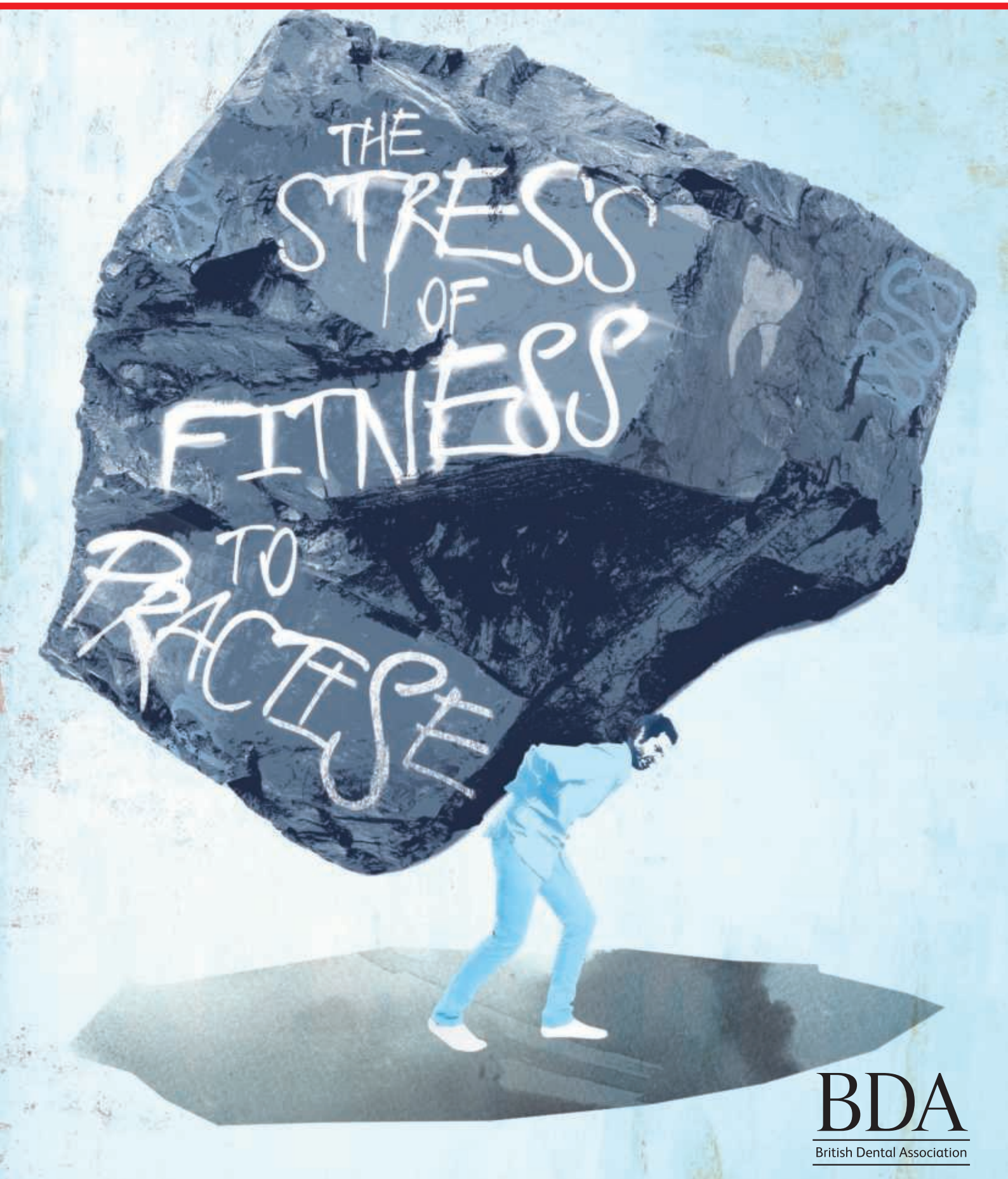
BDJ InPractice
March 2017



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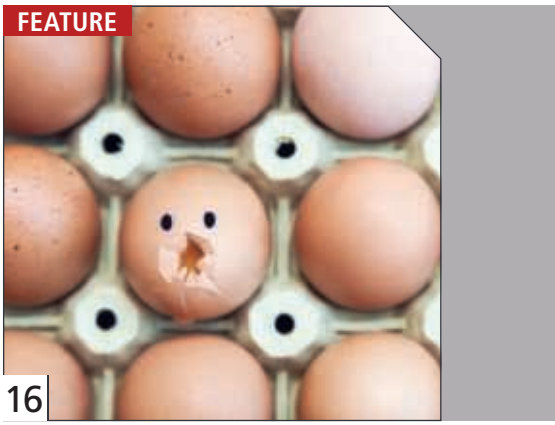

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EDITORIAL

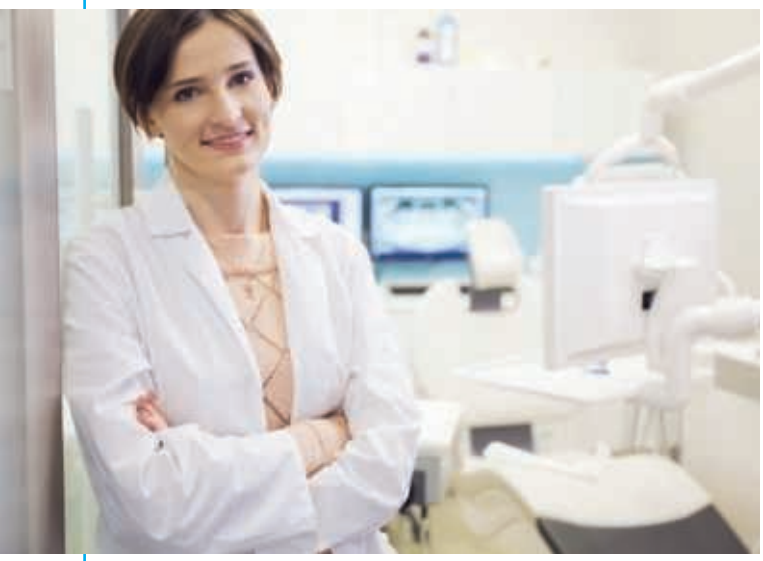
The 'Me' business of dentistry

Peter Ward , Chief Executive, BDA

There are lots of indicators emerging that suggest that a greater proportion of UK dentists will, in the future, be 'doers' rather than 'owners' in general dental practice. The combined impacts of corporate consolidation of practices, growth in levels of graduate debt and changing attitudes to work-life balance mean that many of the current cohort of dentists may never see practice ownership and, instead, be career free-spirits. These developments are at odds with the historic paradigm where typically dentists 'served their time' as associates before the majority ultimately became owners of the practices in which they worked.

With such a transition it could be easy to fall into the trap of thinking that business-related thinking has no relevance to this cohort. My own view is that this is the very time when those free spirits really do need to re-evaluate their approach and reflect on what they want and expect from their career within the profession they have studied long and hard to be part of. Associate dentists are self-employed independent traders who offer their services under sub-contract to practice owners and therein take on the care and treatment of patients of the practice. This self-employed status is much prized and the professional autonomy that goes with it is treasured. The fact that this status may now last a professional lifetime, means that it is worth giving it some consideration in the course of one's life plan.

The nature of a self-employed independent contractor is quite different to that of a salaried employee. Contractors do not enjoy the protection of employment law; they are not entitled to employee' sick pay and have no protection of tenure outside their agreement with the owner. Correspondingly, they should enjoy greater autonomy and freedom of movement and they are responsible for their own acts and omissions. But even more significantly, they are also responsible for their own profitability, their own working arrangements and their own quality standards. The lifestyle expectations that accompany those responsibilities are also in their own hands. The titration between the hours you want to work, the income you expect and the pace with which you operate are all matters within the control of the independent contractor. I know that it may not seem that this is the case, but the ultimate sanction of deciding to serve notice on a given contract and walking away is about as powerful a sanction as anyone can wield. But to decide whether you are getting what you want and need out of a set of arrangements it is first necessary to decide what your requirements are, and equip yourself with the tools you need to achieve those requirements. And then you need the fine tuning controls that will permit you to refine your own version of what a successful career looks like.



These considerations may seem alien to those who think that all you have at your disposal is the opportunity to 'get a job' and take or leave what goes with it. My contention is that that approach is also a matter of choice. Choosing not to steer your own expectations is choosing to accept someone else's version of what's right for you. There may be nothing wrong with that approach, but it is important to remember that you have made that choice if things don't go as you would like.

The alternative to the fatalistic 'take what you're given' approach is to begin to apply some control to your own future pathway. This begins with self-evaluation – what's important to you? What do you expect? What are your desired rewards and what are your acceptable sacrifices?

Only when you have worked out these things can you decide what you want. Only when you have decided what you want can you decide what you need to get there. And only when you have done all of that can you decide what good looks like. When you have got that far you can critically appraise what you have and identify the relative fit and any gaps that may exist. From there you can decide whether you are satisfied or whether you need to make changes and what they need to be. All of that is only any use if you have the skills and wherewithal to initiate those changes.

Over the following months, we will populate our offerings with more detailed materials to help you develop yourself and to maintain a happier and more satisfying career. And we believe this is good news for practice owners too. Satisfied and sustainable associate 'Me' businesses make for better quality practices in aggregate. The greater the motivation and collective self-esteem of the operators the greater the wellbeing of UK dentistry as a whole.

Instead of accepting the slings and arrows from an increasingly hostile operating environment, this offers an opportunity for the dental profession as a whole to take control of its future and to avoid being squeezed into someone else's view of what we are and should be.

So, please read on – let's begin the conversation… ◆

BOOK REVIEW

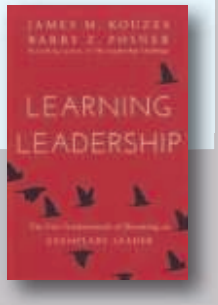
Learning leadership: the five fundamentals of becoming an exemplary leader

James M. Kouzes and Barry Z. Posner

Wiley, 2016

ISBN: 978-1-119-14428-1

£16.99



James Kouzes and Barry Posner are American academics and authors. *Learning Leadership* attempts to present five fundamental principles that will facilitate becoming a model leader. The ability to believe in yourself qualifies as the first principle and specifically the belief that you are capable of leading and even that yes, you can learn to lead. The second fundamental is the ability to aspire to excel. In other words it's essential to attempt be the very best leader possible. To do this you must be clear about your core beliefs and values.

Fundamental three is focused on challenging yourself. This entails stepping outside of your comfort zone and seeking new experiences.

Trying to be a great leader is impossible in the context of a vacuum, thus Fundamental Four states it is necessary to enlist the help of others. This isn't something leaders like to boast about, preferring to give the impression that they did it all by themselves, but undoubtedly having someone to coach them or encourage them is as vital as it is for Olympic athletes. But this doesn't mean enlisting someone to help with your work, but rather to help you learn how to do it better. The final fundamental concerns the ability to practise with the aim of improving your performance. This is not confined to any one activity but one example could be to practise listening attentively to others and setting a purposeful goal in order to achieve this. But ultimately becoming an exemplary leader requires a mindset that promotes continuous growth. ◆

LETTER

A mixed blessing

Sir, thank you for your thought-provoking editorial 'corporates – friend or foe'[1] – about the mixed blessing of corporate businesses in the dental field.

For the last few years, I have had the privilege of teaching a session or two each year to our local FD1s and I have been increasingly concerned that their mind set is one of working within tramlines of corporate process (the NHS is just as culpable as corporate bodies). What has happened to training the new generation of our caring profession to be 'Thinking Dentists'? Where is their focus on doing what is best for the patient? I should stop that particular rant right now but the serious aspect is how they are being conditioned into accepting the corporate principles as being the profession's *status quo.*

Just occasionally there has been a spark of independent thought and that gives me hope for their futures within our profession.

Within 10 years I will probably retire and sell my practice. Your article tacitly emphasised the attractiveness of a single-handed practice, such as mine (www.bedfordplacedentist.co.uk) to a young, thinking dentist who is prepared to stand on his/her own feet. My accountant, who specialises in dental practices, assures me that he has a steady stream young dentist who would be interested in 'going it alone'.

In that way, the arrival of corporates into dentistry will be good for small, independent practices when it is time to sell as we will be of little interest to them but their presence has increased our attractiveness to the future opinion-makers within our profession, those who can think and act for themselves.

Yours sincerely,

Clive Marks, via email.

1. Ward, P. Corporates – friend or foe? *Br Dent J* 2017; **222:** 139.

Working to improve the dental payments system in Northern Ireland

The Northern Ireland Health and Social Care Board (HSCB) has invited the BDA to be represented on their dental payments system user group, to help advise on the issues practitioners are experiencing with the Business Services Organisation's (BSO) dental payments system.

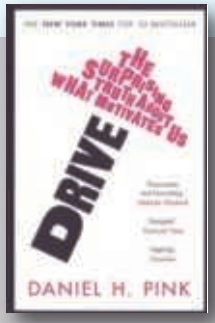
The HSCB acknowledge that there are problems with the system, and in response has established a new user group and has organised training sessions for practitioners.

