BDJ InPractice
November 2017

Lost in **translation**

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BDJ InPractice

NOVEMBER 2017

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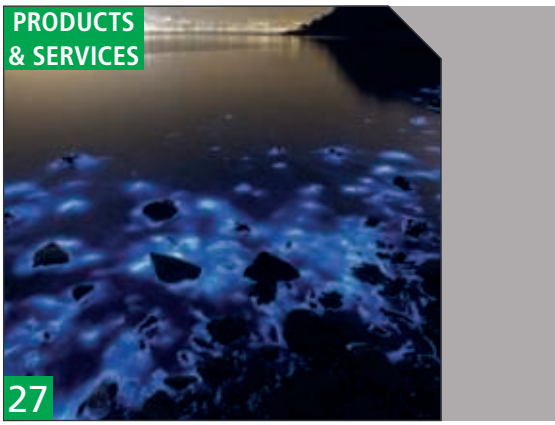

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DDU advises dental professionals to be clear with patients about NHS fee exemption rules

The Dental Defence Union (DDU) is warning dental professionals to ensure patients have read and understood the rules about NHS fee exemptions to avoid misunderstandings and complaints.

The DDU says a number of dental practices have asked for advice after patients were fined £100 by the NHS Business Service Authority (BSA), on top of their fee for NHS treatment, after incorrectly claiming an exemption. In some cases, patients thought they had been wrongly advised about their exemption and expected the dental practice to reimburse them for the cost of the fine.

Department of Health figures reveal that since September 2014, 689,770 dental penalty charge notices have been issued by the BSA, of which 385,770 were issued in 2016-17.

Writing in the latest DDU Journal, Nick Torlot, DDU dento-legal adviser, said: 'Patients are responsible for ensuring they are entitled to claim free NHS dental treatment, but the rules can be confusing. Dental professionals can help by signposting patients to information such as the NHS BSA guidance sheet so they can understand their eligibility and are less likely to incorrectly claim for free treatment.

'Unfortunately some patients might not understand that the auditing of NHS payments and charges is undertaken by the BSA, rather than the practice.

'Patients are often aggrieved by being fined when they believed they were exempt. A large number of complaints of this sort come from the fact that patients feel they were either given poor advice or misinformation when they were filling out the exemption form.'

The DDU has issued tips on how to minimise the risk of patients complaining, as well as helping them to understand their obligations:

Encourage patients to read the claiming free dental treatment factsheet which is available in a number of languages.

Ensure staff involved with handling NHS exemption forms (known as FP17PR) do not offer advice to patients, as it is not within their field of expertise and could lead the practice vulnerable to criticism if there is a complaint.

Explain that the BSA is a government agency and that the fines it administers to patients who incorrectly claim free treatment are not within the practice's control.

Sympathise with patients, acknowledging that the NHS exemption system can sometimes be difficult to understand, but that the responsibility for correctly claiming exemption lies with the patient.

The NHS BSA's website allows patients to check their eligibility for free treatment, and also includes the Practice Staff Guidance factsheet, which offers advice to dental professionals and staff. ◆

© Hero Images/Getty Images Plus

Dentists need indemnity lifeline thrown to GPs

The BDA has said government must step in to save NHS dentistry from skyrocketing indemnity costs, following the announcement that the Department of Health will set up a GP-only indemnity scheme to ease pressures on the medical workforce.

The pledge by Health Secretary Jeremy Hunt to the RCGP conference featured alongside offers of 'Golden Hellos' to improve GP access in rural areas.

BDA Chair Mick Armstrong said: 'Caught in a pincer between facing flat lining incomes and skyrocketing costs NHS dentists must be given access to this new scheme.

'We have a broken indemnity market and government is right to step in, but closing the door to dentists will only make this problem worse. We already face steep costs, and undercutting existing providers by taking away a big slice of their customer base may well impact on prices for those that remain.

'This plan is still on the drawing board, but it is imperative that no health professional, whether private or NHS, should suffer as a consequence of this intervention or as a result of continued market failure.

'Patients across the whole NHS are paying the price for access problems, mounting costs and underinvestment. The government needs to offer common solutions to common problems, otherwise it sends a terrible message to dedicated NHS dentists, and will only deepen the crisis facing the service.' ◆

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BOOK REVIEW

The effective manager

Mark Horstman
Wiley, 2016
ISBN: 978-1-119-24460-8
£22.99

In a nutshell

Former U.S. army officer Mark Horstman and co-founder of the consultancy Manager Tools is on a mission. In the introduction, he's upfront in promoting his company and the handy award-winning podcasts it publishes, but is at pains to stress that his primary motivation is to get the word out about successful people management, either by the free podcasts or via this book. However, he isn't labouring under the illusion that those in need of acquiring people management skills will necessarily wish to hire his personal management consultancy services. In its two hundred pages this hardback illustrates, with excellent examples, how to improve as a manager of people, whether it is in terms of giving feedback or time-efficient coaching or just communicating effectively with employees.

Who is ideal for?

This book is written for managers who have to lead a team or handle difficult inter-personal situations. So 'management' in this context applies to those who have to deal with people as opposed to the popular interpretations of management as propagated by business publications, such as strategy, finance or organisational change. It's not that those subjects aren't relevant to managerial duties, but rather that the management of people should be, in Horstman's opinion, the most fundamental aspect of the job and one which those in nascent or burgeoning managerial positions should tackle first. He also contends that people management is the most important aspect of their work in order to facilitate value to the organisation.

Why you should read it?

Horstman's book tackles what he describes as the 'four critical behaviours' in which an effective manager needs to engage in order to produce profitable results and retain team members. 'Get to know your people' seems a no-brainer, but how many managers know the names of their direct reports' children? 'Communicate about performance' is another way of expressing the action of feeding back on the work of staff and can contribute 30% of the value of the total created in the four critical behaviours. The third element 'Ask for more' implores the manager to 'stress' the staff, but only to the level of 'good' stress which facilitates the best possible quality of working. Finally, the fourth critical behaviour he identifies is the ability to 'push down work' or delegate. In short, this pragmatic and eminently readable no-nonsense book is exactly what you'd hope to expect from a highly successful West Point military graduate. ◆

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

Antibiotic apocalypse - front line staff need government to step up

The BDA has responded to warnings from the Chief Medical Officer, Professor Sally Davies, of a post-antibiotic apocalypse, calling on government to step in and help front line NHS staff deliver an effective response.

The Association has led the debate on antimicrobial resistance in dentistry in the UK, and has expressed concern that huge patient pressures and the lack of funded emergency treatment time will stifle crucial progress.

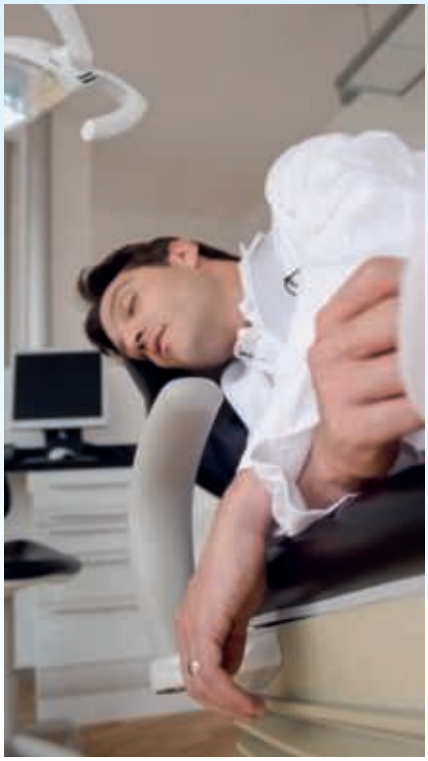
Dentists in England and Wales have faced significant challenges engaging with this agenda owing to contracts focused exclusively on hitting tough activity measures.

BDA Health and Science Chair Russ Ladwa said: 'This is the century's defining health challenge, but health professionals are still bearing brunt of patient pressure, lacking both adequate time and resources. Time-consuming treatment will struggle to compete with prescribing until government recognises and responds to the challenges front line staff are facing.'

Stress and burnout research project

The BDA are conducting research looking into dentists' mental well-being. It will mainly focus on working conditions that can lead to stress and burnout in dentists and the impact this has on general well-being, health and patient care. All dentists are invited to take part in the online survey. All answers will be anonymous and confidential.

To participate, please visit bda.org/burnout.



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FGDP(UK) announces winners of 25th anniversary prizes

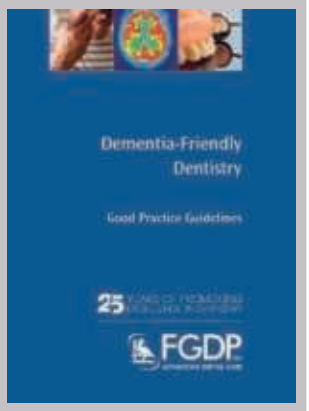
FGDP(UK) has announced the winners of prizes celebrating the achievements of the general dental profession in the Faculty's 25th anniversary year.

The prize for Community dentist of the Year went to Jason Wong for his championing of oral health via local groups, boards and committees, and his commitment to developing the skills and competencies of local dentists.

Jason also has an active profile on social media, which he uses to promote oral health outside of the dental surgery for the benefit of his community and the wider profession.

The judging panel noted that 'Jason has and does work tirelessly for the dental profession; we were very impressed with his work and he is very deserving of this prize.'

FGDP(UK) publishes new guidance on dementia-friendly dentistry



The Faculty of General Dental Practice UK (FGDP(UK)) has published new guidance on the practice of dentistry for patients with dementia.

With around 850,000 people in the UK with the condition — 5% of the population — the Faculty says that dental professionals need to understand it, and adapt their patient management and clinical decisions accordingly. The result of a multidisciplinary collaboration, notably with the Alzheimer's Society, Dementia-Friendly Dentistry: Good Practice Guidelines covers:

- The epidemiology and diagnosis of dementia, and its implications for dental professionals
- Principles of care management, including patient identification, competence and referrals, communication, consent and capacity
- Clinical care, including history taking, treatment planning, care delivery and prescribing; and
- Site-specific considerations for dental practices, care homes and domiciliary care.

The new book also signposts readers to local support, educational programmes and resources for patients, and contains over 50 recommendations for practitioners, categorised using the Faculty's 'ABC' (Aspirational, Basic, Conditional) notation.

Paul Batchelor, Vice-Dean of FGDP(UK) and Editor of the new guidelines, added: 'Dementia affects many aspects of an individual's life, and these guidelines are designed to help the profession understand the condition and its implications for dental practice. By ensuring high standards of care, dentists can help minimise some of dementia's potential effects, particularly those also associated with poor oral health, such as worsening of diet and social isolation, and a concomitant decline in general wellbeing.'

