, or throw up suggestions if they are not forthcoming, like 'is there something in particular you are frightened of?' or 'is there anything else you are worried about?' Use encouraging words and language and give plenty of time for patients to answer. Really listen to understand and receive clues on how to tailor treatment to allay their worries and anxiety, with the aim of helping them to achieve good oral health.

So much can be done to assuage patients' anxiety by developing good interpersonal skills and bedside manner. However, mental health problems are prevalent worldwide, and in 2013, there were 8.2 million cases of anxiety in the UK.[9] This potentially creates a requirement for dentists' to delve further into understanding mental health issues to really serve these patients. Further research and training into how additional therapies such as CBT Cognitive Behavioural Therapy, Talking therapies, and Homeopathy can help patients overcome their dental anxiety and phobia could really help transform the impact we have on our patients and communities.

Tips for navigating the patient

- → Does the patient require more time and management? If a patient is visibly upset or crying, stop and wait for them to calm down. Sometimes, it might take 2 or 3 visits before a patient is calm enough to have a full check-up, discuss and fully consent to treatment, especially if its complex
- → Create a protocol with the patient to let them have 'perceived' control. Do they prefer to listen to music on their headphones as a distraction? Do they want explanations just before treatment commences? Which tooth or area do they want treated first where possible?
- → Agree a 'stop' signal such as raising left hand. Some patients are too frightened to use this, so stop if you sense they are in discomfort and check-in with them
- → Make sure you have good pain control and allow enough time for anaesthetic to take full effect before treatment is carried out
- → In severe phobias, consider whether a referral for sedation or specialist clinic would be in the patient's best interests
- → Frame up the treatment in advance so the patient knows exactly what's happening. Explain to them how long the appointment will be and what to expect post-operatively. There might be pain after root canal treatment and that strong painkillers may be required
- → Follow up with patients after treatment via phone or email, to add further re-assurance

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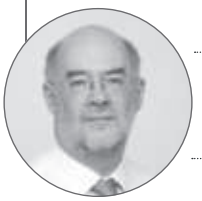
Customer action



by Bob Hughes,
CEO, the Forton Group

In this series of articles about leadership we have covered three out of the four clusters; thinking, involving and inspiring. We now move into the final cluster; doing.

This may seem the most obvious and the most important cluster; surely we should just get on and deliver?

Yes. If we don't know where we going, if we haven't truly involved the team, and they don't feel inspired, then our chances of success are diminished.

There's an old saying: 'Vision without action is a daydream; action without vision is a nightmare'.

The 'doing' cluster has three behaviours in it:

1. Customer action
2. Measuring improvement
3. Proactivity.

Let's start with customer action.

Now, the word customer might not be the right word for you – stakeholder, patient, client all work. And even if you are not in a role with direct contact to those people, you still have an impact, positive or negative on their experience.

As I write this, *British Airways* are still struggling to get over the customer relations disaster that happened when all their computer systems went down. One theory is that somebody inadvertently bypassed the uninterruptible power supply to the computers. If true, that one individual has probably had a bigger impact on the organisation's reputation than any individual front line staff member ever!

So what gets in the way of good customer service?

One of the common things we see is the 'jobsworth' individual. I suffered from one of these recently – in fact, a whole organisation full of them. I missed a deadline to apply for some tickets for a charity event by a couple of days. The event wasn't due to happen for another two months. I tried to persuade them that the deadline was arbitrary. I was as nice as possible and apologised because of course, ultimately, it was my own fault. However, it proved impossible to persuade them to put me on the list, despite this clearly being a very simple thing for them to do.

You could argue they were just doing their job, but contrast that with those organisations that go out of their way to help you. If, like me, you forget to pay off a credit card; you call the company, explain the mistake, and pay then and there over the phone. You then experience a very pleasant surprise when they offer a rebate on the interest.

It's not hard to work out which of those two organisations you'd recommend and want to do business with in the future.

When organisations call us in to improve their leadership, I discuss with the board what exactly they are trying to achieve. Typically, it's a variant on the theme of getting people to take more responsibility and to take ownership. When people do this, it usually has a positive impact on the customer experience.

Now sometimes, we see instances of systems being put in place and people following guidelines that are designed to focus on the customer but somehow just don't quite get it right. I'm sure you've experienced this too. Our bank had mistakenly sent my debit card to my wife and *vice versa*. I wrote asking if this was a lucky coincidence or whether there was a possibility my card could have gone to a stranger. I also asked them to explain what they had done to fix the problem.

They wrote me a standard apology letter with compensation.

I wrote back and said thank you but I'm still no clearer on what the problem was and how you fixed it.

They wrote again, and with more compensation.

By the time we had amassed a tidy sum, but with no clear explanation or security guarantee, we moved our account to a different bank.

People who display the 'Customer Action' leadership behaviour at the level we call 'adding value' are those who will make an effort, take a specific action, resolve an immediate problem, but go no further.

What we need is for leaders to see the bigger picture, to create solutions that provide an immediate customer resolution and have a longer term impact on customer satisfaction, perhaps affecting a number of customers.

Here are some tips to help leaders develop this particular knack. They link well to other behaviours we've already discussed; empathy and influence for example.

Tip: Build high quality relationships with customers.