Practitioners have been sent details and the BDA encourages members to attend. Topics covered will include the payments claiming process, payments reconciliation, ensuring the accurate electronic transmission of claims to the BSO and explanation of error messages.

If you are experiencing issues with the payments system, please contact grainne.magee@bda.org and we will take your concerns to the HSCB. ◆

BOOK REVIEW

Drive: the surprising truth about what motivates us
Daniel H. Pink
Canongate Books, 2011
ISBN: 978-1-84767-769-3
£9.99



Before becoming a best-selling author, specialising in the psychology of business Daniel Pink worked in several positions in politics and government, including serving as chief speechwriter to Vice President Al Gore between 1995 and 1997.

In motivational experiments conducted over sixty five years ago using monkeys and twenty years later with humans, scientists Harry Harlow and Edward Deci discovered that material reward on its own was not a prime motivator and in some instances it actually acted to demotivate. A later example of what author Daniel Pink refers to as intrinsic motivation was the comparison of two nascent encyclopaedias, one produced by Microsoft at a cost and one produced at no cost by everyone. Encarta was abandoned in 2009 whilst Wikipedia goes from strength to strength fuelled purely by altruistic, unpaid contributors. This trend is repeated with non-profit open software such as Firefox and Linux and gives rise to Pink's assertion that we are now in an age of Motivation 2.0

Pink's book is studded with real-life examples of how extrinsic motivators (eg, payments, fines) do the reverse of what is originally intended. These include paying blood donors (decreases donations), fining late parents picking-up children at kindergarten (increases lateness). But Drive is not just reliant on scientific theories and concrete examples. It actually offers some practical solutions. Taking as a given that the baseline rewards (wages, salaries, benefits, etc) are adequate and fair, Pink addresses the issues of motivation that might otherwise be considered intractable. Boring, repetitive but essential tasks can be ameliorated by offering a rationale for why the task is important, by acknowledging the task is boring, but in that way evoking empathy and also by allowing people to complete the task their own way, thereby perhaps offering the chance to add a touch of creativity.

The final third of the book, and arguably the most useful, comprises a 'Type I Toolkit' (Type I behaviour is dependent on more intrinsic motivators and less oriented to material rewards) lists motivational strategies within nine discrete sections including individual and organisational motivation, an annotated reading list of fifteen essential books on the subject and a short overview of six business 'gurus' who understand this subject well. Whatever the reader's motivation, they are unlikely to be unaffected by this timeless and thought-provoking book. ◆

Denplan to rebrand as Simplyhealth Professionals

Denplan has announced that it is to rebrand as Simplyhealth Professionals. The company held a special event for the press at the Museum of Brands in London on Wednesday 15 February to announce the changes to the new brand.

As Simplyhealth Professionals, the company has taken the strategic decision to combine the strength of Denplan and Simplyhealth, in order to continue to provide the highest levels of service to dentists, and remain the leader in the healthcare marketplace. Denplan first joined forces with Simplyhealth in 2011 and have been working together successfully ever since. Between the two companies they have over 140 years of experience in the healthcare arena and are innovative leaders in their fields.

By uniting under one brand and identity, they will now build on their shared expertise and strength of their reputations. The company wants to focus on making Simplyhealth the most recognised public and professional brand in everyday health. Simplyhealth Professionals will continue to provide the full range of leading Denplan dental payment plans under the Denplan product name. ◆

No need to be down in the mouth, TV Licensing tells dentists

TV Licensing is reminding dental practices they need a TV Licence if patients watch live television at their premises when they turn up for their appointment.

Many dentists across the UK have TVs in their reception areas, where people can relax before having treatment.

And for many, a visit to the dentist can be a stressful time – but there are a number of options open to anyone who finds themselves in a stressful situation to reduce distress and fear, such as listening to music, having a friend or relative with them, watching TV, or programmes on iPlayer.

Professor Craig Jackson, Professor of Occupational Health Psychology and Head of the Psychology Department at Birmingham City University, said: 'When people are anxious, they tend to perceive things around them as being more stressful than they really are, as well as having a lower threshold for discomfort or pain. This can manifest as acute stress in many individuals. Any environment that has exciting, varying and distracting properties, such as music, watching TV or even having a friend or relative present, can help reduce distress and fear. Stress reduction such as this can also make long term avoidance of that environment much less likely.'

Dental practices need a TV Licence if customers or staff watch live TV programmes or download or watch BBC programmes on iPlayer – whether on a TV, tablet, computer or any other type of equipment.

If the premises does not have a licence then the business risks prosecution and a fine of up to £1,000. Customers watching live TV on their own devices when out and about, however, are covered by their home licence.

Caps on legal fees long overdue, says DDU

Proposals to impose fixed limits on the fees charged by lawyers in lower value negligence claims were announced by the Department of Health today. Responding to the announcement, the Dental Defence Union (DDU) said while the proposed reforms may be effective with some dental claims, they will not go far enough to make a meaningful difference to the overall burden of clinical negligence litigation on the NHS.

John Makin, head of the DDU, said: 'Fixed costs for legal fees are long overdue as we are still seeing fees charged by claimants' solicitors that far exceed patients' compensation. In lower-value claims, the fees claimed by claimant lawyers are still, on average, above the level of damages awarded.

'However, we are disappointed the caps are proposed only for claims where the level of compensation paid is between £1000 and £25,000. The original pre-consultation by the Department of Health proposed introducing fixed costs for claims up to £250,000 which would have had a more immediate impact on disproportionate legal fees seen by the NHS and dental defence organisations.

Lord Justice Jackson is conducting a more wide-ranging review of costs for all personal injury claims with an upper limit of £250,000 and we have submitted our proposals for fixed costs to that review.

'Patients who believe they have been negligently harmed must have access to justice, but fixed costs are fairer and would make claimants' lawyers' legal fees more affordable and proportionate. We will be scrutinising the proposals and responding on behalf of our members.

'In the longer term we need root and branch reform of personal injury law to address the rising cost of compensation claims themselves, which are reaching unsustainable levels.'

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Stress and Fitness to Practise cases; does one follow the other?

By David Westgarth,
Editor, *BDJ In Practice*

The phrase 'elephant in the room' is an English metaphorical idiom for an obvious problem or risk no-one wants to discuss, or a way of thinking no-one wants to challenge. It's not quite the same as burying your head in the sand, but it's not far off.

For too long society has left mental health to fester. That particular elephant in the room looms large. Yes, there are confounding factors – austerity for one has caused significant stress for many – but ultimately the environment we operate in has become a melting pot of issues. Tim Newton and Brid Hendron have previously said stress is '*complex and difficult to define as it is both ambiguous and context dependent. It is experienced by our profession as a whole, service providers both secondary and primary care (independent or corporate) and internally at the level of the individual professional. Individuals often choose their own words to describe stress such as anxiety, pressure or unhappiness but there is a general consensus that stress is something most of us would prefer to be without.*'[1]

BDA research shows 39% of community dentists and almost half of GDPs have self-reported high levels of stress. Those are alarming statistics, even more so considering the average for all British workers stands at 15%.

A simple Google search shows you how prominent the topic is, and how far back people have been discussing it. Indeed one could argue the fundamentals of dentistry may well serve to cause and/or increase stress. A dental contract unfit for purpose, constant government change, financial pressures and the pressure to deliver customer service are all issues previously cited, but there is one that has the potential to cause more trouble than most.

In 2014, the GDC received 3,099 fitness to practise referrals[2]. This also happened to be

the year the BDA took the GDC to court over the unlawful raising of Annual Retention Fees. Make of that what you will. Only four years prior to that, the number of fitness to practise referrals stood at 1,401, and in 2016 the figure showed signs of decline at 2,630. According to a report published by Europe Economics, evidence suggests that male dentists in the UK are more likely to be referred to complaints or disciplinary bodies than female dentists. This is also supported by evidence from literature about other healthcare professions.[3]

The effect

Stress can cause a number of repercussions, some more obvious than others. Everyone can understand money, so we'll start there. In 2015, Dentists' Provident paid **£58,956** for 'work related stress'. In 2016 they paid **£125,735** for the same reason[4].

In 2015, Dental Protection published the findings of a survey of their members who had been investigated by the GDC. In their response to the GDC's consultation on *Voluntary Removal from the Register*,[5] they stated that 78% of dentists reported a detrimental effect upon their mental or physical health, 94% reported an impact upon their stress and anxiety, 76% said it had an impact on their personal life and 67% reported an adverse effect on their confidence. A staggering 34% of dentists considered leaving the profession after having been investigated by the GDC. There is little doubt that as an investigation can take years to conclude, dental professionals' mental and physical health might suffer as a result.

Pertinently, the same response also stated: *'Unfortunately in these situations suicide is a very real risk'*.

Let that sink in for a minute. A Fitness to Practise case could potentially lead to suicide.

Unfortunately for medical colleagues, that potential has become a reality. During 2005-2013, the GMC reported 28 cases of suicide or suspected suicide while the doctor in question was under investigation for fitness to practise[6].

Rory O'Connor, a co-ordinator at the Dentists' Health Support Programme, told *BDJ In Practice* he wasn't particularly surprised.

'There is little doubt fitness to practise cases brought against an individual can induce significant problems in their lives', he said. 'In my experience, besides the anxiety caused by cases that go to hearing, there's an element of guilt and shame involved too. It doesn't matter if there's no case to answer, calling someone's professionalism into question is going to cause a ripple effect.

'The biggest issue I see in the process is the time span between being notified of a case and the outcome. In our opinion it is totally unnecessary and causes more harm than good. I understand there is a process to go through and the GDC need to gather evidence, but too often it is a process drawn out way beyond what we consider reasonable. Perhaps in the past there has been a 'one size fits all' approach to cases, and that is no way for a regulator to approach such a delicate process. Furthermore, signposting to where and how the individuals in question can seek support throughout the duration of these cases is severely lacking.

'You are entitled to support throughout the process. It isn't an easy time, there's no getting away from that. The problem is people do not know where to go, where to look, who to turn to. This is when problems start to mount. The GDC pop a line or two at the end of the fitness to practise notification, but by halfway through the letter you're understandably concerned about the content, it gets overlooked.

'We have long suggested that the GDC should follow the same model as their veterinary colleagues, the RCVS. They send out the support programme in a separate letter detailing what the help and support protocol is. It's clear, definitive and no doubt helps the practitioner involved throughout.'

> 'There is little doubt that, as an investigation can take years to conclude, dental professionals' mental and physical health might suffer as a result'

The right approach?

In July 2014, the GDC placed a number of advertisements – one of which appeared in the *Daily Telegraph* – encouraging patients to contact the Dental Complaints Service (DCS) if they were not completely satisfied with their private dental care. The advert neglected to mention local resolution, and instead advised patients to contact the DCS.

Looking past the legitimacies, the nuances and the timing of the ad, Rory believes it was another line in the ad that could do the most damage.

'In it there was a line about the GDC 'protecting the public', and I asked myself from what? The message there is completely wrong. The regulator is not a barrier or a line of defence between the public and the profession. Around one in four adults already have dental anxiety, and if our own regulator is suggesting they're protecting the public from the profession, what sort of message does that give out?

'It was an unnecessary thing for the regulator to do, as it provoked fear. It was little wonder the profession reacted in the way they did. If, as a practitioner, you are constantly practising in fear of having a complaint made about you, then it is highly likely someone will complain about you.

'If you practise without fear, with confidence in your abilities, the chances are greatly reduced. It is like playing not to lose and playing to win; you often find those playing not to lose will be on the wrong end of a score.'

John Makin, head of the DDU said: 'The already significant workload that dental professionals have to cope with, the need to meet patient demand and the large amounts of information to absorb, make dentistry a high pressure profession at the best of times. This can be further increased by the duty to cooperate with GDC investigations. While responding to investigations is part and parcel of being a dental professional they can be the source of significant personal stress.

'A DDU survey of just under two hundred dental professionals who had faced a GDC investigation or negligence claim in the previous five years, found that over 50% worry about being sued or complained about again. Roughly 33% of respondents said the experience meant they no longer trusted patients or treated them differently, while 14% suffered health problems following the complaint or claim.'

MDDUS Head of Dental Division Aubrey Craig added: 'Being on the receiving end of a GDC complaint can be extremely stressful and it is natural for dentists to fear the worst, even though few of these cases make it beyond written correspondence.

'The often unjustified threat of regulatory action can destroy careers and reputations and lessen public confidence. That serves neither patient nor dentist.

'We strongly believe that the GDC fitness to practise process needs to be more sensitive to the needs of dentists. The current dental complaints system is slow, disproportionate, outdated and cumbersome. As a result, many dentists face unnecessary stress and anxiety.

Resolving more complaints at local level would benefit patients and reduce stress on dentists.'

A renewed focus?

With the GDC seeking feedback on its future plans, and government understood to be contemplating wide-ranging reform of health regulators, the BDA is preparing to reach out to its members and seek their views on shaping the future of regulation. While change is clearly needed – and to some extent underway – BDA Chair Mick Armstrong believes the reappointment of his GDC counterpart is a missed opportunity.