Emma Bould, Programme Partnership Project Manager at the Alzheimer's Society said: 'Dentists have a crucial role to play in the community for people with dementia, and because dementia gets worse over time, it is important, as far as possible, to establish a dental care programme at, or soon after, a diagnosis. We also know that for many dementia patients looking after their teeth can become a real problem – remembering to brush regularly, communicating dental pain and even managing dental appointments can all be a real struggle. Therefore it is imperative that all dementia patients have access to supportive oral healthcare and are understood when they visit their local dentist. We welcomed working with the FGDP(UK) on these new guidelines, which are an important step to helping more people affected by dementia to live well with their condition, and we hope that dentists across the UK will put them into practice.' ◆

Practice goodwill values – a geographic split?

The latest practice goodwill survey results have just been released by The National Association of Specialist Dental Accountants and Lawyers (NASDAL) and it does appear that the market as a whole is still buoyant. However, there may be a geographical divide opening up across the UK.

The survey did see an overall increase in average goodwill value of 4% in terms of deals done and the most recent sales data showed very high values achieved in areas such as London, the South East, Birmingham and Manchester – over 200% of gross fees for NHS practices was not untypical. But, this return is not always being seen in areas such as the North East, Cumbria and away from major conurbations.

Alan Suggett, specialist dental accountant and partner in UNW LLP who compiles the goodwill survey, said: 'In general the market still seems to be in rude health. Nonetheless, I am hearing that in many areas the lack of associates means that contracts are becoming difficult to fulfil and therefore those practices become less attractive. There may be a Brexit factor at play too as many roles were carried out by EU nationals and the current political climate perhaps makes them feel less welcome in the UK?'

The goodwill figures are collated from accountant and lawyer members of NASDAL on a quarterly basis in order to give a useful guide to the practice sales market. These figures relate to the quarter ending 31 July 2017. ◆

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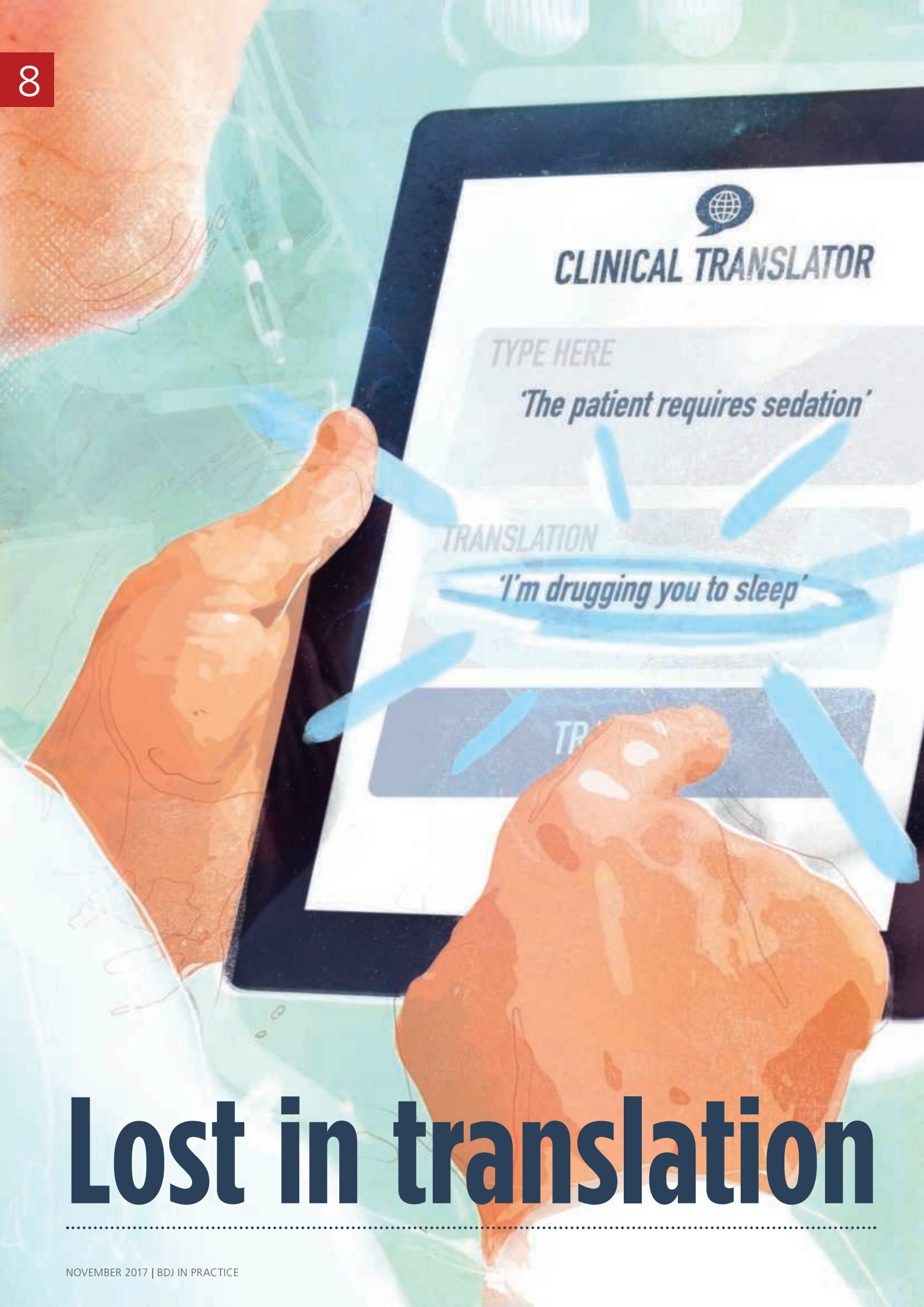


Lost in translation

By David Westgarth,
Editor, *BDJ In Practice*

Fork 'andles.
Four candles?
Fork 'andles.

There you are sir. Four candles.

The lines of the famous sketch by *The Two Ronnies*. Rumour has it this sketch was completely unplanned and based on an actual conversation that had taken place not long before the pair went to work.

The nuances of the English language are fascinating. Bought can sound like boat. Coat like court, cord like code, and so on. I have found myself in the midst of awkward conversations overseas, as my accent can – and often is – difficult for the un-trained ear to decipher. The important thing for me is these are low level transactional conversations – ensuring I have the right food on my plate and the correct wine in glass isn't what I would call a life or death situation.

That sentiment may also ring true about a routine dental appointment, but for the patient – and for you – the consequences of getting it wrong go farther than a food order simply lost in translation.

In 2011, the ONS performed a detailed analysis of English language proficiency in England and Wales[1]. The data revealed English was the main language for 92% (49.8 million) of usual residents aged three and over. Of the remaining 8% (4.2 million), who had a different main language, the majority (3.3 million) were 'proficient' in English, while 863,000 were 'non-proficient'. Of the 863,000 who were 'non-proficient', 726,000 could not speak English well and 138,000 could not speak English at all.

Drilling deeper into the report, it also highlighted the top 10 local authorities with highest proportions of 'non-proficient' aged 3 to 15 year olds. The top five was entirely comprised of London boroughs, namely Hackney, Ealing, Brent, Haringey and Newham.

Finally, the Census asked the population to rate their health as either 'good' or 'not good'. In total, around 300,000 usual residents in England and Wales had 'not good' health and were 'non-proficient' in English. Local authorities including Tower Hamlets, Newham, Leicester, Haringey and Brent made up the top five.

So what's the link to oral health? Well, the 2015 Oral Health Survey of five-year-old children[2] revealed the mean DMFT of those sampled was 1.3 in Tower Hamlets, 1.2 in Newham, 1.9 in Leicester, 1.2 in Haringey and 1.3 in Brent. The national average in England was 0.8.

However you care to interpret those figures, something isn't getting through to patients in certain parts of the country.

The profession's role

When faced with English-speaking dental professionals, use of informal interpreters such as family members is common, although this may be problematic when faced with embarrassing issues or when the informal interpreter's language skills are poor. While this approach has a number of benefits, including saving money on booking professional interpreters and the potential for relatives to offer moral support and to help patients remember complex information, there are well-documented disadvantages.

Confidentiality may be compromised and patients may not want to divulge sensitive or intimate information in front of family members or friends. There is also uncertainty about how well the person interpreting can speak the target language, particularly if they are younger family members as is sometimes

the case. This can lead to mistakes or incomplete transmission of vital information. Obtaining informed consent may be difficult in such circumstances.

So why are interpreters so crucial to the treatment planning process?

Data obtained by the Royal College of Surgeons have previously shown in one year 29 medics from the European Economic Area faced allegations of 'inadequate knowledge of English language'. By contrast, only 10 doctors from outside the EEA faced the same accusations during 2014/15, the figures obtained by the RCS from the General Medical Council show.

Fast forward to now, and the Nursing and Midwifery Council (NMC) have announced plans to change the way the English language test is carried out, as some nurses have found the test too difficult and does not show occupational context[3].

And in dentistry? The GDC's Standards for the Dental Team states: 'Necessary knowledge of English is defined as 'a knowledge of English which, in the interests of the person and the person's patients, is necessary for the practice of dentistry in the UK.

'You must be sufficiently fluent in written and spoken English to communicate effectively with patients, their relatives, the dental team and other healthcare professionals in the United Kingdom.'[4]

The range of requirements across allied healthcare professionals perhaps shows the 'jigsaw' approach to integrated health that many critics have previously highlighted do not work in the patient's best interests. If, for example, there is a breakdown in communication in a referral, is that working in the patient's best interests?

> 'It is important to approach the consultation in the same way as you would any consultation, ensuring the patient is the centre of your attention.'

The patient

According to the Principles for High Quality Interpreting and Translation Services[5], patients must be able to access primary care services in a way that ensures their language and communication needs do not prevent them receiving the same quality of healthcare as others.

Not providing an interpreter can affect patient experience and health outcomes, increase missed appointments and make consultations less effective. Anecdotal evidence suggests the involvement of an interpreter has in some instances led to a failed treatment plan, although cultural and other external influences may have played their part.

Under the Equality Act 2010 it can also be indirect discrimination on the grounds of race. The GDS contract states: '[Subject to clauses 26 and 28A,] the Contractor shall only refuse to provide services under this Contract to a person if it has reasonable grounds for doing so which do not relate to a person's race, gender, social class, age, religion, sexual orientation, appearance, disability, medical or dental condition.'

Where a dental practice – NHS or private – refuses to provide a language interpreter, they must have considered their interpreting provision and come to a conclusion that fulfils a test of 'due regard' under the public sector equality duty. The CQC states: 'If the practice could prove that a policy not to provide interpreters was proportionate to achieve a legitimate aim, this would not be unlawful. This applies to both NHS and private treatment.' While you could point out to your Local Area Team (LAT) that this is a mutual responsibility shared by both the LAT and providers and that some funding should be made available to contribute to the additional expense of providers having to meet this requirement. However, based on the wording of the contract, it would be difficult for you not provide a translator as this would be seen as discrimination and a breach of the contract.

One way some practices seek to provide treatment without the additional expense of a translator is allowing family members or friends to interpret for a patient. Victoria Mitchell, Practice Management Consultant at the BDA, said that while that particular practise may be cost-efficient, it is not without risk.