By doing this, we can begin to truly understand their needs. There is a famous quote from Henry Ford 'If I'd asked my customers what they wanted they would have asked for a faster horse'. But of course that doesn't mean we can ignore our customers; only by understanding their need to go faster could Henry Ford have been able to persuade his customers of the benefit of a car over a horse.

Tip: Put yourself in the customer's shoes.

We need to understand what it's like from their perspective. I recall phoning an organisation and being told that I needed to be put through to a different department. The agent at the end of the phone was very helpful and offered to connect me. This involved her going in to the initial point where I would have gone to. As is common, she then had to select a number to move onto the next selection and therefore went through the same frustrating process we've all experienced from automated systems. When she got to the fourth selection she exclaimed 'oh for goodness sake!' I laughed and said 'now you see what we have to go through'.

Tip: Be very clear about the connection to the customer whenever business decisions affect them.

We can't just assume that they, or our colleagues and employees, will make that link for themselves. Far too often, we see changes being made that, I'm sure, the company truly believes counts as progress and improvements, but not when seen through consumers' eyes.

> 'What we need is for leaders to see the bigger picture, to create solutions that provide an immediate customer resolution and have a longer term impact on customer satisfaction, perhaps affecting a number of customers.'

Two examples are Microsoft and Samsung.

The initial release of Windows 10 by Microsoft was seen by many as a retrograde step, designed as it was for touchscreen computers that most people didn't, and still don't, have.

With Samsung, they keep upgrading software that changes the look and feel of the apps that I use on my phone. I am sure they are convinced these are improvements, but to me they waste my time as I relearn how to use the app.

Tip: If you are making decisions that impact on other people, then involve them in the process.

We've worked with organisations reviewing their organisational values. Some companies like to send their executive board on a retreat to craft the new values. Other organisations prefer to use focus groups of existing employees and sometimes even customers, to create the values. I'm sure you can see that the second approach is more likely to get better buy in.

When we start to understand our customers better and make decisions based on their needs as well as our own, then we can truly focus on them. We move from just fixing the problem to creating real long-term value. The credit card company I mentioned earlier not only refund interest charges; they did three other things. Create a reminder to check that everything was all right a month later; offered to set up an alert to my mobile phone for my monthly payments and arranged a more efficient way for my direct debit to work.

Since finding new customers costs between four and ten time more than keeping an existing one, investing in better customer relationships through Customer Action is demonstrably worthwhile.

So let's take it up another level. I talked about actions that will improve the focus on our customer but to demonstrate this behaviour at the highest level, we need to see changes in systems and processes that will benefit all customers.

So the sales agent that takes their experience with one customer and suggests improvements to the processes that will benefit all customers is demonstrating this behaviour at the highest 'strategic' level. Organisations that change their processes, whether prompted by an individual or by a constant monitoring and questioning approach, will be naturally more successful.

I don't usually talk about Ryanair in the context of good customer focus. For many years they didn't even have a customer complaints department on the grounds that their product was so cheap people had no justification complaining if the service was poor. Michael O'Leary, the boss there, said 'Are we going to say sorry for our lack of customer service? Absolutely not.'

Recently, however, they changed their mind and now have a department to deal with customers. Whilst I applaud that move, I'm not so sure about the rationale behind it. O'Leary candidly admitted: 'If only I'd known being nice to customers was so good for business I'd have done it much earlier!'

At its highest level, this behaviour is about lasting, strategic change. Fundamental changes to the organisation that put the customer at the forefront. This includes everything the organisation does to the business processes, the structures, even the reward systems so change is evident and is linked, throughout the organisation. That's radical.

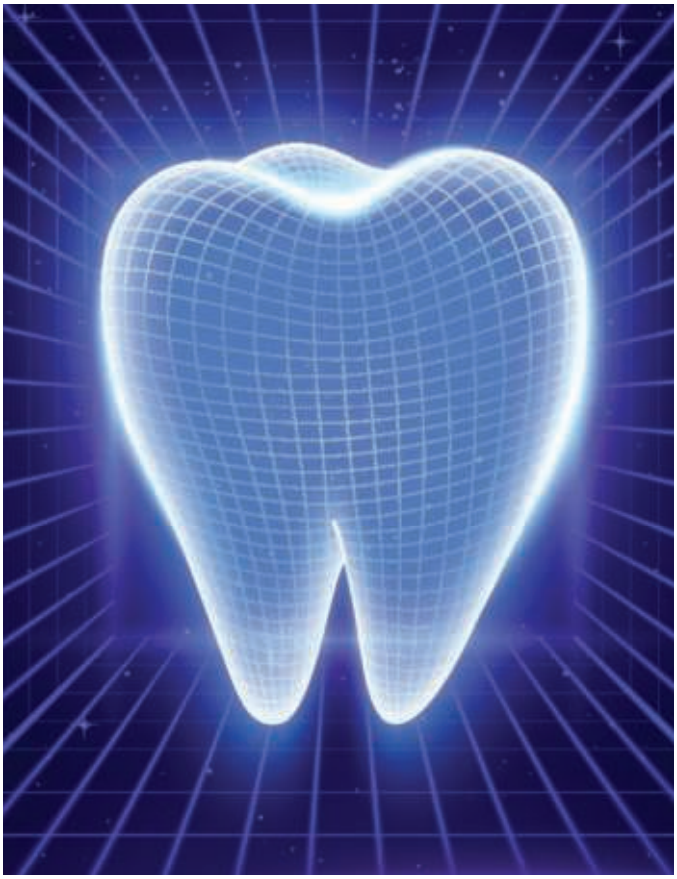
I'll leave you with this question. What radical changes do you need to put in place that will transform your organisation through customer action? ◆

Seminar Series

BDA
British Dental Association

New whitening trends 2017

The future of tooth whitening and minimal invasive aesthetic dentistry



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Cleaning up your knowledge

Everything we do is based on guidelines and standards. House style and certain forms of referencing, adherence to guidance such as DBOH and Child Protection and the Dental Team – to name but a few – for dental professionals.