'The GDC Chair's term in office has been defined by a total collapse in trust in professional regulation among this profession, and the question remains whether such a figure can ever deliver the change we need', Mick said.

'While this reappointment represents a missed opportunity, our priority remains clear. Patients and practitioners deserve a regulator and a chair that really understand dentists and dentistry.'

Raj Rattan, Dental Director at Dental Protection welcomed the GDC's willingness to reform, but believes there are a number of areas that still require attention.

'Firstly, the length of time taken by the GDC to carry out initial investigations needs to be addressed. Long investigation times can be detrimental to dental practitioners' health and wellbeing.

> 'The already significant workload that dental professionals have to cope with, the need to meet patient demand and the large amounts of information to absorb, make dentistry a high pressure profession at the best of times'

'Secondly, Interim Orders Committee (IOC) referrals continue to be made far too freely and this is concerning. In our experience a significant number of cases do not meet the necessary legal test for an interim order and should not have been referred to IOC in the first place. Referrals can be made late into the process, even when the GDC has had the papers for months, if not years during the initial investigation phase suggesting that there is no real urgency or perhaps even necessity. These delayed cases undermine the reputation of the GDC in the eyes of the profession and the public.

'Thirdly, the GDC must make clear that 'misconduct' is very serious, so an ordinary registrant and/or member of the public understand that an investigation is necessary to protect the public.

'Finally, whilst undertakings are used as a quick and effective way of ensuring public protection, they must be proportionate and manageable to be acceptable.

'The suggestion that undertakings be offered and agreed as an alternative to a Practice Committee Hearing is a sensible alternative – both from a public protection perspective and a cost perspective - and is a welcome proportionate proposal in the context of achieving 'right touch' regulation.

'The procedures the GDC have already put in place to deal with cases at a local level, when there is no realistic prospect or likelihood of a finding of current impairment, are a positive step forward. However, reducing the number of unnecessary Fitness to Practise hearings is also vital and something we have consistently called for.

'While safeguarding the public is vital, it is also important that dental professionals are not put through stressful and preventable inquiries by the regulator. A review of dental regulation is necessary and we welcome the opportunity to join the debate.'

Commenting on the GDC's recent activity, John added: 'The GDC has acknowledged the need for change and, after discussion with the DDU and others, has already made some welcome changes to its Fitness to Practise processes.

'One example is the introduction of Case Examiners with a view to reducing the number of protracted cases leading to stressful and costly Fitness to Practise hearings. However there is still more work to do to improve the process so that the Fitness to Practise process is proportionate and fair to registrants while maintaining public protection.

'The GDC's recent publication *Shifting the Balance* discusses further potential measures and we welcome the increased focus on prevention as there are still too many complaints going to the GDC that fall outside its powers and should be made more appropriately elsewhere. We will be scrutinising the proposals in detail on behalf of members and responding to them.'

MDDUS has also welcomed the 'ambitious and radical plan' from the GDC to shift the priority to upstream prevention from downstream punishment, to refocus fitness to practise work and to make the complaints process more transparent, consistent, fair and responsive.

Aubrey said: 'We fully support any steps that will make the complaints and regulatory processes less stressful for dentists and reduce the number of unjustified final hearings.

'Early local action is key to defuse complaints. In our experience, patient complaints that are dealt with quickly and efficiently between the patient and the practice are far more likely to be resolved.

'Wider reform is needed to achieve this. So we welcome work on a profession-wide complaints handling initiative that strengthens first-tier complaint resolution and the steps being taken to improve efficiency, transparency and decision making in the fitness to practise process.

'We believe focus should only be on the most serious allegations, usually where there is an apparent immediate risk of harm to the

patients. The GDC's challenge now is to turn aspiration into credible and effective action.'

In response to the launch of the consultation and their renewed focus, Jonathan Green, Director of Fitness to Practise at the GDC, said: 'We have made a number of significant changes to the Fitness to Practise (FtP) process in recent years; many with the aim of reducing the stress of the process and providing more support for practitioners who are involved in it.

'We ask every dental professional involved in the FtP process for feedback on their experience and feed any learning back into our improvement programme. We have also worked with Samaritans and the BDA Benevolent Fund to provide training for all staff on identifying and supporting practitioners who are struggling to cope with the system and to create improved signposting for them.

'We have also developed a more proportionate approach in our early triage process, which has included using 'cease and desist' letters more frequently and making sure that less serious cases are referred to other organisations in a better and often more appropriate place to deal with the issues, which is often the dental practice. Our work on signposting patients to the Regulation of Dental Services Programme Board (RDSPB) joint statement on complaints is also helping to change patient behaviour.

> 'Overall the quality of dental care is good. Relative to the amount of dental appointments that happen each year, the proportion that result in a complaint or an FtP issue is very small'

'However, we want to go further than this. We want to rethink the model of dental regulation, so that it focuses on preventing harm rather than responding to it. We are doing this for the benefit of patients.

'We want to work with professionals, partners and patients to further examine what we mean by 'serious', which will help to ensure that we are only deploying our FtP powers – which unlock tools to manage serious risk – where it is appropriate.

'Overall the quality of dental care is good. Relative to the amount of dental appointments that happen each year, the proportion that result in a complaint or an FtP issue is very small. Less than 2% of the total number of people on the register ever enter the process.

Why we need change

The following is a letter published in the British Dental Journal[7] and is the type of situation that can give any healthcare professional – let alone a dentist – cause for concern

Sir, in February 2011 I started a simple course of upper arch orthodontic treatment for a patient. I was asked if I would give a discount for cash or if a discount could be applied, as the patient could obtain cheaper treatment in China (I declined both requests). All went well. A year later treatment was completed, the patient was happy with the result and had paid in full, without discount, prior to completion. On reviewing the upper retainer I was asked if I could provide a lower removable retainer. I agreed to do so for £60. The patient felt this should be included in the cost of orthodontic treatment, I explained why this was not the case (we had not agreed a treatment plan involving a lower retainer, only an upper one), the patient reminded me that it could be obtained at less cost in China. I agreed that that was likely. The patient left and was discharged from my care.

Six months later I received a letter from the GDC stating that the patient had made a complaint. I had been accused of racist behaviours throughout the course of treatment. The GDC listed a charge of professional misconduct and a fitness to practise case was to be heard. I was asked to provide a list of my employers/places of work. The GDC immediately contacted my employers to inform them of the complaint and the reason for it, they also instructed them that a fitness to practise hearing was to be held. The GDC requested the patient record and trawled through it to see if they could find anything else to add to the charge list, whether related to the initial complaint or not.

Time moved on very slowly. I experienced sleepless nights and increasing levels of stress associated with the threat of losing a living. I had to take several days from clinic to attend meetings with Dental Protection and their legal team. I was asked to approach friends and acquaintances for character references. My legal team had to write to them and set out the list of charges before asking for the reference, all very embarrassing.

Two years following the initial complaint to the GDC I was instructed that the hearing was to be held in the last week of July 2014, I was told to cancel the week's clinics and book a hotel in London. Two months before the hearing I received notification that the complainant had refused to provide a witness statement and was refusing to attend the hearing. The GDC wrote advising that the 'likelihood of securing the case as proven was low' and that with advice the hearing was cancelled.

As of yet they have not written to my employers informing them of the outcome and the reasons for it. When contacted, the GDC advised that informing employers of such an outcome is not something they would do. I asked Dental Protection what the approximate cost of this process would be, I was amazed to hear it would be £15,000-20,000.

I can conclude the following. The GDC is not fulfilling its role in a fair nor efficient way. Asking registrants for more money to fund such a system is unbelievably arrogant. Any patient can cause havoc without facing redress. Legal advice is expensive. The whole process is wrong.

Yours sincerely
Stephen Ward

'The current model of dental regulation needs to be reassessed. By using education and learning, we want to support dental professionals throughout their career to improve their knowledge, skills and behaviour. I am confident that our proposals in *Shifting the Balance* can make the system better for patients and fairer for dental professionals and strengthen public confidence in dental services.

'There is no denying being referred to FtP can be extremely stressful. We have learned from the feedback we have received and the work of other regulators and organisations in managing stress created by the regulatory process. We remain committed to making ongoing operational and strategic improvements to our FtP process to make sure that it does not unduly or unnecessarily add to that stress.'

Implications

According to Rory, there have been instances whereby individuals have struggled to get indemnity, even if they have been through a Fitness to Practise case and the decision was no case to answer.

'That is a distinct barrier to your professional life', he said. 'On most occasions the indemnity is significantly – and potentially in the thousands – more expensive, but we have also spoken with dentists who cannot get indemnity at all, even if there is no case to answer. The whole process is wrong, and simply does not look after its own.'

MDDUS stated that 'Risk sharing across the profession is at the heart of what we do. Only where a dentist's risk profile falls seriously out of line with others, will we consider restricting the benefits of membership or very rarely declining to offer renewal.

'All individuals who are interested in joining MDDUS must undergo a careful risk assessment process that is implemented fairly and consistently. Such a process is necessary as due to the fact that we are a mutual indemnity organisation and have a responsibility to protect our members' interests by ensuring the decisions we make do not incur any inappropriate risk – this can sometimes mean refusing applications for membership.

> '...we have also spoken with dentists who cannot get indemnity at all, even if there is no case to answer. The whole process is wrong, and simply does not look after its own'

'The combination of our mutual status, lifetime protection and flexible use of discretion in our members' interests gives greater protection than the commercial alternatives available.'

John told *BDJ In Practice*: 'The DDU is part of a mutual not-for-profit organisation owned by its members and as such, we must act in the interests of all those members. This includes monitoring for and managing risks to which the organisation may be exposed.

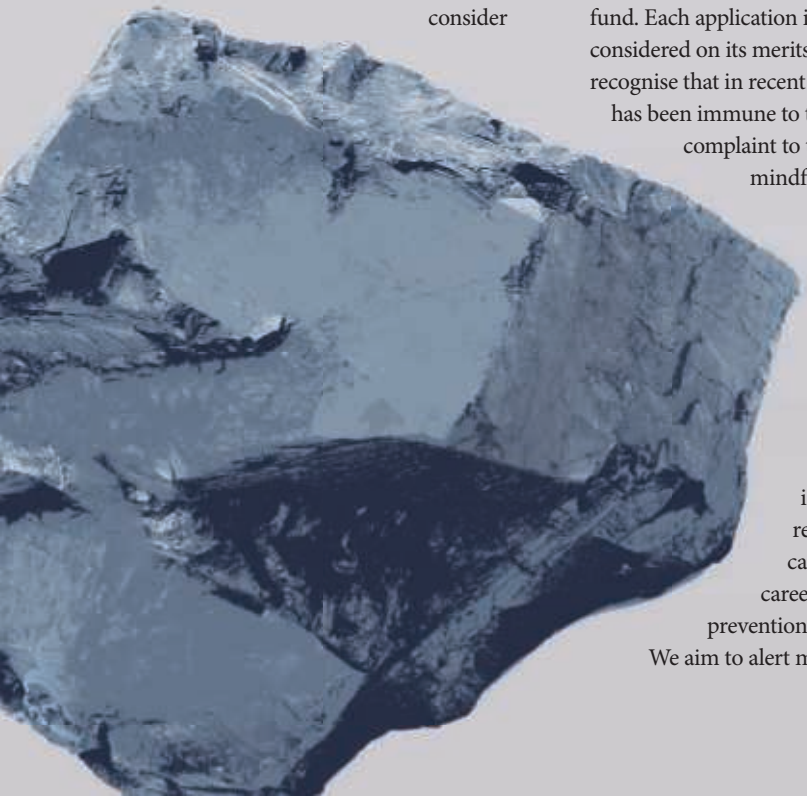
'When considering new applications for membership from colleagues who want to join the DDU, we take in to consideration the interests of our existing members and the risk any new applicant may pose to the mutual fund. Each application is, therefore, carefully considered on its merits. However we do recognise that in recent times no colleague has been immune to the potential risk of a complaint to the GDC and we are mindful of this.'

Raj said: 'Our approach to risk carefully balances the needs of the individual member with those of the membership as a whole. We are well aware of the potential impact that claims and regulatory proceedings can have on a member's career, and believe that prevention is better than cure. We aim to alert members when their risk profile differs from that of their peers, and work with them to reduce their risk, although this may not always be possible.

'Our focus is to protect and support the professional interests of over 300,000 members around the world. We believe that the majority of members should not be compromised by the small minority who receive a comparatively high volume of claims, and in these instances we will act to ensure that their actions do not adversely affect the mutual fund.

'When making any decision on future membership, we take into account the whole history of a member, which may include information that the GDC does not hold and is not aware of.'