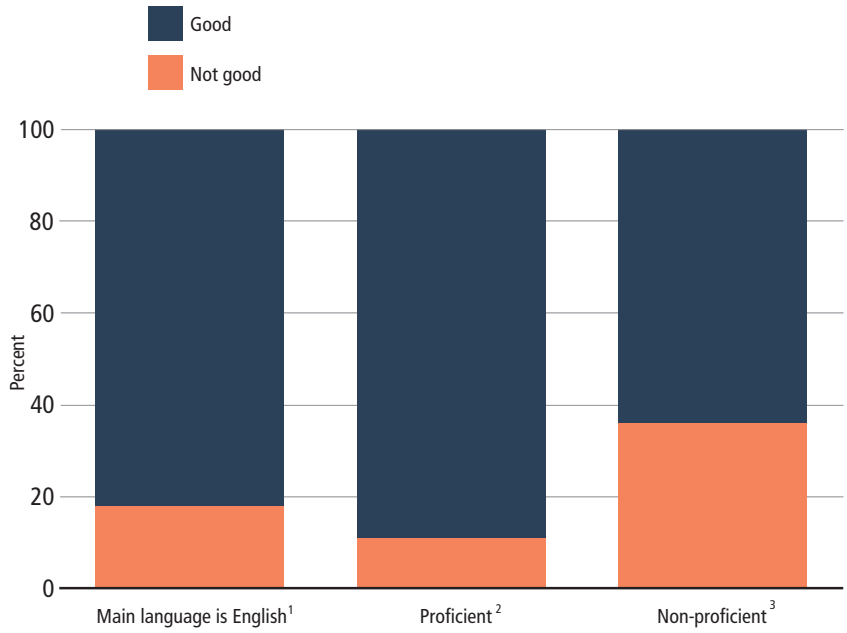
'Dentistry is an incredibly complex subject, and one that even the most proficient of English speakers may not understand from time to time', Victoria said. 'There is no guarantee that the family member or friend understands the message, or can interpret it correctly. Unless you speak the language – in which case there may not be a need for a translator – you cannot be sure the patient is getting the right information.

'It is a risky situation. You never know the history of the patient's past relationship to the translator. The correct information may not be passed along at all if there was a medical emergency or was bad news, for example.

'If you are in any doubt, we – and the CQC – would advise you to contact your indemnifiers or the advice team at the BDA before treatment takes place to ensure you know where you stand in the event of mistranslation.'

On the topic of translators, MDDUS dental adviser Rachael Bell said: 'We would advise

General health by proficiency in English language, England and Wales, 2011



Source: Census - Office for National Statistics

against using a family member as a translator as it could undermine both patient confidentiality and the objectivity of the consultation. In an emergency, a family member may be too distressed to remain calm. Instead, dentists should use professional translation services wherever possible.

'Family members won't have the relevant experience of terminology and phrases of a trained interpreter and may not be able to effectively communicate what both parties are saying. Using a professional interpreter is more likely to result in effective communication between you and your patient.

'Under no circumstances should children be allowed to translate for older family members as this raises serious ethical issues.

'In situations where a patient wishes a family member to translate, dentists should gain consent to this using an independent translator in order to ensure the consent is valid.

'Dental professionals should not act as an interpreter for care they are providing and should only interpret if it is in their training and job role to do so. Use of an independent translator will ensure both the treating dental professional and their chaperone understand what is being said.

'It is important to approach the consultation in the same way as you would any consultation, ensuring the patient is the centre of your attention. Dentists should say everything that they would if they were consulting with an English-speaking patient and leave extra time to allow for the translation process.

'Dentists should follow NHS England guidance on using professionally-trained translators entitled Principles for high quality interpreting and translation services and Now we're talking, interpreting guidelines for staff of NHS Scotland.'

Stephen Henderson, Senior Dentolegal Adviser at Dental Protection, said: 'A consultation with a patient who does not speak the same language as the dentist raises the risk of a potential misunderstanding and a failure to obtain valid consent. Anyone acting as an interpreter to facilitate communication between a clinician and a patient should be competently bilingual and know how to identify and interpret the key points the dentist needs to get across without omission or misinterpretation. This is particularly important in relation to the clinician's ongoing duty to obtain valid consent at all stages of the patient's care. Interpreters should be independent and impartial, understand the duty to maintain confidentiality and should resist the temptation to speak for the patient. This can best and most reliably be achieved by using a professional interpreter who will also be able to clarify cultural nuances.

'When it comes to urgent or emergency care, accessing an interpreter can be more difficult.

'If professional interpretation services cannot be accessed in time, and communication between a patient and clinician is urgent and essential in the best interests of the patient, using a family member may be a necessary compromise. A child should only be relied upon to interpret in the most extreme circumstances, because a child, however mature, may not be able or willing to discuss their parent's private medical problems. The reliance upon a family member should not be considered appropriate on a routine basis.'

To illustrate the point, the above letter was published in the BDJ in May 2013[6]:

Letter published in the BDJ in May 2013

Sir, I have been treating a Polish patient in my final year Outreach placement. The patient speaks no English and brings his son as an interpreter. Despite the language barrier, I obtain valid consent for the course of treatment, via his son's translations. The treatment plan comprised of full clearance of all remaining teeth, and provision of immediate complete/complete dentures with a view to construct definitive dentures after a six month period.

Although slightly more time was required than usual per appointment, I was able to successfully communicate through the patient's son. When the patient attended for delivery of the immediate upper denture, there were still three teeth in the upper arch requiring extraction.

As the patient is needle phobic, I had previously used topical anaesthetic prior to infiltrations, if only for psychological purposes. Once anaesthesia was achieved, I began to luxate the first tooth for extraction.

The patient began choking unexpectedly. I sat the patient forward and started back slaps in case he had inhaled something. The patient continued choking and was struggling to breathe. He began to panic and I asked his son to tell him to calm down and encourage him to cough. The patient's son was also worried and was not translating, instead shouting at me to 'do something'. I was unable to speak to the patient to ascertain what had happened. I checked the patient's mouth for airway obstructions or fractured teeth/broken restorations. Nothing was evident.

I called for my supervising clinician and explained the situation. The patient was still choking and struggling to breathe. Due to the communication issues, we could not fully manage the patient or calm him down and the son was too emotionally involved to be of any help to us. As neither the supervising clinician nor I were aware of the cause of choking, it was decided to phone for an ambulance and send the patient to hospital for further investigation.

At the patient's next appointment, his son explained that there was no conclusive reason for the choking and that the most likely cause had been swallowed topical anaesthetic. The lack of sensation to the throat probably panicked the patient. I feel that I could have managed this situation better had there not been such an obstacle to communication. The requirement for a non-biased, independent interpreter is evident to me now and I have learnt not to use family/friends as translators in the future.

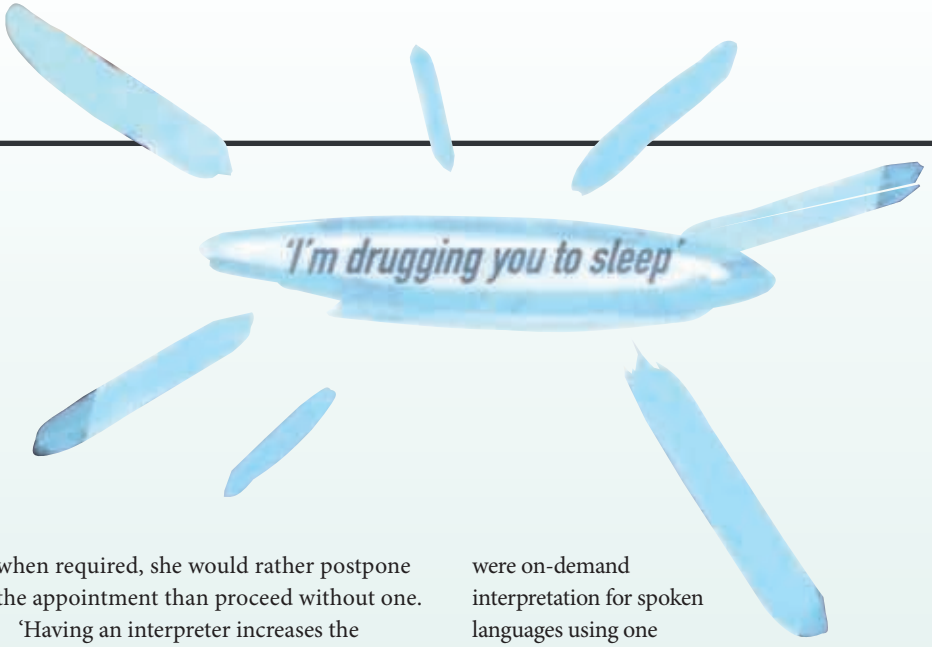
It would be encouraging if there were guidelines in place to prevent the use of family members as translators in a dental setting and instead use an independent individual who has experience in working in medical/dental environments.

Consent and safeguarding

That particular example highlights the need for greater clarity on whether independent interpreters should be brought in. While this was a case of panicking, there is another reason independent bodies should be considered.

The role of the practitioner in safeguarding is well-documented. However, if an interpreter is required and a family member is present, this has the potential to muddy the waters.

The same could be said about consent. The concerns surrounding successfully putting across the correct information have the potential for a detrimental effect on



treatment, but also securing consent to carry out the treatment.

Dr Jenny Harris, a Consultant in Paediatric Dentistry, Sheffield Teaching Hospitals NHS Foundation Trust and BSPD's Safeguarding Children Lead, believes there needs to be a balance between the support family members acting as translators can provide and respecting patient/practitioner confidentiality.

Dr Harris. who follows her own Trust's guidance, said: 'For consent to be valid the patient must understand the risks, benefits and available alternative options. A patient who has English as a second language is likely to need the support of an interpreter to understand complicated clinical information and to ask questions.

'Family members can provide invaluable emotional support and assistance at dental appointments. Interpreting by family members may be appropriate and useful to assist with appointment arrangements, establishing communication needs and in urgent/emergency situations, or for the routine passing on or requesting of information.

'However, relatives or friends or other untrained interpreters should not be asked or expected to interpret. The reasons for this are that the patient may wish to communicate confidential information and has a right for confidentiality to be respected. In addition carers, family or friends may not be able to communicate information on an impartial basis or medical information may be communicated inaccurately. Involving family members may also disguise problematic family dynamics.

> 'You can't have a family member or friend translating as they are too involved, where both consent and safeguarding are concerned'

'In some situations it may be necessary to provide separate interpreters for the child and for the parents or carers. If you suspect a child has experienced injuries or you have any other concerns and you cannot obtain a satisfactory explanation then an interpreter must be used.'

Urshla Devalia is a Consultant in Paediatric Dentistry working at the Eastman Dental Hospital, UCLH and Great Ormond Street Hospital for Children. A high proportion of her appointments involve an interpreter, and if one cannot be present when required, she would rather postpone the appointment than proceed without one.