In 2009 the release of HTM 01-05 was considered one of the most important developments in the profession. The formalising of standards relating to decontamination and infection control brought everyone onto the same hymn sheet. *BDJ In Practice* spoke to Patron of the Society of British Dental Nurses, Fiona Ellwood, about what the last eight years have meant for the dental team.

Fiona Ellwood
Patron of the Society of British Dental Nurses

In your view why was HTM 01-05 so significant?

Decontamination and infection control were always part of core training for dental professionals prior to that, but when we look at significant developments and key changes, the publication of that document went a long way in basing what we did and would do on best practice. It's not too much of an exaggeration to suggest things changed forever – and for the better – at that point.

Dentistry is a fast-moving profession, so how often does HTM 01-05 get looked at?

It was formally assessed again in 2013, but there were a number of amendments introduced before then. I'm lead to believe the latest review of the standards should have already been published.

I do think it is important documents like this are reviewed frequently. We as dental professionals always look for what we do and how we do it to be evidence-based. The problem many practitioners found when it was first released was parts of that document were not evidence-based. Some of the amendments introduced over time, such as the storing and packaging of instruments, was done on the basis of new information being presented.

So what was the biggest change pre and post HTM 01-05?

For me the answer is twofold. Decontamination and infection control

standards in the community dental and hospital services were already structured and streamlined. Those working in general practice were operating their standards more by way of unwritten rules and what they considered to be the right thing to do. For those, that change was enormous.

Looking back, those in hospitals and CDS were probably better equipped than general dental practitioners and one-man practices, who may have found it quite a challenging change. The workflow had to change and it was costly – people were expected to buy new equipment, for example. Timeframes had to change too. For example the dental nurse who was already doing 100 things had to do that as well. For those with the revenue, they employed 'decontamination assistants', but the principle remained the same – it was further financial outgoings not long after the economic crash in 2008. The structure, the flow, the consistency and the way we approached packaging were the biggest changes.

Fast forward eight years. That document is embedded. It's now part of everyday life in practice, but what is the impact of those changes and developments?

If you talk to nurses involved in the workstream, if it has been part of their training and they were born into the profession after 2009, they don't know any different – it's always been a part of their job.

> 'There are different types of gloves, but the issue is the use of cleaning agents such as hand washes and hand rubs between changing them. Some take the former as a replacement for the latter, and that is absolutely not the case.'

Those who were part of the change have adapted – because they had no choice – but they adapted well. The challenge for many dental teams is now keeping their knowledge up to date. That's proving to be more difficult than it sounds. There are mixed messages on what you should/should not be using. Unfortunately we are increasingly seeing people and companies providing CPD from a sales perspective rather than theoretical and learning one. Throw in antibiotic stewardship and the need for a wider understanding of why those issues are important and there is a huge expectation on dental nurses and the entire dental team to understand why.

What are some of these mixed messages?

Take the changing of gloves for example. There are different types of gloves, but the issue is the use of cleaning agents such as hand washes and hand rubs between changing them. Some take the former as a replacement for the latter, and that is absolutely not the case.

Where do these mixed messages originate?

There are a variety of areas, and that in itself is a problem. We have the guidance yet many professionals interpret what is said in a number of ways. As a Society we take a great deal of guidance from one of our Fellows who specialises in oral microbiology for dentistry. We also have decontamination leads within the Society.

Is that something you would recommend?

HTM 01-05 recommends you appoint a decontamination lead. Sadly we still hear about practitioners taking on the responsibility and juggling multiple expectations. There isn't really a group to share best practice with, so it's done on an ad-hoc basis. Everyone draws from a different point of knowledge.

Could HTM 01-05 go a step further than recommending one is appointed?

I don't think it would be too far at all. Yes there would be challenges with not only implementing the directive, but who would give it in the first place. I firmly believe decontamination and infection control standards are so important for the dental team this should be considered.

So what should people looking for CPD in this area consider?

If I look at the courses out there, there is a

criteria I would encourage people to look at before attending. Does it meet GDC standards? Does it meet CQC? Does it meet both? As with anything that is potentially product-driven, there will be an agenda behind it. This is such an important topic we have to look beyond that.

Find a competent and qualified lecturer who you feel comfortable with and believe has the knowledge to deliver, can award CPD and goes through quality assurance practice.

When we developed our courses we assessed what the GDC requirements are, what CQC says and what the current standards are and our quality assurance programme. We have developed an accreditation approval pack so nurses can see the advice is coming from the Society. That's quite an important point for not only dental nurses to consider, but for the principal dentist too. When registration changed, nurses then had ownership of their professional position and an expectation of learning. No longer were dental nurses expected to turn up, do their job and go home; they were expected to become involved as wider members of the dental team.