There is little doubt surrounding the appetite to change. In an ideal world groups like the Dentists' Health Support Programme would cease to exist. We would look after our own better than we do now. Confounding issues such as the contract and a challenging economic climate have and will continue to take their toll, but, as Rory points out, it is – or at least it should be – the role of the regulator to ensure the welfare of its members are at the forefront of policy moving forward. The consultation process will no doubt shed some light on what BDA members think of the GDC's appetite for change. For the sake of their mental and physical wellbeing, it is one we all hope will satisfy their hunger. ◆



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The jigsaw of dental business

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

As a Dental Business Consultant who has travelled the UK over the past 10 years, one of the many grumbles I get from principal dentists is that their Associates are not interested in the business of the dental practice. They say that all their Associates want to do is come into the practice (sometimes late) deal with the patients on their day list (whatever is on there), provide good dentistry for their patients, go home and collect their monthly pay. They tell of a reluctance to get involved in team meetings because it isn't paid for; refuse to take part in marketing activities, because that's not what they are trained for and so on. The list is long.

However I know that this is not the case with many many Associates who do get involved; they are interested and also benefit greatly from being so.

The Associate Jigsaw

Associates enjoy the freedom that their self-employed status brings them. Their view of the world of a dental practice can be limited and their jigsaw of the dental practice may only have a relatively small number of pieces.

Those pieces are:

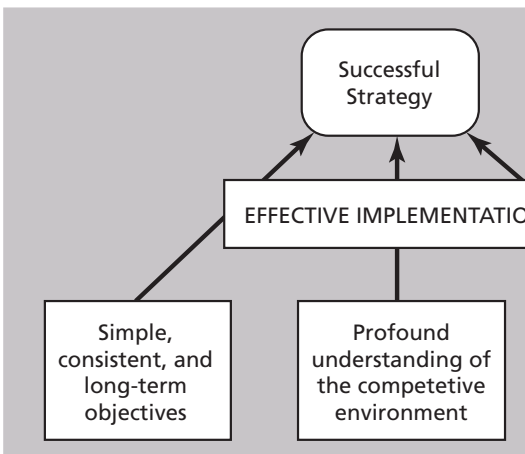
- Patients
- Principal dentist
- NHS
- CQC
- Dentists
- Nurses
- Therapists
- Hygienists
- Receptionists
- Practice Manager
- Laboratories
- Materials
- Equipment and technologies.

As long as these pieces are in place then the Associate will be content and able to function. However the question is how well will the Associate function? As an example if the practice doesn't have enough patients coming through the door there could well be gaps in the day book, resulting in reduced income. The more an Associate understands about the business of running a dental practice then the better able they are to be able to influence their working environment and gain greater rewards. There are many more pieces that a dental practice owner has to consider such as strategy, financial and business planning, marketing, compliance to name a few, and if any one of these pieces is missing then at best the dental practice will not achieve its business potential and at worst something will go badly wrong.

Business strategy

Strategy is very much the 'centre piece' of the dental business jigsaw around which the other pieces fit. Whilst many dental principals may not have a document headed 'Business Strategy' they will know in their own minds what the overarching aims of the practice are. This could be to be a totally private practice, or a mixed NHS and private practice. They may go further and know that they wish to grow to a certain size , become a referral practice or deliver certain specialisms and so on and will have set themselves certain goals and objectives.

Robert M Grant opens up his book '*Contemporary Strategy Analysis*' with '*Strategy is about winning... Strategy is not*



The Common Elements of Successful Strategies
Robert M Grant. Comtemporary Strategy Analysis

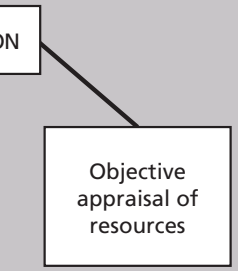
a detailed plan or pragram of instructions; it is a unifying theme that gives coherence and direction to the actions and decisions of an individual or organisation'.

Goals and objectives need to be simple but importantly, consistent. It is a great idea to get the whole team involved in setting goals. The dental team really do know the patient base well and they also know the practice local catchment area very well too and their contributions are invaluable. If the principal has chosen not to include the whole team in developing the dental business strategy, by showing an interest and sharing good information to support and even add to goals will enable you as an Associate to have great input and control over what is expected of you.

Knowing and understanding your competitive environment is critical in the dental world. This isn't just about location, types of services and pricing of your competitors. It is about how they operate in the marketplace, how they communicate with their patients, what their patient base is made up of, what profile and reputation they have and what customer service standards they deliver.

Appreciate that all dental professionals will want to deliver good dentistry. That's a given. You need to understand what differentiates you from the other practices in your locality. What are your strengths and do you communicate these well to your patients? What are your weaknesses and what do you propose to do about them?

Don't be complacent. You need a constant eye out for what is happening around you and what impact it may have and understand how you can adapt and change. Don't be just a follower, you need to be a trail blazer and constantly review what and how you deliver to be consistently ahead of your competitors.



Fully appraise the resources that are in place and evaluate if they will enable you to achieve the practice objectives. Are you confident that the equipment that is in place will adequately meet the demands of the future plans? Do you need additional members of staff or staff with different competencies such as a Treatment Coordinator, to achieve your goals

As an Associate you may feel that these are areas that you can have little influence over. However if there is a new bit of kit which you feel would be really useful and beneficial to the practice consider not just asking the principal if he/she can provide it but pull together a business case as to how you feel the kit will be able to add value to not only you but to the whole practice. A well thought through and detailed case may make it hard for your principal to turn it down.

> 'As an Associate the greater the understanding that you have of what the practice wants to achieve the more likely you are able to commit to working towards those goals'

Without efffective implementation any strategy in place will be of little value. Having good detailed plans to support the delivery of strategy is critical and having good measures and monitoring systems will ensure that every element is kept on track. However what is also key is communication with the whole team. If they know exactly where the practice is going and what part they have to play in that then they will 'buy-in' to the business objectives and be more committed to the practice achieving its potential.

As an Associate the greater the understanding that you have of what the practice wants to achieve the more likely you are able to commit to working towards those goals You will be able to partcipate in meaningful dialogue with your principal regarding progress and address what steps might be required to deal with performance issues; arguably a more rewarding experience all round.

Your practice manager is an essential piece of the jigsaw of the dental practice. A great Practice Manager will manage and give direction to ensure that patients are happy and safe and that the team are happy and efficient. They will ensure everything that is non clinical in the practice is running smoothly and efficiently and be constantly looking out for improvements. They will manage the practice performance communicating results and manage the practice's compliance with necessary regulations and laws. It's a massive and responsible job to undertake.

To achieve effective implementation of strategy, the practice needs to have a good team behind it. That team needs to have a skilled and knowledgeable Practice Manager at its helm. As an Associate don't underestimate the size of the job and recognise the value that the Practice Manager brings to the practice and to your working environment. Having a good relationship with your Practice Manager is hugely beneficial. They are the 'go to' person in the practice for everything and deserve your appreciation, support and cooperation. However don't just go to them with a problem, think it through and take a possible solution along too.

Your principal dentist is another prime piece in the jigsaw of dentistry. Having a good relationship with your principal dentist will reap many rewards. This isn't just about having a good social relationship. For you, the principal and the practice to achieve potential a good Associate/principal relationship is an essential element. Showing interest and becoming involved in all of the elements described will above all else enrich your daily working experience and whilst that may mean investing a little bit of extra time each day it should, if done well, convert into increased financial return for you.

So in summary, there is a lot to be gained by Associates gaining a deeper understanding of the jigsaw of the business of dentistry.

As a self employed Associate you have choices. You can work **alongside** your principal and team and achieve your personal goals. However you can also work **with** your principal and team and achieve the practice goals and most likley exceed your personal goals. All that is required is the investment of a little of your time. ◆

Carol Groombridge has gained an excellent reputation as a highly skilled 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.

Unscheduled Dental Care: Managed Clinical Networks

by Ashvir Basra,
Clinical Fellow in Dental Public Health, Health Education England

The Acute Services Review defined Managed Clinical Networks (MCNs) as '*linked groups of health professionals and organisations from primary, secondary and tertiary care; working in a co-ordinated manner unconstrained by existing professional administrative boundaries, to ensure equitable provision of high quality clinically effective care*'[1]. Recognising the benefits of such networks, there is increasing momentum in establishing MCNs in a number of dental specialities.

A well-recognised challenge our Urgent and Emergency Care (UEC) system faces is that patients with perceived urgent dental conditions present to emergency departments and GP settings. Variation in unscheduled dental care (UDC) provision across England and confusion surrounding how best to access services are two likely reasons for this.

As part of the national UDC review, Dr Sam Shah (*Chair, Unscheduled Dental Care Working Group)* has said: 'The provision of UDC varies greatly across England, and it is recognised that development is required to improve access and service quality, and ensure integration with the wider urgent care system'. This review has been carried out to better understand these issues in an effort to make UDC services more equitable and accessible; thus relieving compounding pressures on the entire U EC system.

Stakeholder views sought during this review provide general consensus that dedicated local UDC networks would be beneficial to the profession and most importantly, patients. These would allow important stakeholders (see box) to regularly communicate on how to improve services for their local populations.

Some of the duties of these MCNs could include:

- End to end review of cases for audit purposes
- Reviewing patient feedback and complaints
- Reviewing provider feedback and complaints
- Reviewing and advising on commissioning updates
- Incident review
- Promoting antimicrobial stewardship
- Determining appropriate appointment lengths
- Working collaboratively to optimise patient pathways.

Figure 1 shows the proposed way in which a UDC network could fit within the UEC system as a whole:

Work is currently being undertaken to set up these networks in areas across England. More information on setting up an MCN can be found in the March 2003 issue of Royal Society of Medicine's *Clinical governance bulletin*, available online[2].

Two areas in England have already made significant progress in establishing their own networks; Cumbria and the North East and also the South West.

Cumbria and the North East (CNE)

By Julie King, Chair of Cumbria Local Dental Network

Following NHS reform in 2013, the dental commissioning for this vast area became the responsibility of one dental commissioning team. Three areas joined together and each had their own LDN chair. These areas were Cumbria; Northumberland, Tyne and Wear (NTW) and Durham Darlington and Tees (DDT). It became obvious from the start that the provision and quality of urgent and emergency dental care both out of hours and in hours varied greatly across this region.

An unscheduled urgent and emergency dental care pathway review was undertaken starting in 2015. This was conducted to undertake a whole system review to identify how patients access UDC for their perceived dental problem.

The resulting local pathway re-modelling and service re-procurements will also ensure that local Central and North East (CNE) services and pathways are compliant with published dental urgent care, general urgent care and clinical hub guidance and standards.

The delivery approach being adopted locally within CNE will be achieved in two phases:

- Phase 1 – Improve NHS 111 integration and procure in hours unscheduled care services to address identified commissioning gaps and meet best practice across CNE.
- Phase 2 – Re-design and re-procure dental out of hours services including dental nurse triage and integration with the North East Vanguard Clinical Hub. To be completed by 01 April 2018.

'An unscheduled urgent and emergency dental care pathway review was undertaken starting in 2015. This was conducted to undertake a whole system review to identify how patients access UDC for their perceived dental problem.'

A subgroup of the CNE dental steering group is performing this work. This includes a LDN chair, experienced in UDC, undertaking the role of clinical lead supported by a member of the NHS England dental commissioning team.Further input is received from Public Health England (PHE) and other stakeholders, including providers and patients. The remaining LDN chairs provide specific local knowledge as required and are instrumental to this work's success. It is envisaged that as work progresses and the terms for MCNs become clearer, this group will transform into a UDC MCN.

This group has also been able to contribute to national work being carried

Key groups for inclusion within UDC MCNs

- LPN
- Urgent and Emergency Care Networks
- LDC
- Specialist groups
- Local commissioning groups
- Local NHSE teams
- HEE
- PHE
- Other UDC networks
- UDC providers
- NHS 111

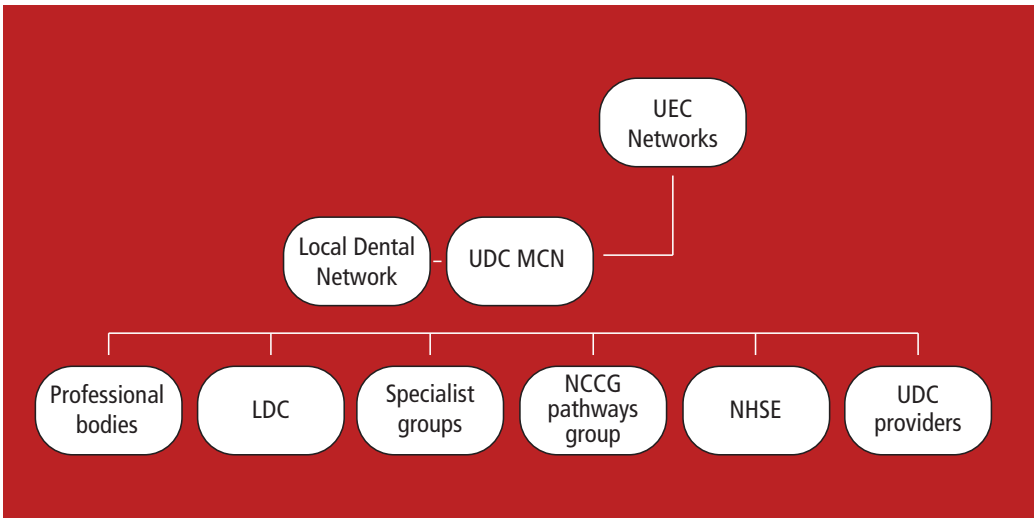


Figure 1 Proposed UDC network structure (developed by the UDC working group 2016).

out in relation to UDC. They are active members of the national UDC review and guidance development group to help ensure we can build in emerging best practice standards and requirements for out of hours, dental nurse triage and clinical hub services beyond 2018. We are also active members of the NHS pathways dental subgroup and actively engaging with North England Commissioning Support as the Directory of Services leads local re-structure and cleansing the NHS 111 system so that it profiles unscheduled in and out of hours services correctly; ensuring patients reach the right service at the right time and within nationally prescribed response times.