'Having an interpreter increases the amount of time the appointment takes. However, it is essential from a legal perspective and I feel safer knowing there is full understanding from a patient and parent perspective', Dr Devalia said.

'You can't have a family member or friend translating as they are too involved, where both consent and safeguarding are concerned. Unless the parent or legal guardian understands what's happening, we won't go ahead with the procedure. The trust does not allow family or friends to translate, especially for a first new patient appointment. From a legal point of view, the interpreter has a registration number which must be written on the consent form signed by the parent or guardian.

'From working in a trust where telephone translation was introduced, I know I would much rather work face to face with a translator as non-verbal communication can be as important as the spoken word. Some of our interpreters are regulars to our department and they know their job (and ours!) well. I can tell that they are giving the parents oral hygiene and dietary advice, and not just sticking to a word for word translation.'

Considerations

Accessing interpreters in a timely manner for medical needs is often an issue, particularly in areas where there is already a shortage of interpreters. As Dr Devalia suggests, appointment times often swell as a result of the need for an interpreter. However, new technology may offer other avenues for timely access to interpreters.

A New Jersey hospital in America that serves a high percentage of non-English speakers required interpreting services in 46 spoken languages during a two-year period. In 2003, after exploring several solutions, the hospital contracted with an interpreting agency to provide interpreting via video conferencing. Among their requirements for the service were on-demand interpretation for spoken languages using one device. The service had to be easy to use, with information encrypted for HIPAA compliance, and the interpreters had to be medically trained.

Hospital administrators found the service to be effective, particularly because it helped realise 'large financial savings by not employing live interpreters with huge financial guarantees'.

At a time where budgets across dentistry are reducing at a rate of knots, it is not beyond the realms of possibility that technology akin to the one trialled in New Jersey finds its way into healthcare systems in the UK. Family and friends may provide a financially-pleasing alternative, but their accuracy and ability to deliver under pressure will always be questioned.

Regardless of whether technology comes into the equation, one thing is for certain – some patients will continue to miss out on valuable education, and that is not a message that should be lost in translation. ◆

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The benefits of investing in mentoring

Helen Caton Hughes

There's some great tangible benefits to mentoring – personal to the people in the mentoring relationship – and valuable to the workplace.

Mentors help people to do their current job more effectively, and offer insight into potential career paths for them. This is hugely supportive to people who have to determine their own career paths, or are looking for guidance on which route to go. Mentoring also supports the motivation or ambition of the mentee, giving them confidence to make that journey.

The mentor may have, and be willing to share, access to networks and connections, or have insights into personalities or relationships, of potential value to the mentee. This is vital, because so much of corporate culture is hidden to outsiders. If you don't know an organisation, it's sometimes hard to understand why things are done in a particular way. Think of organisations which are strongly bound by legal and ethical obligations for example, even in dentistry this varies according to the context.

So a mentor may offer their knowledge and understanding of the structural, political or social field of the workplace – both the visible and invisible structures – such that the mentee is better able to be resourceful, influential and successful in that environment.

That's the benefit to the mentee – what's the benefit to the mentor?

So many mentors tell us about the desire to 'give something back'; whether that's to the profession, to their practice, or to their original place of study. The beauty of the mentoring experience is that it cements our humanity – it's a felt, shared emotional experience – not just a transfer of information.

There's no greater feeling than the swelling pride we feel when someone achieves something as a result of our input or effort. Just recently I received a text from a mentee saying that he'd won the job he'd wanted. I punched the air with pride! I'd supported him with CV advice – how best to present himself on paper – and with a little bit of interview practice. I remember advising him to be prepared to work hard at his many applications – encouraging his commitment and persistence.

Of course, he did all the hard graft himself. I know that his wife was supportive and encouraging too. But the feeling that I'd played a small part – there's nothing like it in the world!

Then there's the workplace benefits. And this is where people are baffled. Why (or, more often, 'why on earth') would a practice owner pay for and encourage mentoring services for staff? Won't they just up and leave? Aren't you just encouraging staff turnover and dissatisfaction with their situation in life?

Let's think about new joiners in your team. Did you know it typically takes up to 18 months for them to get fully up to speed and operating at their peak effectiveness? Imagine the benefits if you could speed that process up and get them working at their best sooner. That has a real financial benefit to the practice – and a knock-on benefit to your patients and carers too[1].

And no, the induction process isn't enough. Sure, they know their way around physically at the end of two weeks, but do they really know their way around your culture, systems and standards in that time?

Imagine offering your new hires a mentor for the first three months. If you can speed up their knowledge and understanding of your systems, you'll improve their workflow sooner.

And what about the low-performers that you don't want to lose? Individual mentoring can help readjust their expectations and point out development areas in a non-threatening way. If you're the line manager, whatever you say will be taken as a 'direction', an order. This can often put people on the defensive and lower their performance further. Asking a colleague or third party to offer mentoring can remove the fear while delivering better performance.

And then there's your high performers – your stars. The team member you really don't want to lose. Chances are that if you know what their ambitions are, you can hold onto that person longer by offering them some mentoring and support. You'll lose your most ambitious people anyway – but what you'll gain is someone who, wherever they go, talks well of you and your organisation. Since word-of-mouth recommendations are the most valuable of all advertising methods, the mentoring is an investment in your business.

The benefits

Personal benefits

We've already talked about how people – mentees and mentors – both experience personal benefits.

Specifically, mentees can clarify their next steps; solve problems; discuss the way forward and address the big questions about their own personal development and career pathway – and get used to receiving input and feedback on their performance and development needs.

Helen Caton Hughes

Helen is the MD of the Forton Group, an international leadership and management development organisation delivering training, coaching and mentoring services. Helen has worked in the health, pharmaceutical and medical device sectors since 1992 and with dental professionals for the last five years. An international writer and speaker on inclusive leadership development, she is committed to standards and qualifications for all leaders and managers.

Mentoring is both poor performance prevention and cure. Having a trusted mentor to discuss technical concerns with avoids the slippery slope – by heightening awareness of risk and taking steps to prevent poor performance. When things do go wrong mentoring is a great way to help people who have the willingness to take feedback and make improvements get off the slippery slope too.

There's a ripple effect too. A mentor will pass on his or her skills both consciously and unconsciously, and these improvements are felt by the rest of the practice. It's a great way to embed a particular standard of either behaviour or practice. Let's take something simple like making eye contact with a patient or carer. The mentor can advise the mentee to do this on greeting someone and saying 'goodbye'. The mentor can model this behaviour themselves – and they can acknowledge that behaviour where they see it in the practice. Each of these steps, modelling the desired behaviour, helps embed that behaviour more widely in the practice. There's nothing like teaching someone else a good practice to encourage it in ourselves!

So this ripple effect will impact on colleagues, patients and carers; it goes far wider than the two individuals in the conversation. The ripple encourages team engagement and better teamwork in the practice too.

The skills that mentors learn, build and use – such as listening, questioning, and probing – are used more generally in other conversations too. In informal conversations they are a preventive investment: they prevent blind spots, poor performance and time wasting. Mentoring skills can actively promote the right decision-making in practice generally and they support autonomy too.

Tangible business benefits

There's got to be payback for your business by spending time mentoring, or training a member of your team to mentor others. And it's an investment in your time as well as money.

So what's the win-win?

We've already talked about prevention; you can use mentoring to remedy problems and improve performance; and you can use mentoring as a way to develop people.

In terms of cost benefits[2]; think about the costs to your business of poor judgement, or bad decision making, whether clinical or in stock management. The reflective time people spend in mentoring means that they improve their information gathering before making spending (or other) decisions; they get clarity and they learn to communicate better.

Imagine using mentoring to get a better business development plan, or using the time to choose the right Continuing Professional Development (CPD) activity so that your career direction is clearer. Imagine using it to make more effective use of your time.

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Mentoring can reduce waste, risks and save costs. You can use it to reduce broken appointments; improve patient compliance and help people feel more relaxed.

If you set up a mentoring programme in your practice, you can measure the benefits against the bottom line – just by asking mentors and mentees to keep a record of the benefits they notice as a result of the mentoring , is an excellent start.

The Huffington Post[3] reported these examples of business benefits:

- Education, learning and knowledge transfer
- Reducing employee turnover rates
- Developing management skills
- Time saving
- Focus.

Imagine spending less time finding new staff, building their confidence and, most importantly their efficacy. A report carried out by Oxford Economics[4] found that 'on average, workers take 28 weeks to reach optimum productivity which has an attached cost of £25,181 per employee'. Plus of course, there's the 'cost' to the business owners and team members in supporting these peoples' development over the 28-week period. In dentistry, this cost could be so much higher.

There are some good reasons why some people don't use mentors, and the top three reasons[5] are finding the right help, understanding the value and benefits and that they lacked trust or confidence, or had a bad experience.

Of these three responses, the third points to the need for using trained mentors and investment in mentor training. An investment in acquiring mentoring skills, reaps benefits in all of the four GDC CPD domains (clinical, professionalism, leadership and management, and communication), and will support an integrated commitment to CPD. ◆

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NICE to know you

Dr Arianne Matlin
Head of Health
and Science Policy

To your patients, NICE is probably just the body that periodically hits the headlines when it declares that new treatments are, or are not, cost-effective for provision by the NHS. But the National Institute for Health and Care Excellence, with its mission of 'Improving health and social care through evidence-based guidance', is responsible for much more than making these sometimes controversial decisions – and it's some of the other aspects of its remit that are particularly important for dentists in day-to-day practice.

What is NICE?

Originally established as the National Institute for Clinical Excellence in 1999, NICE was created to reduce variation in the availability and quality of NHS treatments and care. It began developing public health guidance in 2005, after merging with the Health Development Agency. Its current incarnation was enshrined in primary legislation in 2013, when its name changed to the National Institute for Health and Care Excellence to reflect its expanded role in developing guidance for social care. The guidance that NICE produces applies specifically to England, but the devolved administrations in Wales, Northern Ireland and Scotland can decide how to adopt it elsewhere in the UK and are often consulted on its development.

NICE guidance and dentistry

NHS dental practitioners in England have a contractual obligation to follow relevant NICE guidance:

'The Contractor shall provide services under the Contract in accordance with any relevant guidance that is issued by the National Institute for Clinical Excellence, in particular the guidance entitled 'Dental recall - Recall interval between routine dental examinations'.

The dental recall interval guidance mentioned in this clause from the standard GDS contract is an obvious example of NICE guidance specifically aimed at dentists, and oral health promotion in general dental practice is another familiar topic. Examples of guidance that applies, but is not exclusive, to dental practice cover smoking/smokeless tobacco cessation and harm reduction, antimicrobial stewardship and infection control, recognition and referral of suspected cancer and the much-debated issue of antibiotic prophylaxis against infective endocarditis. Behaviour change is perhaps a lesser-known guidance topic that is relevant and helpful to dental professionals.

Recommendations within the guidance are developed after extensive analysis of the published literature and drafted with input from expert stakeholders, to make them effective in optimising care and improving patient outcomes.