You mentioned anti-microbial stewardship earlier. How does that play a role?

We are trying to let dental nurses know about good infection control and prevention. We can stop infections from developing by educating those within the team responsible for decontamination and infection control how these things start and break that chain. If they don't understand what they're doing, they won't be in a position to prevent bacteria from spreading.

Do you think extended roles within the dental team are a benefit?

Absolutely. Extended roles are a huge benefit. If you take CDS, who have a decontamination lead, the person responsible does the monitoring, auditing and competence checks. I go back to responsibility and accountability. It can keep nurses motivated. I was chatting to a dental nurse not long ago who said she could earn more stacking shelves, so they're in it because they care for people. Developing a nurse who is passionate about decontamination and infection control standards can be an asset.

> 'We are trying to let dental nurses know about good infection control and prevention. We can stop infections from developing by educating those within the team responsible for decontamination and infection control how these things start and break that chain.'

Is there one point you want to emphasise when it comes to standards?

That's simple! Not to assume everyone knows what they're doing. It's a funny thing to say given the level of qualifications and training needed to enter the profession, but it's a dangerous, natural assumption to make. Sometimes we find the induction process is quite often poor so, the key thing is continual training to ensure you and the team are up to date.

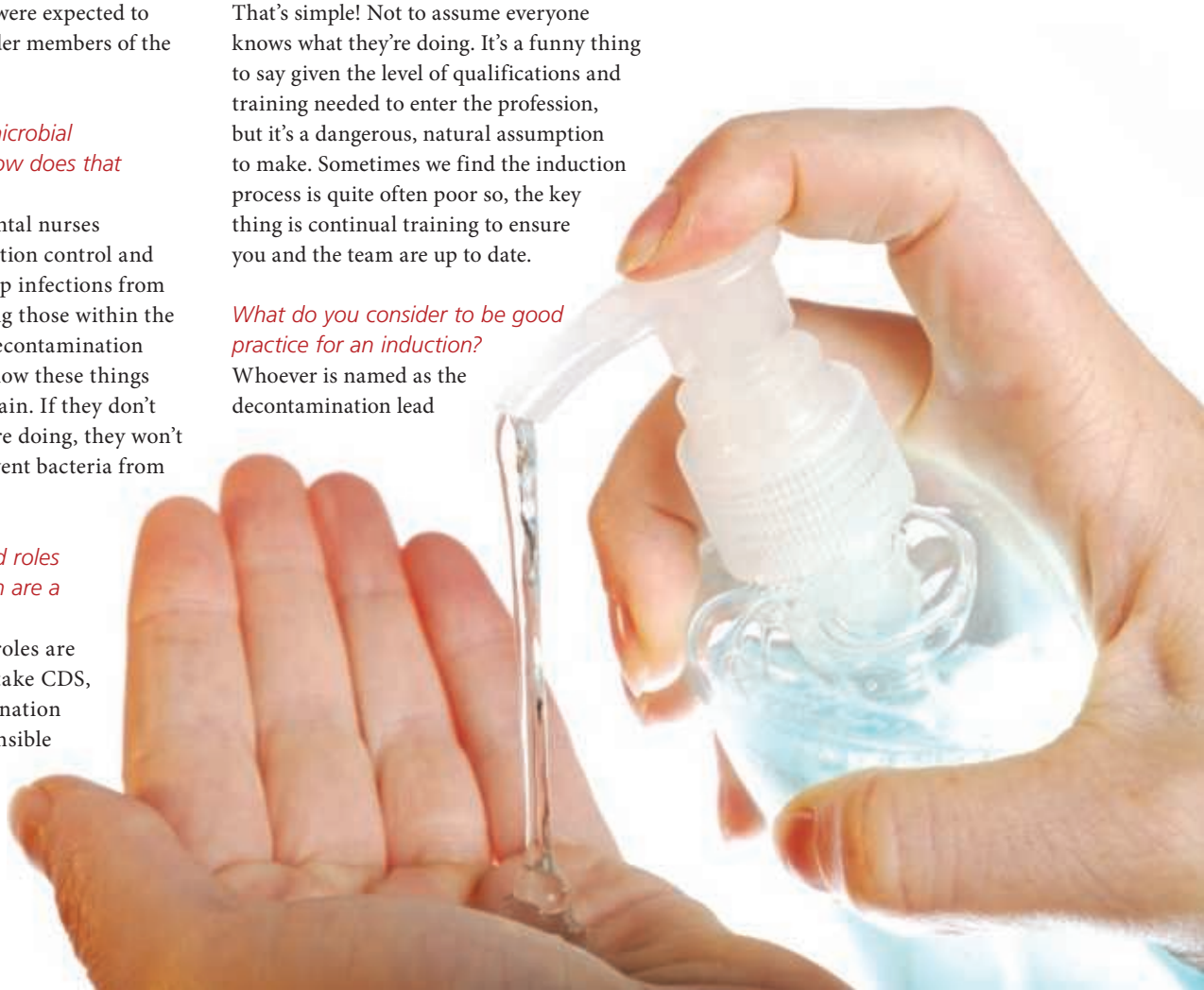
What do you consider to be good practice for an induction?