This collaborative work will produce true clinically led needs-based commissioning for CNE. There have been challenges along the way with all those involved being busy with other work pressures, it is often difficult to allocate the necessary resources. It has however strengthened and developed the relationship between NHS England, PHE and the LDNs and given us a greater understanding of national direction of travel so that our services will, we hope, be best practice.

South West UDC Network

By Peter Howard-Williams,Clinical Chair Dental Local Professional Network

The NHS England South (South West) was originally formed from the Devon, Cornwall and Isles of Scilly and Bristol, North Somerset, Somerset and South Gloucestershire local area teams.

As there is now only one commissioning team responsible for the South West it has been decided that a single LDN would be a more pragmatic approach, considering the restraints of clinical commitments, administrative time and resources. One of the key objectives is to establish a consistent approach to the delivery of dental services and outcomes across the region.

The identified challenges for UDC were:

- Patients can be unsure of who to contact and are given different messages
- Patients are sometimes given false expectations about availability of treatment
- Patients often have to repeat information after being transferred
- Patients do not always have access to clinical advice
- Currently as a legacy from the previous Primary Care Trust structure, we have a range of different approaches across the South West
- Dental helplines, NHS 111 and the in and out of hours urgent care services all have different providers and sometimes there is a lack of cooperation between services
- Locally, we have experienced issues with the implementation of NHS 111 for dental triage.

The ambitions for UDC services are:

- The same high quality and accessible service should be available to all residents of the NHS England South (South West) area and should be available as locally and promptly as possible
- The in hour and out of hours access to UDC and dental helpline services will be delivered by best value pathways, which will be commissioned on a whole pathway basis through all levels of commissioning.

> 'The same high quality and accessible service should be available to all residents of the NHS England South (South West) area and should be available as locally and promptly as possible'

Following attendance at the UDC Stakeholder event held in Manchester, a UDC group was formed, chaired by the LDN chair. A comprehensive turnout was achieved with representation from providers, triage and helpline services, PHE, commissioners and NHS 111.

The key role of the group was to provide clinical leadership and work collaboratively with commissioners to support delivery of quality and safety in new and existing models of care. The group were asked to give feedback on their current services and comment on a draft service specification for UDC.

The group has met twice and a summary of the recommendations from the meetings is as follows:

- The need for consistent service provision across the South West that patients can access easily and obtain appropriate advice or an urgent appointment no later than the following day
- The need to work closely with NHS 111 so that patients can be easily transferred through the system to the most appropriate responder
- Evening clinics should be discontinued and emphasis placed on a guaranteed urgent appointment no later than the following day. Weekend and bank holiday clinics should be retained.
- Dental helplines should start early; we have agreed locally an opening time of 06:00am.
- Urgent slots should continue to be commissioned with GDPs and they should receive remuneration whether the slot is filled or not
- The outcomes for all UDC need to be closely monitored
- Mechanisms to improve data and feedback from patients and the public are required
- There is a need for closer links with other healthcare providers.

Future work of the UDC network will include:

- Distributing a patient survey amongst stakeholders, starting in January 2017
- Updating the draft service specification incorporating the working group feedback and circulating for comment to the LDN
- An audit to be conducted using a standard data sheet for the current systems to determine call volumes, nature of the call, how the call is managed and capturing demographic data (e.g. postcode).

The next steps will be to re-design and re-procure the UDC service for the South West.

Conclusions

It is hoped that LPNs across England will help drive development of these networks in an effort to ensure provision of accessible services and reduce any existing oral health inequalities within their local populations. This will also support collaboration with the wider UEC system and help to reduce the existing compounding pressures our UEC services are facing. ◆

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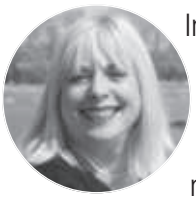
Why we all really, really need cultural intelligence



In the second part of the series, **Dr Janine Brooks** discusses the need for cultural intelligence

1. The need for collaboration

We can't solve big problems alone. Leading across boundaries through collaboration is increasingly crucial. Dentistry needs to collaborate with other health professionals, public sector and private sector, if we are to beat oral disease.

2. The reality of networks

The world is becoming more connected. Leaders must build and leverage networks in order to deal with this new inter-connectivity and capitalise on the opportunities presented. A culturally intelligent dental leader knows there is more to having a successful dental business than being a clinician. We need to network with those outside dentistry, those in technology, communications and ethical marketing.

3. The importance of trust

People use services they trust, listen to sources they trust and choose to follow leaders they trust. It's much harder to establish our own trustworthiness with people whose frame of reference is very different. Dentistry is a multi-cultural profession serving a multi-cultural population of patients. Culturally intelligent dental professionals continually try to understand their patients, what is important to them about their lives and their oral health and what challenges they have. Understanding fosters trust.

4. The demands of demographics

Relationships between generations are becoming increasingly disconnected, right across the world. We need to bridge generational divides for both young and old alike. Culturally intelligent dental leaders know that they can learn from all age groups, whether that be colleagues, staff or patients.

5. The urban magnet

People around the world are moving to cities as never before. These cities are (or are fast becoming) magnets of talent, bringing together people from multiple backgrounds and different cultures. If you work in even a large village these days you will find a diversity of cultures, the larger the place in which you work in the greater the diversity.

6. The diverse workforce

Dental professionals working in the UK are drawn from a multitude of countries and cultures. Many colleagues' primary qualification was achieved outside the UK. Culturally intelligent leaders know this brings huge opportunities but can also bring huge misunderstanding. Leaders with cultural intelligence go out of their way to know more about colleagues and use our differences to build stronger teams.

Toe curling failures:

A survey of complaints from Thomas Cook and ABTA reported in Wanderlust Travel Magazine (2011) gives some great examples of failures of cultural intelligence:

'It's lazy of the local shopkeepers to close in the afternoons. I often needed to buy things during 'siesta' time - this should be banned'

'On my holiday to Goa in India, I was disgusted to find that almost every restaurant served curry. I don't like spicy food at all.'

'There are too many Spanish people. The receptionist speaks Spanish. The food is Spanish. Too many foreigners now live abroad.'

'I was bitten by a mosquito, no-one said they could bite.'

These may seem like caricatures, sadly they aren't. How sad that the people making these comments missed out on learning and tasting (literally) wonderful new experiences. Although I'm not sure about the mosquito! Listen out for examples of failing cultural intelligence in everyday conversations. Do this not to feel smug, but to use as questions for yourself. Have you ever caught yourself saying or thinking something similar? Be honest.

It is very difficult to know just how culturally intelligent we are. That's where feedback from others is so important. To get good feedback ask people from different cultural groups to tell you how culturally intelligent they rate you as being. Ask for real, critical friend feedback, what are you good at? Where are your blind spots? How might you get better and improve your cultural intelligence of their specific cultures? You could choose someone of a different age to you, a different gender, a different religion, from a different professional sub-culture. Ask them for feedback because you want to improve your cultural intelligence, listen to what they say, take it on board and think how you could use their feedback to enhance your cultural intelligence. Be curious about other cultures, ask enquiring questions and **LISTEN**.

Core and Flex

Core and Flex help to define who we are, but they include more than just our identity. They account for everything from spirit to behaviours and habits, from grand beliefs to small actions. A well-defined Core and Flex underpins our ability to experience new things and adapt to other people without fear of losing who we are as individuals – changing and accommodating without ever compromising on what really matters. Sometimes the fear of losing who we are can be a real barrier to learning about new people and cultures.

Core

Our core is made up of things we would either never do or always do – the things about us that don't change no matter where we are. They are intrinsic to who we are and include our values or identity, and also our behaviours – the things we do that are core to who we are – they don't change, they remain the same anywhere we are, without these values and behaviours we are not ourselves. They are defining attributes that others recognise about us.

Leaders need to know what is in their core, because if they are not aware of it – both the good and bad – they will confuse and unsettle themselves, and others, on a regular basis. A tighter, well understood core also makes it much easier when you have to flex. You know what you can give up or change and what you absolutely can't. By being constant this enhances the trust other people have in us. People know what to expect, there are no curve balls.

Flex

Our flex is made up of those aspects of ourselves that we adapt to differing circumstances, which aren't hardwired into who we are as individuals. Generally our flex is seen in our behaviours. Behaviours are very important signifiers, as we operate in other cultures, not least because they demonstrate that we have flex. As we start to go beyond behaviours and deeper into flex, it gets more complex. Flexing how we behave is one thing, we can do this consciously and in many ways it is a surface observation. We can behave in a way that takes account of other cultures, but flexing what we believe gets very tough. If you don't truly believe in the behaviours you are exhibiting then you are not being authentic. The behaviour has to be underpinned by belief, it has to be done for real, in good faith, without flinching; otherwise it transmits a false pretence and others will know this. Behaviour without belief is just acting, you might be able to act well for a while, but eventually it will show through.

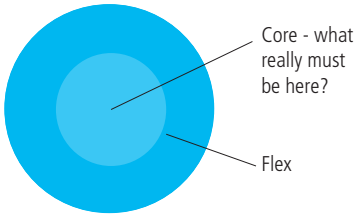
Try this:

- → List what you believe to be in your own Core and Flex
- → Think about values, behaviours, skills, beliefs and identity
- → List them fast
- → Don't stop to put them in any order.

Do this exercise very quickly, take no more than 1 minute, this is about your gut reactions, it should be fast and instinctive.

Why have you chosen what you have?

It can be helpful to think about what you have chosen and perhaps discuss it with a friend. Think about your core and flex as in the diagram above – how big are the circles of core and flex? If your core is larger than your flex, why do you think that is? Do you really,



really need everything in your core, where are the possibilities to move values, behaviours, skills or beliefs into flex. Just talking this through can help your perspective. It can help even more to talk through with someone from a different culture. You may be surprised by how much core you share.

Over time as we grow and mature, our core is likely to get smaller and contain fewer things that really must be there. We learn what is really important to us and what we cannot change. We also learn that we can adapt and flexing is a natural part of increasing our cultural intelligence. However, it's important to understand that we retain the duality of having core values and, at the same time, the openness to challenge our beliefs and assumptions from experiences of different cultures. As it gets smaller, our core will also become sounder and more robust. Though this may sound counter-intuitive, the more inflexible our core becomes over time, the greater our ability to flex becomes, because we'll know where we genuinely can and where we genuinely can't move. All this improves our trustworthiness, and with it, our cultural intelligence.

I hope this article has given you pause for thought. I hope it has made you think a little more about the wonderful diversity we dental professionals live and work in and made you curious to learn more and develop your cultural intelligence. It's not something that you will achieve overnight, indeed it's an ongoing activity that you need to practice constantly. There will always be cultures you know little about, there will always be something new to learn. Don't be dismayed by that, be excited. People who develop their cultural intelligence constantly will never be short of friends. ◆

Dr Janine Brooks MBE is a Non-Executive Director for a Community Dental Service Social Enterprise, Clinical Lead, BUOLD Ethics, University of Bristol, Educational Inspector for the GDC, Coach for Professional Services Unit, NHS Thames Valley, Author, owner of Dentalia Coaching and Training Consultancy, Co-founder of Dental Mentors UK and Director of the Dental Coaching Academy.