NICE quality standards

For some topics, NICE also publishes quality standards setting out priority areas for measurable quality improvement in the commissioning and provision of services. These are based on NICE's own guidance or other accredited sources. Each quality statement – for example, people prescribed an antimicrobial have the clinical indication, dose and duration of treatment documented in their clinical record – is accompanied by information on collecting data to measure performance, as well as the rationale for the statement and the implications for both patients and professionals involved in the pathway. Some 'developmental' statements focus on emergent areas of service delivery or technology, such as electronic prescribing, and NICE recognises that these are more aspirational and not currently achievable without significant change. Quality standard topics include oral health in care homes, antimicrobial stewardship, suspected cancer and a standard currently in preparation for promoting health in ethnic minority groups.

Dr Arianne Matlin advises on scientific and public health issues relevant to dentistry and manage the BDA's expert Health and Science Committee.

How does the BDA ensure that NICE guidance is appropriate for dentists?

The BDA is active in a variety of ways to monitor and influence the advice published by NICE and ensure that it is appropriate for dental professionals and their patients. We register as a stakeholder (only an organisation can do this, not an individual) for all potentially relevant topics, to enable us to engage on behalf of the profession.

NICE consults on draft versions of all new or revised guidance and quality standards, and also asks its stakeholders whether existing publications need to be updated, for example if additional evidence emerges or novel methods of treatment become available. The BDA's expert advisory committees and elected representatives of the profession provide input to consultation responses on both the scientific or public health and the service delivery aspects of NICE's proposals, highlighting areas where further work is needed or challenging any requirements that are not appropriate for dentistry.

We also check that NICE includes dental expertise in its guideline development groups when needed, and have recently persuaded NICE to do so for its forthcoming publication on antimicrobial prescribing for the management of common infections.

Where can I find NICE guidance and further information?

You can access the NICE guidelines, quality standards, advice and other publications at www.nice.org.uk. The BDA highlights important new or updated guidance to the dental profession via our website and member communications. ◆

Claiming free treatment?

Dr Charlotte Waite

Dr Charlotte Waite, Vice Chair of the BDA England Community Dental Services Committee, discusses exemption status in England and an issue faced by community services.

As the current Vice Chair of the BDA England Community Dental Services Committee, I have worked with colleagues to understand the issues faced by vulnerable patient groups, when declaring their exemption status in England. We believe that the current system is causing a significant barrier to care and we are working with the NHS Business Services Authority (BSA) to find a solution. I understand that similar issues are encountered in the devolved nations, however the procedures and legislation may vary. The legislation discussed below is in relation to the delivery of NHS dental services in England.

NHS dentists are highly skilled when it comes to navigating bureaucracy and cutting through red tape. We are all too familiar with the form filling which is required in order to provide NHS dental services. In this digital age most of us have computerised patient record systems. However, certain documents require a signature from the patient or their representative. In England the 'Practice Record Form- Patient Declaration' (PR form) must be signed by the patient or their representative for each new course of treatment. The first part of the declaration is essentially concerned with consent, to allow the dental provider to examine them under the NHS and give them any necessary care and treatment that they are willing to undergo within NHS arrangements. The next paragraph is an agreement to allow the NHS BSA or other authorised bodies to examine them or their dental records. They must declare that the information on the form is correct and complete, and that if it is not, appropriate action may be taken against them.

The second page of the form is for those claiming for free or reduced cost dental services. There is a list of qualifying benefits and a warning that checks are undertaken to confirm you are entitled and that incorrect claims for free or reduced cost NHS dental services will result in a penalty charge of up to £100, in addition to the cost of NHS dental services.

In a patient information poster produced by the NHS BSA our patients are told:

'It's your responsibility to check whether you're entitled before you declare that you don't have to pay. If you claim free NHS dental treatment that you're not entitled to, you could be facing a penalty charge of up to £100- as well as the original treatment charge. An additional charge of up to £50 may apply if you don't pay within the required timescale.'

Dr Charlotte Waite
Charlotte is the current Vice Chair of the BDA England Community Dental Services Committee and has worked in a number of community dental services over the past 14 years. She is a Senior Community Dentist within Derbyshire Community Health Services NHS Foundation Trust and is based in Leicestershire.

On the face it this would seem very reasonable. We all need to protect valuable NHS resources. The NHS Constitution tells us: 'We maximise our resources for the benefit of the whole community, and make sure nobody is excluded, discriminated against or left behind. We accept that some people need more help, that difficult decisions have to be taken and that when we waste resources we waste opportunities for others'.

So what about our patients who can't take responsibility for checking that they are entitled to claim free dental treatment? What about our vulnerable patient groups, those with learning disabilities and dementia? It is estimated that 930,400 adults in England have a learning disability[1] and 850,000 people in the UK currently have a diagnosis of dementia, this is set to rise to over 1,000,000 by 2025[2]. If they or their representative can't make the declaration because they do not know if they receive any qualifying benefits or are in receipt of an exemption certificate, are they at risk of being 'excluded, discriminated against and left behind'. I would say absolutely and this is totally unacceptable.

Many of the adult patients seen within the Community Dental Services (CDS) could be defined as vulnerable, according to Section 59 of the Safeguarding Vulnerable Groups Act 2006. Most CDS provide Special Care Dentistry, which is concerned with the 'oral health of individuals and groups in society who have a physical, sensory, intellectual, mental, medical, emotional or social impairment or disability or, more often, a combination of these factors'.[3]

There can be no doubt that the exemption declaration system is difficult to navigate and this may have a particularly negative impact on patients with additional needs and those who attend with them in a supporting role. The result is that community dental staff are spending a significant amount of clinical time trying to accurately determine their patient's exemptions status. Valuable time is lost which could and should be spent delivering care to patients.

In my experience the vast majority of patients and those who attend to support them, are unaware of their exemption status. Carers are often unwilling to make the declaration on behalf of the patient because they don't know or don't have access to this type of information. Some CDS send the relevant documentation, regarding claiming free dental treatment out in advance of the appointment however all too often the information is still often not forth coming.

I experience this issue on a daily basis but I wanted to have a better understanding of the full extent of the problem. Through the BDA we contacted a number of CDS in England and asked them to explain the impact the system is having on their patients and their ability to provide dental care. Dentists from 17 provider organisations from across England shared their concerns. There was an over whelming response that this bureaucracy is creating a significant barrier and leading to some vulnerable patients being denied dental care.

Domiciliary services provided a particular challenge. A common concern was that staff at residential homes had been told not to sign the PR form, for fear of completing the declaration incorrectly and being fined. Services were sending out the forms in advance of the appointments in order to save time during the appointment but on many occasions the forms were incomplete or not completed at all. Some services reported needing to cancel patients on numerous occasions because the PR form could not be completed.

Dentists reported being left with a dilemma; should they see the patient without the PR form completed, should the patient be sent away and denied care or should they be asked to pay, and arrange a refund if they are entitled to free care?

For many of our vulnerable patients it is a real challenge to attend dental appointments, we can't afford for any clinical time to be wasted. All of the appointment time must be dedicated to delivering dental care. It is essential that this bureaucracy does not impact on precious clinical time. Careful planning also has to be made by those attending to support the patient, for example additional staff at care homes may be required to facilitate the dental appointment, parents may have to take time off work and ambulance transport may be required. It is not acceptable that care should be denied because the PR from cannot be completed.

> 'In my experience the vast majority of patients and those who attend to support them, are unaware of their exemption status.'

The impact that this system has on patients and their representatives cannot be underestimated. Dentists reported concerns about the distress it was causing both patients and their carers, particularly, where fines had been issued. Figures show that 30,000 fines challenged by patients from May 2014 to July 2016, were overturned (which represents nearly 9 in 10)[4]. This statistic only serves to underscore the difficulties in determining whether a patient is exempt or not.

I recently met with members of the NHS BSA and NHS England to discuss the concerns expressed by my colleagues and to explain the impact the system is having on patients and their carers. I outlined the negative impact that the system is having on our ability to provide care to vulnerable patients.

So far our engagement has been very positive and there is a genuine appetite to find a solution. Members of the NHS BSA attended a CDS clinic and saw first-hand the difficulties patients had in making the declaration and were able to speak to CDS staff about their concerns. I also outlined many of the specific cases which colleagues had shared and it give them a real flavour of the breadth and depth of this problem.

The solution may not be a simple one. Patient charge revenue contributes significantly to the income of many CDS and in services which are already underfunded and overstretched this revenue must not be lost.

We all want to deliver safe, high quality dental treatment to all our patients and at the same time strive to reduce health inequalities and remove barriers to care. It is our aim to ensure that clinical time is spent on providing clinical care and thus ensure the best use of NHS resources. This can only be achieved if there is a simple scheme whereby patients (or their carers) who do not know their exemption status can receive care. For those who are fined because carers have made an incorrect declaration, there must be access to the BSA helpline and appeals system and it should be accessible to all, including those with communication difficulties.

The NHS BSA have put forward a number of options, which they hope will improve this current situation. There will undoubtedly be pros and cons with each of the options but we will work closely with them over the next few months to find a solution, which I hope will benefit our vulnerable patient groups and those involved in providing their dental care. ◆

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Leadership skills: A menu for future success

By Stephen Gates
CEO, Bright Light Leadership Ltd

I recently received a news update from the LinkedIn (business) social media site entitled – 'Is your business ready for the micro-chipping of your employees?'

After rolling my eyes at the lengths some businesses seem willing to go to exert 'control' over their employees it struck me deeply that this type of move is totally counter-productive and unlikely to lead to a positive leadership environment. However, as technology advances, this is increasingly the type of issues that tomorrow's leaders will have to wrestle with.

So this article will seek to examine, now we have covered the importance of leadership for the practice owner and the associates and team members in previous articles, what are the leadership skills that will be required for tomorrow?

How will great practices keep on ensuring that they are alive and thriving over the next ten years?

How will leadership skills have to change and evolve to cope with what feels like an ever-increasing pace of change?

And this increasing pace of change can have major impact for companies too – it's not a 'theoretical' issue. Analysis undertaken in the USA[1] suggests that companies in the S&P500 are failing at an increasing rate – with the 'average' lifecycle of a company decreasing from 61 years in 1958 to 14 years by 2016. So, the authors predict, if this accelerating trend continues 75% of the S&P500 companies in 2027 haven't even been created yet!

So if businesses fail to adapt to this changing environment this can have catastrophic consequences…

And we can see a potential reflection for UK dentistry too. Of all the CQC requirements, the category that is most often failed is that of 'well led'. So it appears that strong leadership will be an increasingly important tool for practices to ensure that they can continue to grow and thrive.

The leadership challenges of the future – what are they?