Whoever is named as the decontamination lead should spend time getting up to speed in the practice long before they start working. A model of not thrown in at the deep end and escalating into working is a good way to approach it.

You always have to consider the implications for CQC and the standards set by the GDC. Patients have a right to be treated in a clean and safe environment. Ask yourself; what would your team say about your procedures? What would your patients want to know? It may be useful to promote your decontamination lead in your practice reception.

It was interesting to note the CQC report into dentistry was positive for infection control, but well-led was one area for improvement. For me, well-led crosses over into infection control.

A well-led practice deals with situations that arise when you don't expect them. It also means they have processes and fail safes in place to ensure they don't happen. I'd consider this in the induction process too. ◆



Extinguishers in your dental practice

By Stuart Collyer
Staff Writer at Fire Protection Online

Having the correct fire extinguishers in your dental practice, and installing them throughout, is one of the best ways you can prepare your business for the worst.

Along with a fire blanket in any kitchen area so that a small fire can be tackled without fuss or mess, extinguishers need to at least be in corridors, in waiting rooms, offices, treatment rooms, and staff-only areas.

As a rule of thumb, you should have at least one extinguisher for every 200m^2 of floor space, and on every floor. When it comes to choosing extinguishing equipment, you must consider the potential fire risks in that area, taking note of your fire risk assessment.

Picking the right extinguisher

A number of portable extinguishers are likely to be needed, of a variety of different types, sited in suitable locations, such as by specific threats or on escape routes.

Water extinguishers are suitable for general fires including paper, cardboard, rubbish, and furnishings, while foam extinguishers can additionally be used for flammable liquids.

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Powders are versatile, lighter, safer – if inadvertently used on electrical equipment – and also suitable for flammable gases. However, they can affect visibility and breathing, so should be mitigated by a health and safety risk assessment.

On electrical equipment, CO_2 extinguishers are the best extinguisher to use. Not only will they protect the user from electrocution, but they will prevent further damage to the electronics.

Generally, 9ltr water and 2kg CO_2 extinguishers are the best choices as they'll tackle the fires you're most likely to encounter. But a 9kg powder extinguisher must also be considered, particularly for where any flammable liquids or gases can be found in your dental practice.

Installing and maintaining extinguishers

Remember that extinguishers are not doorstops. To prevent them from becoming damaged, fire extinguishers must either be installed on the wall or at least on an extinguisher stand. They will also need to be partnered with the correct extinguisher identification sign, which will clearly inform users on the types of fires they are and are not suitable for.

When installing new extinguishers, it is highly recommended that you have a professional commission them for you, and this may be a requirement of your insurance policy. They will check that the extinguisher was not damaged in transit, as well and ensuring it's installed at the correct height, in the appropriate location.

Do not trust places offering to commission extinguishers before delivery, as we all know what can happen to parcels in the hands of couriers.

Afterwards, remember to give each a quick once-over at least once a month. Simply look for signs of tampering, whether it is damaged or has been discharged, is suitably pressurised and is in the right place.

Extinguisher servicing

Having your fire extinguishers serviced once a year is a standard laid down under BS 5306-3 and is also required under the Regulatory Reform (Fire Safety) Order 2005.

As a dentist, you know the benefits of carrying out regular checks in order to prevent future problems and to keep things in good condition.

It is the responsibility of the owner to arrange this, and when choosing, the price shouldn't always be the deciding factor.

Low prices often come with hidden charges, and when it comes to lifesavers such as extinguishers, quality, reputation, and even transparency of charges should be held in higher regard.

Also, ask for proof of a specialist fire protection efficacy insurance policy. This means they will pay the cost of the damage should the equipment they pass not work and you suffer financial loss.

Extinguisher servicing involves a visual inspection of the condition, as well as checking for blockages and corrosion. They'll weigh the extinguisher and then provide a service label.

The extended service

All extinguishers also require an extended service every five years, with the exception of CO_2 extinguishers which need an overhaul service every ten years.

This involves carrying out a discharge test to ensure it operates as it should, and to enable the engineer to examine the extinguisher body internally. They will then refill and re-pressurise the extinguisher.

As a result of the extra work and materials needed, the extended service is more expensive, and it is worth considering the replacement of your extinguishers with new ones.

An extinguisher of that age could only be a few years away from the end of its usable life, no matter how well you maintain it. But in some instances, it is actually cheaper to replace and commission a new extinguisher than it is to have an extended service carried out on your old ones. ◆

For more information about extinguisher servicing and choosing the right extinguishers, visit www.fireprotectiononline.co.uk. And when you use discount code 'BDA5', you'll receive 5% off your next purchase.

It all comes out the woodwork when they're on maternity leave

by James Goldman
the 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

Some practices have recently had discussions and taken action over an associate's clinical work whilst the associate is on maternity leave. Speaking to an associate on maternity leave about aspects of her clinical work is fraught with difficulties. Giving her notice of termination of her associateship because you think her standard of care does not meet what you expect in your practice could be the wrong move. Terminating a contract whilst the person is on maternity leave looks on the face of it to be discriminatory.

To the practice, the reasons for termination are nothing to do with gender, it is about clinical concerns. But it could likewise be argued it is also because many practices do not regularly audit their associate's work. For these practices, the first time they find out what their associates are up to is when the associates take a leave of absence from the practice and they start seeing that associate's patients.