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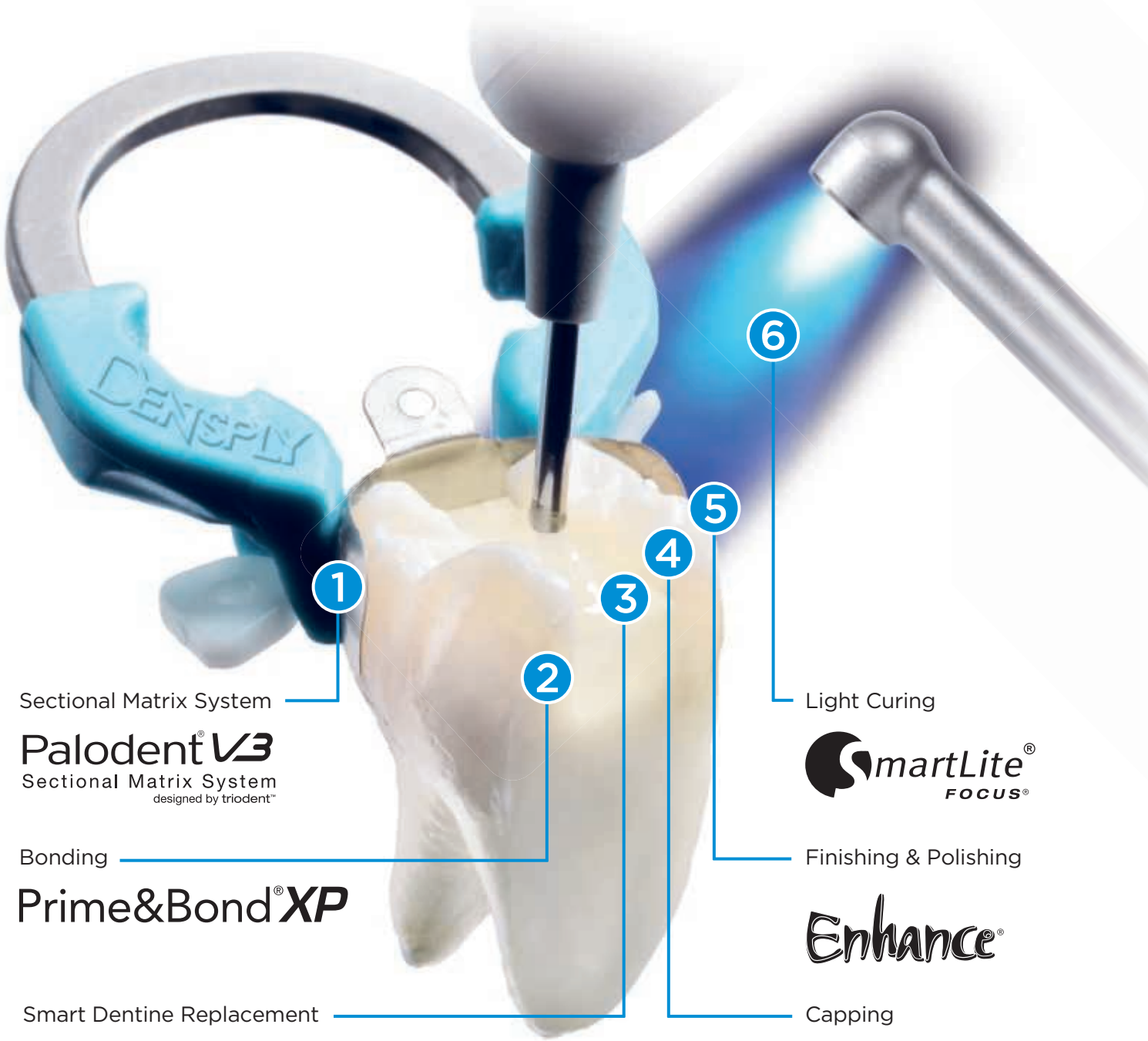

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A new standard on dementia care

With the welcome increase in life expectancy, some conditions take on a growing importance. Dementia is now one of the most common neurological disorders in people aged 65 or older. Estimates suggest that in the population the prevalence is about 5%, with an annual incidence of 2%. By 2025, it is estimated that more than one million people will be diagnosed with dementia, and one in three people aged 65 or older will die from the disease.

Oral health care for individuals who have dementia is one aspect where improvements are necessary. To reach high standards of oral health a joint relationship between the individual and those tasked with care provision is required. Furthermore, the progressive nature of dementia means that the responsibilities may change as the disease impacts on the ability of individuals to contribute to the maintenance of their health through self-care. **Richard Emms** spoke to *BDJ In Practice* about the launch of new standards of care for patients living with dementia.

Richard Emms
Vice-Chair, BDA General Dental Practice Committee

FGDP have launched standards for patients living with dementia. What approach did the working group take regarding the current provision of care for patients with dementia?

We worked with Alzheimer's Society, Public Health England and also from a practitioner's point of view to assess the management of dental patients with Alzheimer's and their changing needs. We wanted to support practitioners in understanding those evolving needs, both of the patient and the care you need to deliver.

How difficult is it for primary care dentists to treat dementia patients?

It varies greatly, which is a problem in itself. There are well-recognised signs at early and pre-diagnosis stage. Some people will be living with it and putting it down to being forgetful. Stigma is preventing people acknowledging the symptoms of dementia and obtaining the help they need to live the life they want to lead. As a result, it is a chronically under-diagnosed disease.

From a clinical point of view, there will be patients with late-stage dementia that treating in a primary care setting is going to be nigh-on impossible. It is the management and understanding of this transition the guidelines are concerned with. It is going to change, but it does so at different rates in different people. There may be good days, there may be bad days.

If you have seen a patient for 10 years and you notice there is a change in their behaviour, be it in their demeanour, behaviour or their oral health care, you might be the first person to notice. The guidance provides suggestions on how you can approach the subject with patients and their families.

Is this a further extension to safeguarding?

Yes it is. We are not going to say it is something else dentists have to do, but like safeguarding children, it is something to be aware of and know what the next steps should be if you feel something needs to be done. If you have your suspicions, these are the options available to you. Safeguarding is absolutely the right way to approach it. We have a duty of care to our patients, and dementia forms part of that.

There's an element of protecting the dentist too. There are specific dental issues as the disease progresses regarding management. What is appropriate treatment-wise in the early stage where that person can still care for their own teeth may not be appropriate treatment as the disease progresses. It may be that you discuss extracting teeth earlier than you would normally do so because it makes it easier for the patient to maintain their oral health, be it a denture, bridge or nothing at all. You don't want to be doing major work when the patient can't comply with it.

You mention it is an underdiagnosed condition. To what extent is that the case?

There is a lack of culturally-sensitive dementia services and families can be reluctant to use services that do not meet cultural or religious needs. Some people don't want to know so don't get the diagnosis. Some may be suffering from it – and know about it – but not want to do anything about it. Alzheimer's Society have helped us better understand some of those barriers. People can just put it down to being forgetful.

What support is out there for primary dentists?

Besides the current referral pathway for those with special care, there isn't a great deal. This is why there is a greater number of people in dementia units in care homes, which provides its own challenges. Continuity of care, consent, lasting power of attorney, delivering safe treatment: these are all issues we know are there. The CQC is involved to look at how we can deliver safe, effective care. Historically dementia patients have had full dentures, which are relatively straight forward to care for. You now have a population which is Professor Jimmy Steele's heavy metal generation who have a lot of extensive crown and bridge work. If that fails in a care home in a dementia patient, that will be difficult to deal with.

What role do care homes and their staff have in providing oral health maintenance?

That's a really interesting point because we are aware of some reluctance on the carer's behalf to engage in oral health maintenance. It's crucial we engage with them to provide basic information to minimise the potential problems that can arise from poorly maintained dentitions.

How big is consistency of care?

Ideally it's best if it's the same nurse, the same team in the same room providing care for the patient. Familiarity is essential. In the guidance we do touch upon making practices dementia-friendly by providing little tips on interaction to ensure an appointment with a patient living with dementia is as smooth as possible.

When did the profession realise this was going to be a significant problem?

The 2009 Adult Dental Health Survey showed we were keeping our natural teeth for longer, and we saw a number of local initiatives develop to address the problem. Merseyside joined forces with Alzheimer's Society to provide a community-based project. IOHOPI in the south of England offered care. This is an opportunity to bring the issue into mainstream thinking and to make practitioners fully aware of the scale of the challenges ahead for the foreseeable future. We're not suggesting practising dentistry different *per se*, but there are things to be aware of if you're seeing a patient living with dementia. Consent is one significant area. What happens if the patient's family or carer is putting pressure on you and you believe it's not appropriate for their condition? We want to provide support and confidence to address those issues.

Is the current – and the future – workforce prepared to deal with the complexities of the challenge ahead?

At the moment my opinion is not quite. It will take a shift in how we deliver services. We will need a lot more time to deliver the care as professionals we think they need.

Does that mean the current contract is unfit for this particular cohort?

Absolutely. Contract reform must take into account the future patient, not just a patient living with dementia. We can't provide the level of healthcare we want to in five minutes, and dementia patients require much longer. We cannot have a contract that is redundant in five years' time because commissioners have not taken into account the changing needs of the population.

We also need to consider the practice management element of the patient's condition. It may be that they are having a bad day and are not able to be treated or come in for treatment. Cancelling at short notice will have an impact on your practice and if there is recognition of that in the contract, it will be of great benefit.

It boils down to having time to care for our patients, adequate funding, and effective commissioning. If the patient's condition means that they require a referral, then the secondary care services must be available to provide this. Community dental services are underfunded and overstretched as they are. They aren't going to be able to provide the additional care which will be required in the future.

Primary dental practitioners can't be expected to see too many patients. If appointments will take longer because the patients have complex needs, we will need to see fewer patients if we have the same workforce. Something does have to change, and the outlook on contract reform needs to change to aid this.

Does the growing corporate ownership model help or hinder the changing needs of the patient?

It is potentially a problem, especially in practices where there is a high turnover of staff. We have already discussed how dementia patients need stability, but if they cancel an appointment and have to change location – even if it is a different room in the same practice – let alone a different dentist, problems could arise.

Conversely corporates may be in a position to tackle the problem head on. Due to their size and exposure in the dental market place, they could be at the forefront in establishing specific dementia-friendly practices.

In all aspects of this work we have sought to provide information to support dentists wherever they work, as they try to provide holistic care for their patients and in particular those living with dementia. ◆

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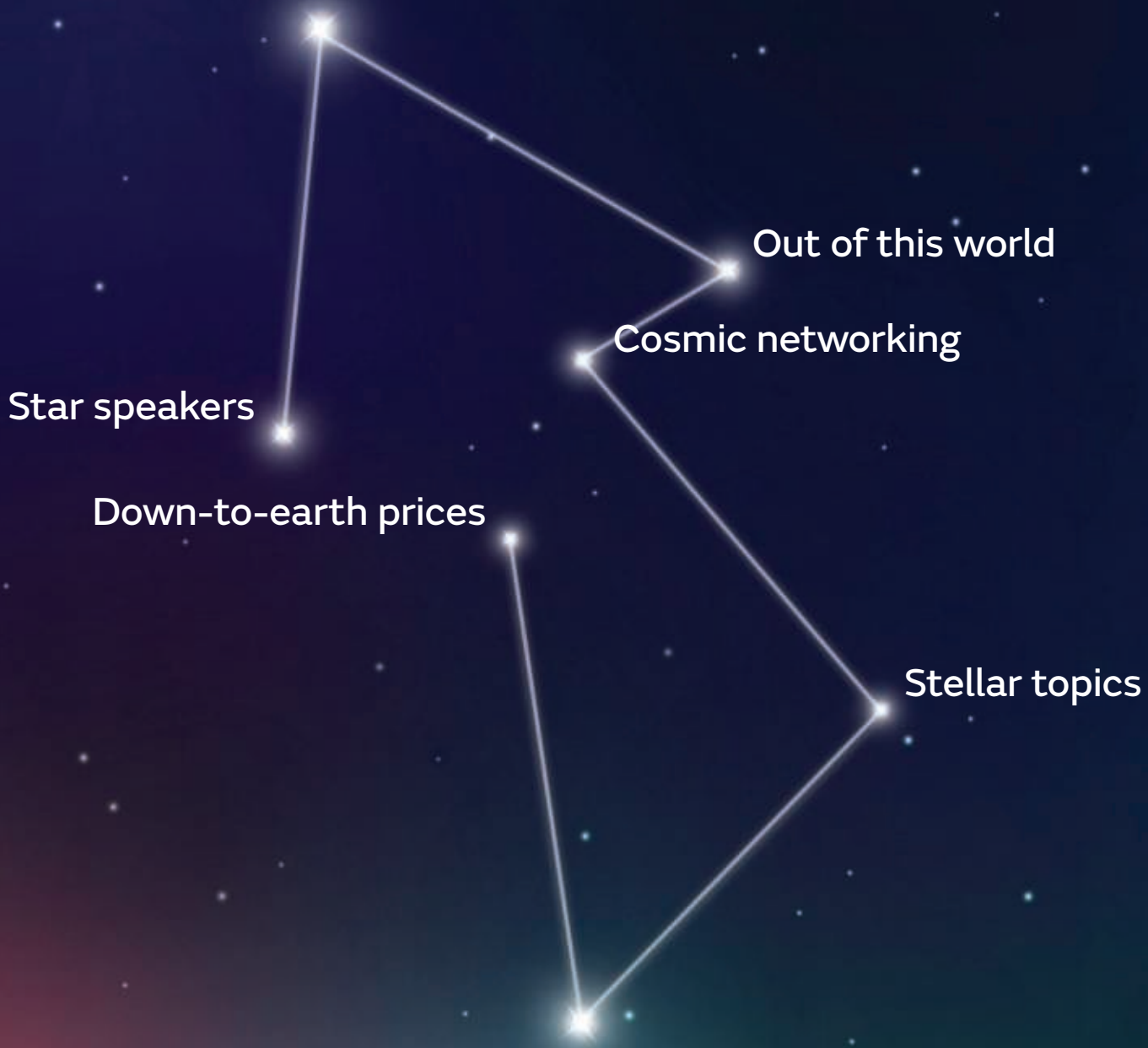

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Associate finances –

Percentage apportionment or rental agreement?

by Claire Bennett
a Practice Management Consultant in the BDA Practice Support Team. Claire qualified as a solicitor in 2008 and advises general dental practitioners on associate contracts and a wide range of employment and other law.