Leadership does not exist in a vacuum – it is grown and nurtured within the current environment. Considering the business challenges that are faced across a range of businesses, including dental practices, the five key challenges that leaders need to respond to could be summarised as:

- **An increasing pace of change** – driven by access to huge amounts of information via the web, businesses are finding that they need to work ever harder to differentiate themselves and develop a competitive differential. Although it harks back to the 1990s, the quote from TV's original Troubleshooter (Sir John Harvey-Jones) that 'If you're not moving forward then you're moving backwards' never felt so true.
- **The 'Always Connected' age** – with the ability to access work emails at home, online appointment booking, and access to practice management software on a virtual basis, it is becoming increasingly difficult to draw a clear link in the work/life balance debate. The days whereby the practice 'locked up' at 5.00pm and no-one undertook any further work transactions until the morning is long gone, and therefore leadership skills need to change to recognise this.
- **The drive for transparency** – within healthcare generally there is an increased requirement for transparency, evaluation and reflective-learning - with the ability to understand how, for example, your own treatment success rates compare to those of your colleagues (with the ever-increasing use of 'league tables' to differentiate competency – rightly or wrongly).
- **The Mental Health challenge** – figures released by the Mental Health Foundation indicate that in 2014,[2] 19.7% of people in the UK aged 16 and over showed symptoms of anxiety or depression, an 1.5% increase from 2013. This percentage was higher among females (22.5%) than males (16.8%). Increasingly the role of employers and work environments in promoting good mental health is coming under scrutiny.
- **Machine-learning and automation** – with the increase in data-processing capacity and the decrease in the price of data storage it's no surprise that it's predicted that machines will eventually take over many professional roles. According to Forbes magazine[3], Healthcare is the number one area that robotics and big data will have an impact – with Johnson & Johnson currently holding a licence for a device which delivers the automatic sedation of patients, no anaesthetist required! So how will diagnostic requirements change when IBM's Project Watson has 'digested' all available research studies and can provide an evidenced-based diagnosis immediately?

So how must leadership skills change?

Into this ever-changing world we therefore need to consider how the skills of those involved in sustaining and running dental practices – the leaders of today and those of tomorrow – need to change to ensure that success is continued.

- **Embedding 'trust'** – The Chartered Management Institute's 2017 'Management Manifesto'[4] highlights the challenge being faced by leaders across the country – 'Trust in leaders is at rock bottom: from the rejection of 'elite' or 'expert' views

Stephen Gates
Stephen founded Bright Light Leadership to encourage the development and support of leadership skills in small and medium size businesses. Prior to this he was Managing Director of Denplan for 16 years.

seen in the Brexit vote to a breakdown of trust in the workplace, fuelled by outdated management cultures, secretive leaders and runaway executive pay.' This means that leaders must now act in a manner that develops far deeper levels of trust than was previously required – it requires them to show allegiance to the practice's goals over their own goals, to listen intently and make changes based on feedback, to work collaboratively in a manner that genuinely engages all members of the team and provide genuine clarity about the future direction of the business.

- **Driving innovation** – When the world is changing quickly, it is the role of the leader to ensure that their team understands the nature of that change, knows what is required of them and how they are expected to make a difference and is constantly 'horizon-gazing' to focus on the next wave of change. While this can sometimes appear 'exhausting', as the practice continually responds to changes to the environment, it is so important if future competitiveness is to be maintained. Everyone at the practice requires a deep understanding of what the practice is aspiring to be – where does it want to be 'competitively' unique? By understanding this the need to prioritise certain changes will become much clearer, and an 'order' through the ever-changing world can be navigated. The American essayist, Henry David Thoreau, summarised the challenge as 'It is not enough to be industrious; so are the ants. What are you industrious about?'.
- **A 'Practice of all Talents' (POAT)** – with apologies for the abuse of Gordon Brown's 2007 analogy of a 'Government of All Talents', successful leaders of the future will be those that create an environment within the practice that allows a contribution from every person within the team. It creates an environment where everyone believes that they have an interest in the success of the business – so they have an interest in constantly improving and making suggestions for improvement. Edward Kemp (Director of RADA)[5] described leaders as those who 'Liberate the energy, imagination and momentum for the whole group'. So just as centralised 'command and control' approaches to business (where power coalesces in the hands of the few) are proving unsuitable for today's business challenges, so the role of the leader must change to being the 'harnesser' of all the innate talents of the current team.
- **'What you want isn't what they want'** – there can sometimes be a tendency to view life from our own perspective – informed by our personal experiences of growing-up and business life. There is however a new generation of dentists and team members who have very different life-experiences and very different requirements from their working lives. The millennial generation[6] have the most negative views on their career prospects and 37% feel their opportunities are significantly worse than those of their parents. Since millennials spend much of their time dedicated to their jobs, 84% expect significant breaks during their working lives – supporting the idea that career waves are the new career ladder in earlier generations. So leadership skills require a recognition that there are now differing requirements within the workplace and the insight and understanding to appeal to the motivations and desires of a range of individuals within the practice. There is no longer a 'one size fits all' approach to motivation and engagement.

> 'When the world is changing quickly, it is the role of the leader to constantly be 'horizon-gazing' to focus on the next wave of change.'

- **Being authentic** – 'The old model of transactional leadership is based on the idea that if you do this, then we'll do this. It is a very simple equation. Transformational leadership is much more inspirational. It is about engaging the emotions of individuals in the organisation. It is crucial for leading change today' said Alan Hooper, Founder of the Centre for Leadership Studies at the University of Exeter. So, in the future, leaders will need to engage both the head and the heart of team members. This will require them to act in an authentic manner. Authentic leaders develop honest relationships with their teams, which value their input and are built on an ethical foundation. Generally, authentic leaders are positive people with a deep understanding of their own motivations and drivers who promote openness – so a focus on people and ethics, compared to a traditional focus on profits and performance.
- **Showing Courage** – 'If given a choice between strategy and character, I'd go for character every time', said stormin' Norman Schwarzkopf, the decorated US Army General. And this is equally important when the world is changing quickly around the dental practice. Courage as a leadership skill will be required to demonstrate that the practice has the right strategy and plans, that it has the courage to execute them (even if there may be some uncomfortable times on the way) and it has the courage to do things differently from other practices – creating something that is unique and compelling about the practice.

So, how exciting is this?

An opportunity to genuinely make a difference in the future of the practice by developing future-proofed leadership skills.

'No one of us is as smart as all of us. The Lone Ranger is dead' said the US academic Warren Bennis – and never has this been so true of the future! ◆

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Pushing patient boundaries

***David Westgarth** talks to Chet Trivedy about pushing patient boundaires*

I have discovered that there are two types of people in this world. There are those who nag, and there are those who get nagged.

I often find myself on the 'those who get nagged' side of the fence. It will often be fine. It will be fine to do another day. I cannot take time off for a long-standing condition I have learned to manage. And so on and so forth.

Unsurprisingly, I find myself not flying solo on this. Data from the Office of National Statistics have previously revealed women are twice as likely to see their GP as men, visiting the doctors an average of six times a year compared to just three for men.

So why is this so significant it merits being highlighted?

For almost all types of cancer, men will die more often than women. For mouth cancer, men are almost twice more likely to die than women. There's no biological reason, so it must be purely down to the timing of diagnosis. So in theory, when men do go to their dentist or GP, their condition may be at a far more advanced stage and therefore much more difficult to treat.

With a large part of the population simply shirking health checks, are cost effective measures the way forward?

Perhaps. Poor oral health has been linked to four of the five major killers – cancer, heart problems, strokes and respiratory problems – in the past, and investing in dentistry could potentially save millions of pounds treating these diseases, enabling the money to be ploughed back into the NHS.

In 2009, the NHS introduced a new programme of 'Health Checks', with their primary aim of identifying and treating the leading causes of preventable deaths from some types of non-communicable diseases (NCDs), including CVD, diabetes, kidney disease and stroke among those over 40. Economic modelling has suggested the programme would result in savings to the NHS of £57 million per year after four years and £176 million per year after 15 years, so the health economics of health checks stand up.

In 2010, Dr Chet Trivedy launched an initiative called Boundaries for Life. Its goal was to offer free health checks for fans and staff attending international cricket matches. Seven years later, the initiative has gone from strength to strength, drawing support from organisations such as Simplyhealth Professionals. I asked Dr Trivedy about the main developments over that span of time and whether health initiatives that work should be considered in the wider NHS.

'The initial goal was to promote the health

of fans attending cricket matches' Chet explained. 'The long format of the game allowed users of the service time to attend the short health MOT we run.

'While the format is very much geared towards some of the larger health problems, it enables us to bring oral health on the same platform as general health by combining health checks to offer both oral and general health components. Being able to say 'did you know looking after your oral health could help to lower the risk of these diseases' is a valuable message. Sports is an incredibly strong vehicle to send health messages, and BFL has used cricket to deliver health messages.'

Simplyhealth Professionals has sponsored this season's cricket matches for Boundaries for Life as the charity is closely aligned to their own goals of raising awareness of mouth cancer. Boundaries for Life is the only free health screening that includes an assessment for mouth cancer and Simplyhealth Professionals has encouraged its member dentists to help at some of the cricket matches and carry out health checks.

Catherine Rutland, Head of Professional Support Services at Simplyhealth Professionals, attended a match at Lord's to help with the free health checks this summer.

Catherine commented: 'During my day at Lord's, the team and I carried out about 70 free health checks and could have done more if time had allowed. We were able to reach people who otherwise might not have been aware that they had some serious health concerns such as high blood pressure and increased BMI.

'Everyone who visited the Boundaries for Life tent was given a card which they could take to their dentist or GP and we were able to play our part in helping people to understand the importance of looking after their overall health and regularly visiting their health providers but in a friendly and positive environment. It was great to be able to spread health messages to people who are not regular attenders with their dentist and encourage them to take responsibility for their own general and oral health and not leave any potential issues.'

Previous research backs up Dr Trivedy's assumption about the power of sports. There is now an emerging body of literature demonstrating the potential for sports stadia to be used in the promotion of healthy lifestyles, highlighting the power of a club's brand and the iconic status of sports venues to engage fans and members of the local community with a view to influence changes in lifestyle behaviours.

'After seven years of free health checks at over nine grounds across England and Wales, we have seen an increase in the number of staff of cricket grounds using this service and some have attended every year for several years', Dr Trivedy added. 'We are now looking at the possibility of developing specific health checks for staff and also training club staff to help run health checks for their community and empowering clubs to use the power of sport to run health checks sustainably across the season. In addition, as cricket is very popular in South Asian countries where there is a large fan base, by targeting matches where South Asian teams are playing, health awareness can be targeted.

'At present cricket is the only sport which has a significant following from South Asian countries. This, combined with the long format of the game, provides an ideal platform to deliver the health checks.'

Given that poor oral health has been linked to four of the five major, is there scope for programmes like Boundaries for Life to grow and be adopted by the Department of Health?

'The current BFL model already provides checks for risk factors for the big killers outlined. A BBC press release earlier this year from PHE and NHSE outlined the role of sports grounds and shops in delivering NHS Health Checks. We are in discussions to see how these could be adopted.