Mentoring

There can be a tendency within general dental practice for each dentist to get on with their work and not get around to discussing it with each other. Some practice owners assume associates just do the work; no one checks. Associates could find they have no one to go to; no one to ask about the best way to do a certain procedure; no one provides feedback. Whilst this is likely to apply to male dentists as well as female dentists, the female dentists are more likely to get caught because they are more likely to take a significant leave of absence for maternity leave. It does not mean that there are no problems with male dentists; it just means no realises when there are problems and in some instances patients might continue to receive less satisfactory treatment.

Clinical audit and peer review are activities that could help clinicians to work together to pick up early on things that might not be going so well. They encourage dentists to examine aspects of their practice, make improvements where necessary and, periodically, re-examine areas that have been audited to make certain that the quality of service is being maintained or further improved. Peer review is a way of dentists getting together with each other – from the same or different practices – to discuss aspects of their work and learn from each other. An in-practice approach of having regular audit and peer review cycles can help identify where individuals might work to different standards and learn from each other in a non-confrontational but collaborative way.

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Unwelcome discoveries

However, if despite being a supportive professional environment, a practice owner does discover concerns about past work the associates may understandably question why this has only been raised whilst she is on maternity leave. And she could well have a point. The associate was working happily for years, they go on maternity leave and all of a sudden their work is questioned.

And for practice owners refuting a claim of apparent discrimination can be difficult. If an associate on maternity leave can show a detriment, for instance their contract was terminated, then it is up to the practice owner to show that the maternity leave played no part at all in their decision and that it was wholly due to other objective reasons, namely their clinical performance. However, if a claim were brought it would be considered whether there was an alternative course of action, short of terminating the associate contract that could have been taken. The practice owner then has a very high bar to jump over to defend themselves.

What to do

First, it might be a good idea to conduct a clinical audit of all associates at the practice. You are then not just picking on the associate who is on maternity leave, but reviewing the performance of all associates.

Second, don't rush straight to termination. Even if the work is so bad that termination could be justified. Put together a list of your concerns and ask to discuss them with the associate at a convenient time. The associate may find it difficult to find time if she is on maternity leave and she has to find someone else to look after her baby. She will need time to understand the concerns, consider them and respond. Also offer solutions, for instance arranging peer-review in future if certain procedures come up or identifying helpful courses.

If you approach the associate, or other dental professional, sensitively and constructively; if you engage in a careful dialogue; if you take and follow good advice, you can avoid some of the claims that we have seen members face recently. ◆

Moving from DFT to self-employed status

By Neeta Udhian
Neeta is a Practice Management Consultant in the BDA's Practice Support team. Neeta advises general dental practitioners on associate contracts and all aspects of employment law.

On the face of it, it appears that very little changes when you move from dental foundation training or vocational training in Scotland to self-employed status as an associate. After all, you'll be working in a very similar environment - if not at the same practice – with similar work and similar hours. But what appears to be a subtle shift in the way you work actually has far greater implications for you.

To begin with, as an associate you are no longer in a special bubble of sorts with the support of the deanery and your trainer to guide you, but more than that, you will no longer have employment law protection.

For instance, as you are self-employed the practice owner can, at any time, without reason, give you notice to leave the practice (see article on page 29). That's right, you could be given your marching orders and you would not be able to claim unfair dismissal because you're self-employed.

That might seem a little daunting at first but there are of course many advantages to being self-employed too. The major one being the way in which your tax is handled. The self-employed have to complete a self-assessment tax return each year to tell HMRC of any taxes owed on their income. The self-assessment takes into account any allowable business expenses they have paid out and tax will be due on the difference. This generally amounts to paying less tax and not having to pay it so soon. Ensure you get the appropriate advice regarding your tax affairs though. And make sure you register as a sole trader with Her Majesty's Revenue and Customs (HMRC); look on-line at www.gov.uk/working-for-yourself.

As you will be in charge of your own tax affairs, it's crucial that you keep up to date financial records. Associates should set up a bank account for any business income and expenditure because it is strongly recommended that all business and personal money is kept separate. Keep a record of all income and expenditure for tax purposes and file all your receipts and invoices in date order.

It might be suggested to you that rather than being a sole trader you might want to set up your own limited company which would then invoice the practice owner for the work you do. Carefully think through the implications for this; it emphasises your independent status as a self-employed contractor but would, if you are working within the NHS, affect your eligibility for certain NHS payments. If you choose to work as a limited company, you will not be eligible for the NHS Pension scheme because your provider will be paying your limited company, which in turn will be paying you. You will also not be entitled to NHS maternity pay, paternity pay or sick pay. Over the course of your working life (and your retirement) this could have a substantial impact upon you.

Of course if you are going to work in a practice providing NHS care you need to first get on the appropriate performers' list or NHS list. Make sure you inform NHS England or Primary Care Support England or Primary Care Services Wales through the appropriate routes of the fact that you have completed Dental Foundation training. In Scotland and Northern Ireland you will need to have a vocational training number and have gone through a mandatory induction process to apply to join a Scottish health board or Northern Irish Health and Social Care Board dental list.