In many respects the commercial arrangement in dentistry that exists between practice owners and associate is a unique one. The premise is that Associates are self-employed; sub-contractors to practice owners, hiring surgery space so that they can provide treatment – be that on an NHS basis, privately, or both – to patients of the practice.

The general arrangement is that the practice owner provides the associate with the facilities, including a surgery, equipment and support staff in exchange for a fee. The technical legal term for this hiring out of part of their surgery is a licence agreement – giving the associate permission to use the premises and other facilities. A key element to contractual negotiations will obviously be to work out how the associate should pay for the facilities. And with the need to meet practice expenses, laboratory bills and earn a living the financial arrangements underpinning an Associateship can be complex.

Associates pay the practice owner, earning money through treating patients of the practice in order to meet this commitment. Commonly, the Associate will pay for use of the practice owner's facilities monthly; the amount paid based on a proportion of the fees they have earned – the percentage apportionment method. However, many practices use the other main approach to associate payments whereby the practice owner receives a fixed monthly amount in exchange for the licence – what is known colloquially, but not, in legal terms, accurately as the fixed-rent method. This can work out fairer for both parties and have a stronger legal basis.

Percentage apportionment

From the contracts I have reviewed, the most common way of paying for the licence provided by the practice owner is for an associate to agree to split their gross income according to a specific percentage. This is generally straightforward but you need to specify how specific costs such as laboratory bills are dealt with, these are often the associate's responsibility as they have been incurred in the course of the treatments they carry out.

There is no set percentage rate for apportioning an Associate's fees; it is a commercial question for both parties to consider. As part of their considerations, an Associate should remember that they are paying a fee for the use of facilities and services and should have regard to factors like practice costs for the such items as the building, equipment, maintenance and repairs, staff, utilities and materials. Look at this in the round, considering also size and nature of the patient base, likely gross fees (in England and Wales this would include the UDA target and the contractual value of UDAs), the quality of the surgery and equipment, the experience and expertise of dental care professionals (DCPs) and, importantly, trends in patient numbers, gross fees and practice costs.

Rental method

Alternatively, an associate's gross pay may be apportioned so that they pay the practice owner a fixed monthly sum – what you may think of as rent, though technically this term is incorrect as associateships do not give associates leasehold rights, or any other rights, in the premises.

Which method?

In practical terms with the practice owner usually collecting all the associate's earnings it looks like the practice owner pays the associate, after deducting what the associate owes to them. Since, as described above this is not the case, you need a clear written agreement setting out how payments are calculated. In my experience the fixed-rental method, is a relatively rare arrangement. The percentage apportionment method is well-established. This position may change, however; professionals and contractors who work within bigger organisations are, in many sectors, being asked to show more clearly the basis of their self-employed status. Paying a fixed amount for the use of practice facilities is one way in which this can be done. And in many instances you may find it is certainly a viable option for arranging your Associate finances. ◆

End of the contractual year

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

Along with colleagues in the BDA Practice Support team I've been speaking with quite a few of you in England and Wales about the end of the contractual year. Sometimes, I have detected exasperation or, even, panic in your voices: are we too far behind; too far ahead; will you get a breach notice; can our contract be terminated? We know year end is a stressful time for contractors with UDA targets and UOA targets to meet spot on; but these concerns can generally be resolved.

Two months

Submit your claims in time, contractors have two months after a course of treatment is completed to ensure that the necessary paperwork is submitted to the NHS Business Services Authority (BSA). And submitting a claim as soon as possible after completion gives you enough time to check, amend and retransmit any rejected claims.

During 2016/2017, as a consequence of delays in the management of the performer list by Primary Care Support England, NHS England suspended the 2 month rule. However, this will not apply for the year end. All contractors are required to submit forms to the BSA by 31 May 2017 for any courses completed by 31 March 2017. Any claims received after this date will be processed and the patient charges deducted, but no UDAs will be granted to the contractor.

What counts?

Courses of treatment started before the new contract year on 1 April 2017 but completed on that date or afterwards sometimes cause confusion. Claims completed after 1 April will be credited to the new financial year's total. However, merely holding off from sending-in completed claims until after 1 April won't mean that they are credited to the new financial year. NHSBSA will look at the completion date of treatment and they will be credited to the relevant financial year.

Running out of UDAs

Close to year end, if you have reached your contract target, there is often a temptation to shut your books completely to NHS patients. Do not do this as you will be breaching the terms of your contract. Your NHS contract still requires mandatory services to be available during normal surgery hours to patients who are currently undergoing a course of treatment. Careful contract management is vital to ensure that you do not end up out of pocket.

Your obligation is to offer patients the next available NHS appointment. You should make sure reception staff have clear protocols on appointment scheduling and allocating new patients. If the appointment date given to the patient is not acceptable to them, then the practice should advise the patient how to access alternative NHS care. Private treatment may be offered if the patient wishes to receive care at the practice prior to the practice's next available NHS appointment.

You should never assume that you will be paid for over-performance or that any excess will be carried over to the next financial year. NHS England's guidance is that where delivery of UDAs is above 100%, unless your contract specifies otherwise, there is no requirement for the commissioner to make any adjustment. Though they may, at their discretion, allow a tolerance of up to 2% to be paid or carried forward to the next year as credit.

Under target

If you are sure that you are not going to meet your NHS target then try to speak to NHS England or your Health Board at the earliest opportunity. Think of ways to catch-up on activity. Can you temporarily take on an additional performer or increase your opening hours? If this is not possible, then calculate how much the underperformance is likely to cost and discuss with the commissioner the best way of resolving the situation.

The NHS does give you a small leeway of 4% of your contracted target. Where delivery of UDAs are between 96% and 100% the under-delivered UDAs can be carried forward to the next financial year. This will mean that you will have to deliver more UDAs in the next financial year to make up the shortfall and these must be completed within 3 months of the new financial year. You can however choose instead to pay back the value of the under-delivery. This would be for you and the commissioner to agree.

Under 96%

Commissioners must wait until the NHSBSA has completed and issued the final year-end reports, which are produced by 30 June at the latest each year. Where delivery of UDAs are less than 96% the commissioner will recover the full amount of any activity not delivered. They may also serve you with a breach notice. And repeated breaches may ultimately lead to contract termination. You should liaise with your local commissioner in good time if you are not on target. ◆

The BDA's Advice Team is on hand to discuss with BDA Extra and Expert members any issues they may have on how to manage contract activity – email Advice.Enquiries@bda.org or telephone 020 7535 5864.

Making Tax Digital

by Paula Slinger
a Business Adviser, helping BDA members with all aspects of business planning, buying and selling practices, incorporation, conversion to private practice and other related areas

The government's tax collectors at HMRC are working on their Making Tax Digital project, a plan to move tax affairs on-line, which will affect all self-employed dentists – including practice owners and associates – in the next few years. From 1 April 2018 to 1 April 2019, the way in which companies, sole-traders, partnerships and those letting out property report their finances in relation to income tax and national insurance will change. The size of your business will determine the date by which you will need to have made this change. These changes will also be required for VAT from 1 April 2019. By 2020, HMRC will have moved fully to a digital tax system. Your tax obligations will operate much more closely to real time and bring an end to having to complete an annual tax return. The Government has stated that this new tax system will keep everyone up to date and remove the risk of missed deadlines, unnecessary penalties, debts arising and errors in the system being carried forward from one year to the next.

Personal tax accounts

The new tax system will also give taxpayers access to their own digital accounts. They will be able to see a complete financial picture in their personal digital tax account, very much in the same way they may see their financial information when checking their online banking. You can set up your online account by searching for "personal tax account" on the GOV.UK website.

These accounts by enabling taxpayers to report information as they go along will mean there is no need for an all-encompassing annual tax return. However, there will be a requirement to notify HMRC at least quarterly of your business's main source of income and any secondary source of income above £10,000.

Headache

As reported in our news item last month (*A taxing issue*, *BDJ In Practice*, February 2017, page 3) the National Association of Specialist Dental Accountants and Lawyers (NASDAL) has spotted that the changes won't be straightforward. The submission of regular updates doesn't match the way most practices arrange their accounts. Small businesses previously have not needed to prepare monthly management accounts. Indeed, given the profile of practice expenses and income, monthly accounts may not give as clear a picture as annual accounts but they are likely to become necessary in order to feed information into the HMRC at the correct time. NASDAL's Alan Suggett told *BDJ In Practice*: 'The aims of the scheme appear to be laudable in terms of simplifying and making the tax system more efficient. However, the dental sector will face specific challenges. In short, it will create a severe headache for the majority of dentists'.

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Adapt

Whilst clearly making the process easier for the HMRC and providing some advantages to taxpayers through online accounts and being able to check your liabilities on an ongoing basis many businesses will have to review their accounting procedures to make sure they align with the new system.

It is important that you keep fully up to date with your income and expenditure. Start now to consider if you need to adapt the ways that you keep on top of your financial affairs. Rather than just giving your accountant a folder with all the paperwork at the end of the year, businesses will benefit from having a book keeping system that will make quarterly reporting easy. Ask what services your accountant will be introducing to facilitate this, what you can do to assist them in relation to the data they need and how this will alter your end of year accountancy fee.

Training for you and your team on the new requirements would be beneficial so that you can manage the changeover more smoothly. HMRC itself runs free tax related courses through the year – contact the local HMRC office that you normally deal with to find out what free tax courses are available.

Also liaise with your software provider to ask if they are developing any updates that will be compatible with the new HMRC systems. You need to know whether they will provide reports that produce the type of data that HMRC will request from you.

Getting independent financial advice ahead of these changes will be crucial. You must talk to your accountant about how you will be affected. The GOV.UK website also has more information listed under Making Tax Digital. ◆

Receive specialist advice on financial and accounting matters

Conradi Morrison & Co specialise in assisting dental practices and dental associates and can advise on financial and accounting matters such as Personal Savings Allowance. From 5 April 2016 (Tax year 2016/17) the new Personal Savings Allowance was introduced and tax no longer deducted from savings at source.

The New Personal Savings Allowance allows basic rate tax payers to receive up to £1,000 in savings income before tax is due. Higher rate tax payers get a £500 band and additional tax rate payers have a nil band. The Government expects that this new allowance will take 95% of savings out of the tax system.

Persons moving between basic, higher and additional tax rates will find more savings income will become taxable as it progressively falls outside the PSA. Some taxpayers may be used to receiving a refund of tax deducted at source and so are normally eager to file their tax returns in order to speed up the refund. From April 2016 savings income will normally be received gross and it is likely that for taxpayers with larger interest receipts, tax will be payable.

Some of Conradi Morrison & Co's clients had thought that savings were now outside the tax system but this is not the case. Any interest received over £1,000 or £500 for higher rate tax payers will still have to be declared. It is therefore still beneficial to consider ISAs.

Conradi Morrison & Co would be very glad to meet you and discuss the possibility of tax planning in your business. Call 01322 278188 to arrange a meeting without charge.

Get smart

Clinical imaging company INFINITT UK have launched a web-based service to streamline digital imaging and reporting workflow in the UK dental radiology community.

INFINITT SmartNet for Dental Radiology is a cloud service optimised to simplify management and exchange of dental images and for radiologists requiring a remote reporting platform. SmartNet enables real-time viewing, sharing and scalable storage of dental images and diagnostic reports. Online worklists provide real-time status updates with integral analytical review tool options.

Associated users in the dental community are invited to log into a subscriber's service via Infinitt's secure Portal to submit templated referral requests and supporting history data. It provides an easy route for general dental practitioners to place orders (using a selectable upload function) and also to review orders and resulting images/reports/comment.

Diagnostic reporting and surgical procedure planning is supported with online viewing and measurement tools plus layout options including FMX templates for all dental image types. Includes Infinitt's own Xelis 3D Dental module for CBCT and Implant Planning.

This hosted platform delivers the same dedicated INFINITT image & information management solution used in NHS Dental Hospitals and private practice.

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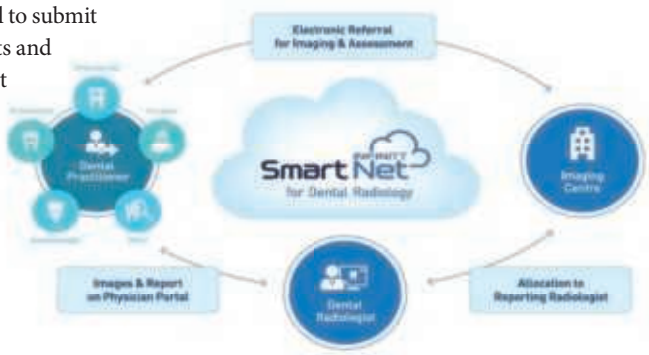
For further information please contact sales@infinitt.co.uk.



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A conversation starter

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A worthy investment

Stef & Philips are a leading social housing provider based in North London with established relationships and strong guaranteed rental contracts with borough councils in and around London.

As part of our service, we source properties for our investors then lease them on guaranteed 3-9 year contracts. As an investor you will have: 100% ownership of the property, a steady income stream, NET returns of 6.5%, a fully managed 'hands off' investment and guaranteed rent for up to 9 years whether the property is occupied or vacant.