> 'Poor oral health has been linked to four of the five major killers – cancer, heart problems, strokes and respiratory problems – in the past, and investing in dentistry could potentially save millions of pounds treating these diseases.'

'There is no doubt that we are keen to work with the Department and other commissioning bodies to see how such models could be used to deliver cost-effective and sustainable services for the public to engage with their health. There is a need for it, and more importantly we have demonstrated a demand too.'

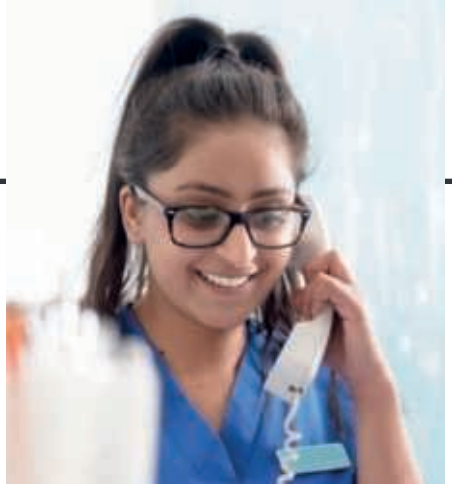
The demand for free health checks over the cricket summer of 2014 and 2015 yielded 513 participants at seven different grounds. The majority of those attending were male, and all would recommend the service. Again, perhaps not a surprise, given that access to dentistry and GP waiting times have often been cited as reasons for not following up health problems.

Could programmes like Boundaries for Life alleviate some of the pressure on a creaking system?

'We have to be very clear that a BFL check can and should never replace the relationship between a patient and their regular health care provider', Dr Trivedy stated.

'It is important to note that these initiatives are not designed to offer treatment or extensive investigations. 'Providing health advice in arenas such as cricket grounds has to be simplistic and cannot be considered as a replacement for definitive care. The aim is to provide users an opportunity to learn more about their health and empower them to engage with their health.' ◆

Patient satisfaction – after care calls



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By Claire Bennett

Claire is a Practice Management Consultant in the BDA Practice Support Team, she qualified as a solicitor in 2008 and advises members on associate contracts and employment law issues.

Telephone calls to customers or clients following the sale of a product or service are commonplace in lots of commercial sectors. After care calls to dental patients to find out their level of satisfaction or discuss the patient experience generally happen much less often. There may be any one of a number of reasons for this: dental practices are busy working environments where staff already have a lot to do clinically and operationally; concern within the profession that such calls may be perceived as pestering patients; or a belief that the information gained does not justify the time or costs involved. Whatever the case may be, it is difficult to deny the value in seeking to understand what patients think about your services.

By understanding what your patients think, you are in a better position to deliver the kind of dental services they want. Satisfied patients tend to be loyal patients, who are happy to recommend you to family and friends.

Why make the call?

The direct reason to call is to find out if they have any ongoing problems that might need your attention. However, you also find out about their experience of coming to the practice and attitude towards you. Also calling them shows you have empathy with them about the care they have just received. You may use written questionnaires for obtaining patient feedback, though after care calls generate equally useful feedback.

A broad range of issues can be discussed as part of an after care call, including the quality of the dental care provided, the appointment or booking experience and any improvements to facilities the patient may wish to see. An after care call can also provide the chance to talk to patients about any changes that are proposed for the future. Demonstrating that you are interested in your patients' views contains value in itself.

Case study

Justine Robertson is Business Manager at Denbeigh House Dental Clinic, Birmingham where after care calls have been in place for two years. Denbeigh House Dental Clinic has used the calls to gather patient feedback on everything from staffing changes to patient engagement in the practice reception area. Justine says the calls have been hugely successful in measuring patient opinion. They have resulted in changes to practice facilities, effective complaints handling and increased staff morale.

Justine is of the view that 'talking to people is the only way you find out what they are really thinking'. She believes after care calls often provide a more balanced picture of patient opinion. She says: 'Positive feedback is often given by the patient in the chair, which is not always the case with criticisms or concerns. Care calls can help identify any negative views patients may have about the dental services. Once we understand those, we are in a position to make changes and improvements'.

Holistic care

Calls can help keep any clinical issues at the forefront of a patient's mind. Care calls can provide an opportunity to remind a patient of your diagnosis and treatment recommendation. There are also advantages in terms of managing the appointment book. An after care call in which the patient reports that they are doing well may allow you to reschedule a review appointment.

Practice improvements

It's an opportunity to ask patients how they think your practice may be improved. Is there a product or a service that you are not currently offering that patients might be interested in? Do they have any comments on your facilities? Where action is taken in response to a patient suggestion, you should communicate that to patients, which will underline your commitment to them.

Head off complaints

It will not always be the case that a care call produces positive comments about your practice. But acknowledging and responding in a constructive way to negative feedback can assist in averting complaints.

Increase referrals of family and friends

Patients who feel valued and are impressed by your services are more likely to recommend your practice to family and friends, which will assist with business growth and your bottom line.

Build staff morale

Positive feedback from patients about the services provided and those providing them can instil in staff a sense of pride about their work and bolster team morale. Where an issue is identified, perhaps poor patient engagement, it can be addressed through appropriate training.

How to do it?

Before you start making the calls identify the issues you want patient feedback on – quality of care, whether they feel their treatment has been successful, access to services, interaction with staff. A list of focussed questions such as was the receptionist helpful; was the dentist friendly and welcoming; were costs explained; together with more open questions like what would you say the practice does best; and where do you think the practice could improve, will help keep the call on track. For busy patients, spending time on the phone will not always be convenient, so always check, at the start of the call, if it is a convenient time to speak.

If you intend to introduce after care calls, you should ensure that patients are informed that they may be contacted in this way and have given clear permission for you to do so. ◆

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Time for a review: Top tips for associates on asking for a pay rise

By Sabina Mirza
Sabina is a Practice Management Consultant in the BDA Practice Support Team, advising general dental practitioners on associate contracts and a wide range of employment and other law.

We're often asked by associates, what percentage is fair for splitting costs with my practice owner? The BDA doesn't recommend a set percentage and the reason for that is that all practices and their circumstances are different.

Looking at the associate contracts reviewed by the BDA's Practice Support team, it seems that practice owners usually charge a percentage of between 40-55% of gross earnings for you to practise dentistry at their premises. But this is anecdotal, and practice owners will have to make a commercial decision based on their operating costs.

However, it may be advantageous to request your fees be reviewed with the practice owner every year. Remember to take into account your performance and cost of living changes, whilst bearing in mind the practice owner will need to consider his/her practice overheads too. If these discussions are not taking place, ask your practice owner for an annual review.

We would recommend watching a video from the BBC[1] with three tips on how to ask for a pay rise – it's not specific to dental associates, but some of the tips are totally translatable to you. A BBC survey recently suggested that women are less confident than men about asking for a pay rise, and with the issue of gender pay equality never far from the headlines, and the number of women working in dentistry rising, the advice in this video 'to just do it', I think is good advice to follow.

Discussing your issues and problems is important to help combat tension and frustrations, both practice owners and associates need to realise that they have a shared self-interest in making the practice successful, and working together is the most effective way to do this.

Practice owners will tend to look at the gross fees of the practice and the overall costs they have to meet. The practice needs to cover all its costs and expenses and return a suitable profit.

> 'Take a range of factors into account and weigh them up when thinking about what makes you happy at work'

Each year the Government's review body on pay (DDRB) recommends the levels for uplift of contract values across the UK. The Government then decides on whether to agree to the proposed uplift (sometimes at inflationary levels, but sometimes below – technically, dentists' pay has been 'frozen' since 2008 due to problematic NHS finances).

So each year, we undertake a huge amount of research into the state of dentistry and submit recommendations to Government based on our findings. We are the only organisation that does this for you, across the four nations. We consistently make the point that dentists' pay has been deteriorating since 2008, and with declining real term incomes, and that one per cent uplifts cannot reverse the downwards trend.

But one important thing to remember, is that it's not just about pay. We are all, of course, motivated by money to some degree, but there are many other factors that contribute to our level of happiness and job satisfaction at work. Working conditions, flexible hours, the personalities in the practice, respect between colleagues, the ease of getting to and from work, opportunities for further training and career development, are all important things to consider.

You should take a range of factors into account and weigh them up when thinking about what makes you happy at work, and get it clear in your mind what you are willing to negotiate on and what you are not, when you go and have that all important annual conversation. ◆

1. BBC. Three tips on how to ask for a pay rise. Available online at: www.bbc.co.uk/news/av/uk-38052213/three-tips-on-how-to-ask-for-a-pay-rise-from-your-employer (Accessed October 2017).

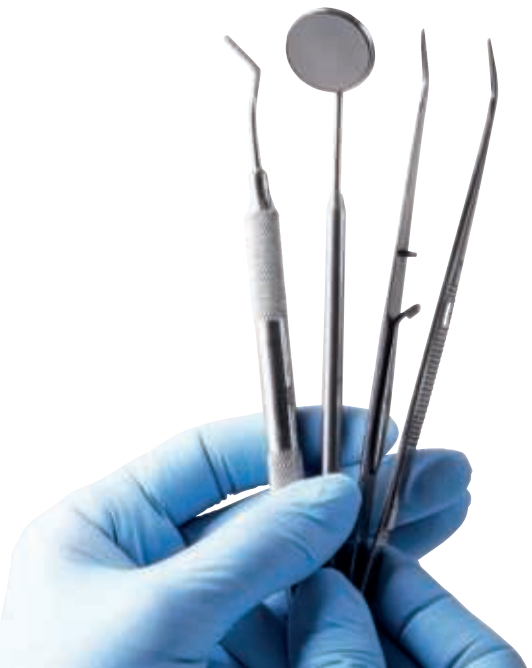
Associates and their equipment

By Claire Bennett
Claire is a Practice Management Consultant in the BDA Practice Support Team

Associates are in effect hiring the surgery equipment from the practice owner. The agreement is a commercial arrangement through which the associate pays the practice owner a proportion of their fees in exchange for the provision of services, including surgery facilities and staff. Therefore defining the terms on which equipment is provided, how it should be handled, repaired or, even, when it should be upgraded are vital considerations when agreeing your associate contract.

What is being paid for?

The contract should state in general terms that the practice owner will provide the standard equipment and instruments that are used in general dental practice. It shouldn't be more specific with makes and models as needs may change, however the practice owner and associate could draw up an inventory and agree to review it at set intervals.



Since associates pay the practice owner to provide the dental equipment, it is reasonable for them to expect to be provided with equipment in good working order. Expectations are not always met, however, so before signing on the dotted line, if you are the associate, you should survey the surgery you will be working in and check the condition of the equipment you will be using. Agreeing to pay for the provision of equipment you think may not be entirely fit for purpose is unlikely to represent a good deal for you.

On the subject of getting a good deal, you should bear in mind that the quality and condition of the equipment to be provided by the practice owner can influence the licence fee (the official contractual term for your fee apportionment). A practice offering state-of-the-art facilities to its associates may be able to justify a higher fee apportionment. A larger than usual licence fee may not be immediately attractive to associates, but, in the long-run, good equipment is likely to provide a better working environment, greater efficiency and save time and money.