Think about what your workload is going to be – it is likely that you will find that the number of patient appointments you are expected to handle will be greater than during your foundation or vocational training. And your earnings will be directly linked to the care you provide. In England and Wales you will probably have a UDA target to reach. Conversely, though, make sure that the practice has a large enough patient base to keep your appointment book busy.

Locum cover is an important consideration for associates. If you are away from the practice for a certain amount of time you will be expected to arrange cover for yourself. Ordinarily this would not include holiday absence up to, say, two weeks but would cover any longer period of leave, sickness absence or maternity or paternity leave. This responsibility is a crucial aspect of your self-employed status and so you must consider what it would entail by discussing it with the practice owner and perhaps identifying a locum or locum agency you could use.

It is also very important for self-employed people to consider income protection insurance in case you cannot work for any reason. Talk to an insurance provider, such as our partners at Lloyd & Whyte, you can check their website at www.lloydwhyte.com/dentists.

Above all, you should ensure your rights and responsibilities are covered in a written associate agreement. Both associate and practice owner are of equal professional standing and so the terms are open to negotiation. The practice owner may be more well-established in business and the agreement has to be right for them as well but this should not preclude a discussion on, for example, the equipment being provided, the hours you will work, your patient list or how you will apportion fees. Consider the terms offered carefully and make use of the BDA's contract checking service by emailing your contract to: advice.enquiries@bda.org ◆

What to do if you have not agreed a notice period

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

One reason given to us why associates haven't bothered with the written agreement is that it makes the arrangement more informal. But it is a mistake for associates to believe that if they do not have a written agreement with their practice owner it makes their working arrangements more informal. It merely makes it more complicated and open to interpretation or disagreement. One major problem is that of how much notice to give.

Notice periods are a crucial part of any associate agreement – when you get into something it is also important to think about how you can get out of it. A notice period also provides an element of security, so the contract cannot be ended immediately leaving you out of work. The absence of a contract and hence a notice clause confuses matters though.

Implied notice

The BDA's Practice Support advisers are asked regularly what notice an associate must give to terminate their agreement in the absence of written terms. It is not easy to give a straightforward answer. A starting point is to refer to the industry norm that appears in many written agreements, which is three months' notice. If there is no written agreement, however, then notice has to be implied. All of the circumstances must be taken into consideration. It might be relevant how many treatment plans the associate is currently dealing with and how long it would take to complete those course of treatment. Length of service would also be considered. If an associate has worked at a practice for only a short time, say, less than six months, perhaps a short notice period may be reasonable. If an associate has worked at a practice for many years then it should be three months but generally no longer.

If there is no written agreement there is a risk that one party may seek to terminate the arrangement between the practice owner and associate with immediate effect. This harms job security for the associate and business planning for the practice owner. Generally, it is unacceptable for one party to end the agreement without notice but it would need the aggrieved party to challenge it legally. This would take time and expense and there is no certainty of the terms that the court would imply, though we know in previous cases they have opted for three months. In one county court case the judge also remarked that he considered the ending of a professional arrangement with immediate effect to be highly unprofessional behaviour.

Unsigned contracts

In some instances practice owners have handed their associate a written agreement but the parties have never got round to signing it. Ideally, the parties should set aside time to discuss a draft agreement, if need be agree any changes and then sign it. However, in the numerous situations where the associate received but did not return or sign the contract the courts would give some weight to the terms of the agreement in the event of a dispute between the parties. If the associate has not expressly rejected the terms there could, by the fact that they have worked at the practice, be deemed acceptance. Therefore associates should not avoid signing an agreement that they find unacceptable but must seek to discuss and explain any changes that they would like to see. Associate contracts by their very nature look long and complex, they have to cover every aspect relating to how associates can make a living. But the BDA offers a contract checking service – you can email your contract to: advice.enquiries@bda.org – a response reviewing its terms will be sent back within 10 working days.

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In order to avoid any complications over your notice period always enter into a written agreement at the outset of any associateship. Generally practice owners will give new associates a draft agreement. This agreement should cover all terms and conditions of the working arrangement such as the equipment provided, the hours the associate will be able to work and how fees are to be apportioned as well as a clause on the notice period. ◆

BDA
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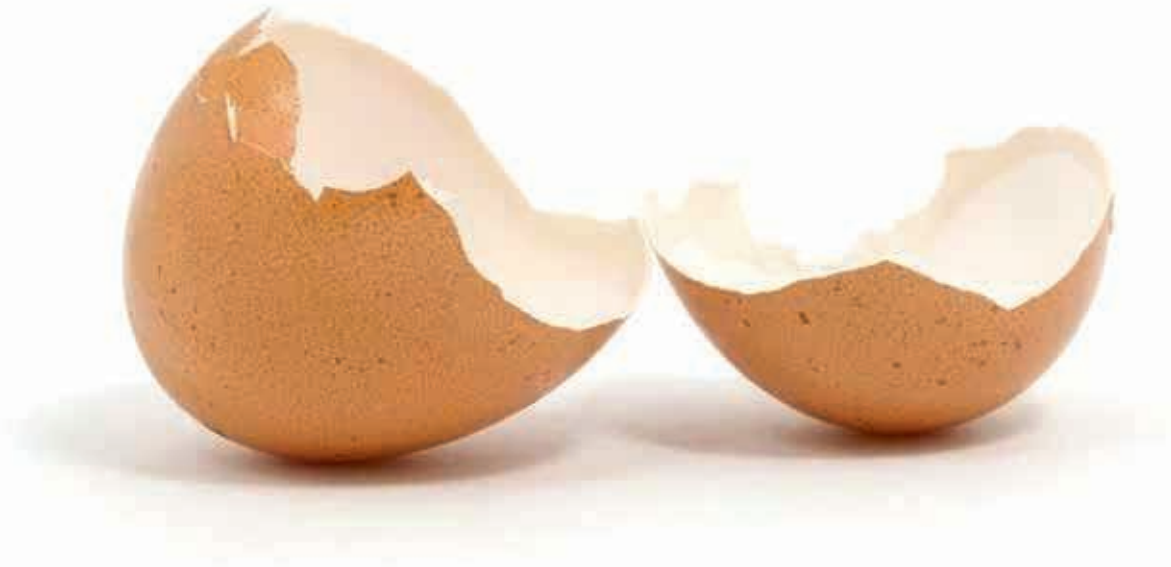
Starting out?