The properties are freehold and come pre-tenanted, the lease with Stef and Philips commences two weeks after completion of purchase, so cash flow is generated immediately. We only have a small number of 3 bedroom freehold houses remaining. Please enquire at doctors@stefphilips.com for further information.

Truly mobile

The team at 3M Oral Care are delighted to announce the release of the new Mobile True Definition Scanner.

This innovative device is the world's first truly mobile scanner, operating solely on a high quality tablet screen. This affords complete flexibility and mobility – in and out of the practice.

The tablet also allows patients to see and understand their own oral anatomy, increasing their acceptance of treatment.

What's more, the True Definition scanner is a demonstrably accurate device, providing more consistently accurate scans than other leading intraoral scanners.

To discover more about this innovative new product, contact the expert 3M Oral Care team today on 0845 602 5094 or visit www.3Mespe.co.uk.

Remove the guesswork to better protect patients

It can be difficult to identify the right type of mouth guard for your patient, and choosing the wrong type could leave them with insufficient protection.

The team behind Saber Protect take all the guesswork away and guide you through the various options to select the best one for every patient.

The specialist team of dental technicians will create a mouth guard to fit precisely within your patient's mouth. They will customise the design to meet specific requirements for the sport, age and competitive level being played, as well as their style.

All you have to do is take an impression of the patient's mouth, fill out a form and send to CosTech Dental Laboratory – within 10 days a custom made Saber Protect mouth guard will be back in your practice ready for your patient.

For a mouth guard that allows your patient to stay in the game longer, and one that will protect your patients' future oral health, choose Saber Protect.

Saber Protect mouth guards are fabricated by CosTech Dental Laboratory. For more information visit www.custom-mouth-guards.com.

Following up with your patients

EndoCare believe that their patients are the most important part of their job as dental professionals. They always strive to put them first and ensure that their journey with them is as positive as possible.

That's why they have started using the FollowApp system for all patients. This intuitive service allows you to closely monitor patients during their home recovery, ensuring that they are always comfortable and reassured.

Patients are sent an SMS message containing a simple, one-minute survey – the responses to which will keep you up to date with their recovery. This way you can offer them advice and reassurance or, if necessary, call them back in for follow up treatment.

To find out more about referring your endodontic cases to the EndoCare team please call EndoCare on 020 7224 0999 or visit www.endocare.co.uk.

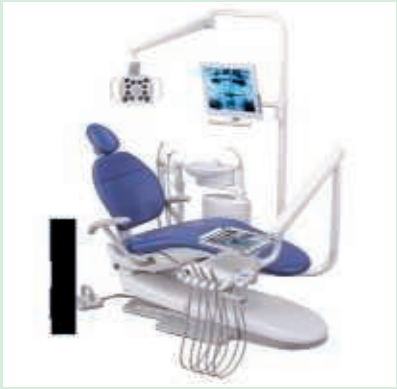
More modularity

The A-dec 300 has been designed to suit practically all clinical scenarios. With an innovative modular design, the adaptable system can be tailored to your specific preferences and professional needs.

With the same high quality and reliability of other A-dec models, the A-dec 300 has the added bonus of being truly flexible. Operators may choose a number of different components and equipment alternatives to create the dental chair they need to succeed.

Perfect for multi-clinician practices, or practices that offer a wide variety of treatment, the A-dec 300 offers a range of different options that allow for an unprecedented level of patient care. From lights to delivery systems, cuspidors and touchpad controls – the choice is yours.

To find out how the A-dec 300 would fit into your practice, visit www.a-dec.co.uk or call on 0800 2332 85.



Going where a toothbrush can't

Archaeological evidence has suggested that, since prehistoric times, the use of interdental adjuncts has been a common component of a thorough oral health care regime.

With the Tandex Flexi Max interdental brush from Tandex, patients can benefit from a modern day tool designed specifically to go where a normal toothbrush cannot.

Effective and easy to use, the Flexi Max will allow patients to successfully self-manage the build-up of plaque and bacteria in those hard-to-reach interproximal areas.

With an ergonomic, flexible grip, this interdental brush makes it easy for anyone to reach to the back of the mouth and apply efficient and gentle treatment to both the teeth and gums.

With a wide range of brushes, finding the best size for small interdental spaces or more complex bridge and implant spaces has never been easier.

For further information on Tandex's range of products, visit www.tandex.dk

Cut down on your burs

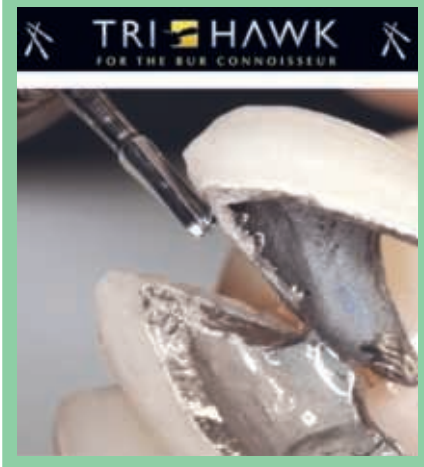
There is no faster cutting bur in the world than the Talon from Tri Hawk.

Available exclusively from Surgery Express, the Talon crown cutting bur has a unique design which allows you to cut vertically as well as horizontally – meaning you can expedite your cutting procedures, save valuable chair-time and provide your patients with a quicker, more comfortable experience.

What's more, a single Talon bur can be used for crown prep, cutting and removal – eliminating the need to use three separate burs for each individual stage. And because the Talon bur is so adaptable, it can actually be used for a great many other procedures too – indeed, Tri Hawk customers have found that at least 80 per cent of cutting procedures can be completed with the Talon bur, and in less time. This helps to streamline your dental armamentarium, trim the fat on your inventory list and optimises sterilisation costs – all thanks to this one high quality product.

Indeed, because the Talon bur is a single-use item, it will help improve cross-contamination within the practice. Each bur is packaged individually and numbered, to provide professionals with an accurate account of their supplies. This, once again, saves valuable time – for both the practitioner and the patient – and will prove to be extraordinarily cost-effective.

For more information, visit www.surgery-express.co.uk, call on 0800 6888 992 or email at sales@surgery-express.co.uk



Giving you Xtra

Steri-7 Xtra – the new range of multi-purpose biocidal cleaners from Initial Medical – is ideal for almost every surface or material in the dental practice. The product range also works as a high level disinfectant to eradicate 99.9999% of pathogens including bacteria, spores, fungi, yeasts and viruses.

Steri-7 Xtra offers protection for up to 72 hours after application. Utilising innovative 'Reactive Barrier Technology' – a specialised micro emulsion that provides an optional sustained release system – it goes on working even once dry, keeping treated areas contamination-free between cleaning cycles. As with all solutions available from Initial Medical, you can rest assured that Steri-7 Xtra is fully compliant with all relevant legislation and will help you achieve the very highest standards of hygiene.

For total confidence in the health and safety of your patients, your staff and yourself, discover the new Steri-7 Xtra range at www.initial.co.uk/medical or call 0870 850 4045.

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British Dental Association

Free CPD available for DCPs

Register on the CPD Hub now and start gaining complimentary CPD.

Courses available:

10 hours verifiable CPD

BDJ Publication
BDJ Team

CORE
3 hours verifiable CPD

Child protection and the dental team

CORE
3 hours verifiable CPD

Oral cancer recognition toolkit

Certificates will be awarded upon completion.

cpd.bda.org

Mobile | Tablet | Desktop

The BDA is owned and run by its members. We are a not-for-profit organisation – all our income is reinvested for the benefit of the profession.

Dentist to Dentist

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

East Anglia

DEVONSHIRE HOUSE

www.devonshirehousedental.co.uk

2 Queen Edith's Way, Cambridge CB1 7PN
Tel: 01223 245266
Email: enquiries@devonshirehousedental.co.uk

Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

283787

Midlands

THE PRIORS DENTAL PRACTICE LTD

www.thepriorsdentalpractice.co.uk

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

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

Mr John Scholey BDS, FDS, RCS (Edin), FDS (Orth) RCS (Edin) MOrth RCS (Eng), MDentSci
Interests: Specialist Orthodontics, Mini-Screw, Lingual Braces
On Specialist List: Yes

Dr Lukas Javorskis MSc Endodontology (Kaunas, Lithuania)
Interests: Endodontics (including Instrument Removal), Use of on-site Microscope

CT Scanner and dedicated implant suite on-site.

236739

PARK ROAD DENTAL PRACTICE

www.parkroaddentalpractice.co.uk

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

North West

ST GEORGE'S DENTAL PRACTICE

www.stgeorgesdentalpractice.co.uk

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

261006

Scotland

BLACKHILLS SPECIALIST REFERRAL CLINIC

www.blackhillsclinic.com

5 Maidenplain Place, Aberuthven Perthshire PH3 1EL
Tel: 01764 664446
Email: info@blackhillsclinic.com
Cone beam CT scanning
Mr Paul Stone BDS (Hons) Lpool, FDS RCSEd, FDS RCPS (Glasg)
Interests: Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts.
On Specialist List: Yes, Oral surgery (60534)
Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants
On Specialist List: Yes, Prosthodontics (66211)
Dr Marilou Ciantar BChD (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel
Interests: Oral surgery, implant surgery, tissue regeneration, periodontology, conscious sedation
On Specialist List: Yes, Oral Surgery and Periodontics (84070)
Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA
Interests: Fixed and removable prosthodontics, endodontics and dental implants
On Specialist List: Yes, Restorative Dentistry and Endodontics (77605)
Mr Graeme Lillywhite BDS Edin, MFDS, MSc, MRD, FDS RCSEd
Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics (68916)
Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd
Interests: Endodontics
On Specialist List: Yes, Endodontics (79246)
Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR
Interests: Cone beam CT imaging
On Specialist List: Yes, Dental and Maxillofacial Radiology (70079)

266979

South East

GROVES DENTAL CENTRE
www.grovesdentalcentre.co.uk

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

279798

TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

DENTAL SPECIALISTS ST ALBANS

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

239826

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

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

209440

WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

284695

North

SPECIALIST DENTAL CARE
www.specialistdentalcare.com

Mr Martin F. W-Y. Chan
BDS, MDSc, FDS (Rest Dent) RCPS (Glasg), DRD, MRD, RCSEd.
29 The Grove, Ilkley, W. Yorks, LS29 9NQ
Tel: 01943 608090
Email: info@specialistdentalcare.com
Interests: Restorative and Implant Dentistry, Prosthodontics, Periodontics, Endodontics
On Specialist List: Yes, as above

261782

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

Training Essentials

BDA
British Dental Association

NHS Regulations - to claim or not to claim

Friday 31 March | London
Friday 14 July 2017 | London

Understand the pitfalls and controls and explore the 'grey' areas of the NHS regulations with the use of case studies and discussions with experts.

The NHS claiming regulations are notoriously difficult to interpret. Misunderstanding of these regulations can have serious consequences, leading to risk of major financial losses and possible referral to the GDC.

This interactive one-day course will offer formal training to practitioners who are new to the NHS system and those who require an update with the current system (introduced in 2006).

5 1/2 hours verifiable CPD

Handling complaints and managing difficult patients

Friday 9 June 2017 | London

Learn how to use complaints as a positive management tool to enhance your relationship with your patients.

If handled properly, a complaint can enhance relations and turn a potentially lost customer into a satisfied patient.

Gain the ability to diffuse upset patients and greatly reduce the possibility of complaints escalating to a Fitness to Practise case.

CORE

5 hours verifiable CPD

Course Prices:

BDA member:	£150
Non member:	£195
DCPs:	£ 95

bda.org/training | 020 7563 4590

Business skills CPD

Q1: In 2014 how many Fitness to Practise cases did the GDC deal with?

A 3,909
B 3,990
C 3,099
D 3,989

Q2: Why is there no set percentage for apportioning an Associate's fee?

A To keep control of finances
B It is a commercial decision for both parties to take
C It allows the Associate greater flexibility
D Set by local commissioning groups

Q3: How long after completing treatment do contractors have to submit their claim?

A Two months
B Three months
C Four months
D Five months

Q4: When does HMRC expect the have a fully digital system?

A 2018
B 2019
C 2020
D 2021

Q5: How many people aged 65 or older are projected to die from dementia?

A 1 in 2
B 1 in 3
C 1 in 4
D 1 in 5

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

To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists polish their business and practice-management skills.

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

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

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

Need help?

To access *BDJ In Practice* CPD online:

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

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

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

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

For support use: cpd.hub@bda.org

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British Dental Association

Our Advisers are here to answers your questions on various topics including...

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- Associateships, disciplinary, dismissal, disputes, tribunal representation

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- Buying and selling a practice, tendering, business planning and incorporation

NHS contracts and regulations
- NHS charges and claims, performers lists, information governance

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As the owner of a busy dental practice, Ravi is always looking for innovative ways to expand his business. He also wants to protect the practice he's worked so hard to build.

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- Insurance Reviews for Dental Practices
  www.lloydwhyte.com/dentistsinsurancereview
- Locum Insurance
  www.lloydwhyte.com/bdalocum

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