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To find out more call the expert VOCO team on our international Freephone number 00800 44 444 555 or e-mail service@voco.de.

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BioHorizons, one of the UK's biggest providers of dental implants, are delighted to invite dental professionals to consider the future of implant dentistry at their Magic 'I' Symposium, a 3-dimensional look at the future of implant dentistry.

Taking place at the Royal College of Physicians in London on 21 September, the Symposium will provide delegates with an insight into how to prepare their practice for the challenges that implant dentistry may bring in the future. In a fast-changing technological age, dental professionals need to be aware of the latest clinical materials and techniques, and how to market their practice to stand out and become the leading practice of tomorrow.

Expert speakers from the world of dentistry will discuss zero bone loss, soft tissue management, the digital revolution and mindfulness practice.

In addition to the clinical experts, BioHorizons will host a surprise guest speaker to motivate delegates to take their business to the next level.

The full schedule of presentations, plus lunch, an exhibition and a drinks reception at the event's conclusion, will provide a fantastic opportunity to network with dental colleagues.

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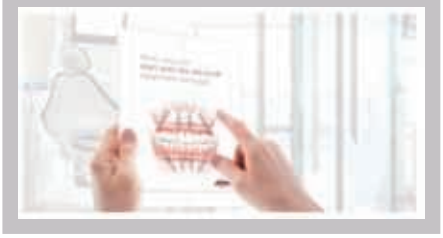

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When it comes to preventing or treating gingivitis and periodontal disease, Wisdom Toothbrushes offers an array of ideal oral health adjuncts for all your patients.

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Wire-free, these adjuncts are also ideal for patients with dexterity problems or those who have previously found wire interdental brushes difficult or uncomfortable to use.

In addition, the Wisdom Super Slim Interspace Brush offers a longer and thinner soft tuft that is perfect for cleaning deeper periodontal pockets, as well as around crowns, bridges and orthodontic appliances.

With more than 235 years of experience, Wisdom is the perfect periodontal. To find out more, please visit www.wisdomtoothbrushes.com or call 01440 714800.

New Anhydrous Stannous Fluoride toothpaste beats sensitivity pain fast

GSK, manufacturers of Sensodyne, have announced the launch of new Sensodyne Rapid Relief which is clinically proven to provide fast relief from the first brush and long-lasting protection from dentine hypersensitivity.

New Sensodyne Rapid Relief works rapidly to form a barrier over exposed dentine and reduce sensitivity in just 60 seconds. The new formulation builds ongoing protection with every brush, supporting the long-term management of dentine hypersensitivity, a painful, chronic condition affecting as many as one in three people.

The formulation contains a combination of stannous fluoride and bio-adhesive polymers which, on contact with saliva, is able to form a gel-like scaffold in the surface of the dentine, helping to trap stannous ions which occlude the dentine tubules. *In vitro* data show that after just one application, stannous ions can extend as much as 80µ deep into the tubules. This robust occlusion is resistant to exposure to dietary acids leading to clinically proven fast and long-lasting relief from the pain of dentine hypersensitivity.

Sensodyne Rapid Relief is available in stores now.

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For more information on Tandex's range of products, visit www.tandex.dk or visit the facebook page: www.facebook.com/pages/Tandex-UK/234855250044190?fref=ts

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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

Midlands

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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

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236739

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

East Anglia

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289511

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Tel: 01223 245266
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Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

283787

South East

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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

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

279798

TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

DENTAL SPECIALISTS ST ALBANS

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

239826

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

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

209440

WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

284695

North

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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

North West

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

261006

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Q2: How often should you have your fire extinguishers serviced?

A Every three months
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C Every year
D Every other year

Q3: Which of these will you *not* be entitled to if you become a limited company?

A NHS Pension
B Flexible working hours
C Employment law protection
D Overtime expenses

Q4: Which of these *would* be included in a general draft agreement prior to becoming an associate at a practice?

A When you can take holiday
B Patient list
C How fees are apportioned
D Flexible working hours

Q5: How should you approach seeking to terminate the contract of an associate on maternity leave?

A As you would with any other member of staff
B Conduct a clinical audit of all associates at the practice
C Consult with colleagues about the associate's performance
D You cannot terminate the contract of an associate on maternity leave

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