Maintaining and servicing equipment

Generally it is the responsibility of the practice owner to ensure that equipment is serviced and maintained and that this is done in accordance with the manufacturer's instructions so that any warranties remain valid. The practice owner should also ensure that equipment is kept in a state of good repair. If, as an associate, you have any concerns about the condition of the equipment you are being provided with, you should raise them with the practice owner as soon as possible so that they can arrange for any issues to be addressed.

Associates are responsible for using the equipment properly. You should expect your associate agreement to contain a clause on this, with the associate agreeing to use the equipment appropriately and to indemnify the practice owner against any damage caused by their negligence or misuse.

Liability for breakdowns

It is in no-one's interests to have poorly-functioning or broken equipment in the practice. Associates will probably report any breakdowns promptly but practice owners should then deal with these as swiftly as possible. This is the crucial point if it is not always possible to anticipate how long it will take to remedy the situation – you cannot always rely on issues being resolved smoothly and in good time. This can create problems for associates affecting the number of patients that can be seen and the work that can be done.

> 'In the long-run, good equipment is likely to provide a better working environment, greater efficiency and save time and money'

To protect associates from losing income in these circumstances, seek the inclusion of an indemnity from the practice owner in the written associate agreement if they don't repair or replace broken down equipment in a reasonable timeframe. It is reasonable for the practice owner to have some time in which to arrange for the repair or replacement of broken down equipment, so what constitutes a reasonable timeframe will probably have to be assessed on a case by case basis – the two parties should discuss this on each occasion, though it may be fair to set an outside limit of one or two weeks or to specify that there should be no unavoidable delays.

Expectations

The nature, quality and condition of the facilities that associates pay to use are important aspects of any associateship and both parties should consider them carefully before entering into an agreement. Associates should be able to expect the provision of dental equipment that is in good condition and working order and for the practice owner to address any issues if that is not the case. ◆

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‘Sea sparkle’ linked with dentistry calvicus

Recently, something amazing happened on an Australian beach – an algae called Noctiluca scintillans bloomed in unprecedented volume along the surf. More commonly known as ‘sea sparkle’ this algae uses a special bioluminescent mechanism that causes it to glow bright blue – meaning that the whole beachfront was sparkling for days. It is an astounding sight and the pictures are fascinating.

But what does all this has to do with dentistry we hear you ask?

Well, a similar bioluminescent photoprotein is being used in dentistry to help practitioners detect active demineralisation, providing an innovative system for the identification, prevention and treatment of dental caries. This state-of-the-art technology is soon to be launched by CALCIVIS, a UK-based company that discovered how this highly specific photoprotein reacts with free calcium ions released from demineralising tooth enamel as an early warning of dental caries.

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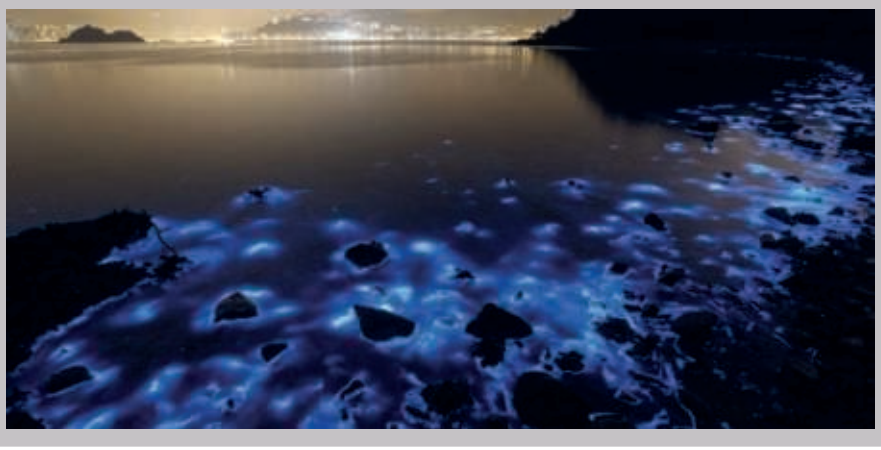

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Email: info@thepriorsdentalpractice.co.uk

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

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

South East

MOOR PARK SPECIALIST DENTAL CENTRE
www.moorparkdental.com

10 Main Avenue, Moor Park,
Northwood, Middlesex, HA6 2HJ
Tel: 01923 823 504
Email: info@moorparkdental.com

Dr Joe Bhat BDS FDS RCS MClinDent MRD RCSEd
Specialist in Oral Surgery and Prosthodontics

Dr Lydia Hopkins BDS MSc Ahea
Specialist in Periodontics

Dr Nick Vyas BDS MSc FDSRCS Cert. Implantology
Specialist in Periodontics

Dr Norman Gluckman BDS Rand
Specialist in Endodontics

Dr Neeta Patel BDS FDS RCS
Specialist in Oral Surgery

Dr Sheetal Patel BDS MFDS RCS MSC Morth
Specialist in Orthodontics

Professsor Raman Bedi BDS MSc DDS honDSc DHL FDSRCS(Edin) FDRCS(Eng) honFDSRCS(Glas) FGDP FFPH
Specialist in Paediatric Dentistry

Dr Amanda Reynolds DDS LDS DDPH(Eng) MSc DPH Dip Endo, Cert Sed & Pain Management, CILT
Specialist in Special Care Dentistry

294230

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82 London Wall, City of London EC2M 5ND
(few minute walk from Liverpool Street, Moorgate & Bank / Monument Stations)
Tel: 0207 6284869 **Email:** info@bhddc.com
Practice Manager: Marcela Pallova

SPECIALIST REFERRAL CENTRE IN THE CITY OF LONDON

Specialities and Interests: Prosthodontics, Restorative Dentistry, Endodontics. Periodontics, Orthodontics, Oral Surgery & Oral Medicine, Implant Dentistry, Implant Rescue Clinic, Aesthetic Dentistry, Sleep Medicine and Sleep Apnoea.

Specialist Referrals:
Robert Crawford Consultant in Restorative Dentistry, Specialist in Prosthodontics, Endodontics & Periodontics
Hatem Algraffee Specialist in Periodontics (Co-founder of PerioAcademy)
Natasha Wright Consultant and Specialist in Orthodontics
Anish Shah Consultant and Specialist in Oral Surgery with Special interest in Oral Medicine
Farid Fahid Specialist in Prosthodontics
Farid Monibi Specialist in Prosthodontics

Dentists with Special Interests:
Aditi Desai Sleep Medicine and Sleep Apnoea (President of British Society of Dental Sleep)
Kostas Papadopoulos Aesthetic Dentistry and Dental Implants

Our aim is to facilitate patient-focused management of complex dental problems in partnership with referring colleagues.

295045

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
Tel: 01908 630169 **Email:** admin@dentalspecialistmk.com
Interests: Orthodontics, Periodontics, Implants, Peri-implantitis, Full Mouth Rehabilitation, Prosthodontics, Endodontics, Oral Surgery including TMJ , Restorative Surgery, Sedation and Snoring.
CT scanner and Zeiss microscope on site
On Specialist List: Yes, Orthodontics Dr Ayodele Soyombo, Dr Patel
Special Interest in Orthodontics: Dr Juanita Levenstein
Specialists in Periodontics: Dr Adetoun Soyombo, Dr Carol Subadan and Dr Olanrewaju Onabolu
Specialist in Prosthodontics: Dr Peter Yerbury and Dr Ulpee Darbar,
Specialist in Restorative Dentistry: Dr Ulpee Darbar
Specialist in Endodontics: Dr Neil Kramer
Specialist in Oral Surgery: Dr Tamer Theodossey, Dr Wale Towolawi and Dr Yinka Lesi

209440

DENTAL SPECIALISTS ST ALBANS
www.thedentalspecialists.co.uk

96 Victoria Street, St Albans, Herts AL1 3TG
Tel: 0172 7845706
Email: admin@thedentalspecialists.co.uk

Interests: Periodontics with a special interest in Peri-Implantitis and hard and soft tissue Regeneration, Orthodontics, Implants, Full Mouth Rehabilitation, Anti-Snoring Devices, Non-Surgical Management of TMJ problems

Specialists in Periodontics: **Dr Adetoun Soyombo, Dr Olanrewaju Onabolu and Dr Carol Subadan**
Specialist in Orthodontics: **Dr Ayodele Soyombo**
Special Interest in Orthodontics: **Dr Juanita Levenstein**
Special Interest in Prosthodontics: **Dr Richard Craxford**

239826

PERIO & IMPLANT DENTAL REFERRAL CENTRE
www.perionimplant.com

351 Richmond Road, Upper Ground Floor, East Twickenham, TW1 2ER
Tel: 020 8912 1346 **Email:** info@perionimplant.com
DR CHONG LIM - GDC No. 70007
BDS (National University of Singapore)
MSc in Periodontics (Eastman Dental Institute, UCL)
MSc (Distinction) in Dental Implantology (University of Bristol)
Specialist in Periodontics
Interests: Periodontics and Dental Implants
On Specialist List: Yes - Periodontics

293125

ROOT CANAL DENTAL REFERRAL CENTRE
www.rootcanalcentre.co.uk

351 Richmond Road, Upper Ground Floor, East Twickenham TW1 2ER
Tel: 020 8050 0351 **Email:** info@rootcanalcentre.co.uk
Dr Nicolai Orsteen
DDS Oslo 2002
Specialist in Endodontics
GDC No. 175404
Interests: Endodontics
On Specialist List: Yes

293124

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

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

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

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, Sedation, Restorative and Cosmetic Dentistry.
On Specialist List: Yes, Endodontics and Orthodontics

261006

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

J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

J Smallridge Dentalcare
Childrens Dentistry
82 Berners Street, Ipswich, Suffolk, IP1 3LU
Tel: 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Consultant Orthodontist
Clinical Psychologist
Specialist Prosthodontist for adults
Endodontist

289511

Business skills CPD

Q1: Why should associates seek the inclusion of an indemnity from the practice owner relating to their equipment?

A To protect them from losing income

B To ensure the equipment is repaired and replaced in a reasonable timeframe

C To ensure the practice owner deals with faulty equipment as swiftly as possible

D All of the above

Q2: What percentage do owners usually charge to practise at their premises?

A 35-40%

B 40-45%

C 40-55%

D 45-55%

Q3: Why make patient after care calls?

A To find out if they have ongoing problems that need attention

B To upsell treatment

C To rate the service

D To remind them of their treatment

Q4: According to the ONS, how many people were 'non-proficient' in English?

A 368,000

B 683,000

C 836,000

D 863,000

Q5: How much did economic modelling suggest could be saved through 'Health Checks'?

A £57m per year after four years and £167m after 15 years

B £57m per year after four years and £176m after 15 years

C £75m per year after four years and £167m after 15 years

D £75m per year after four years and £176m after 15 years

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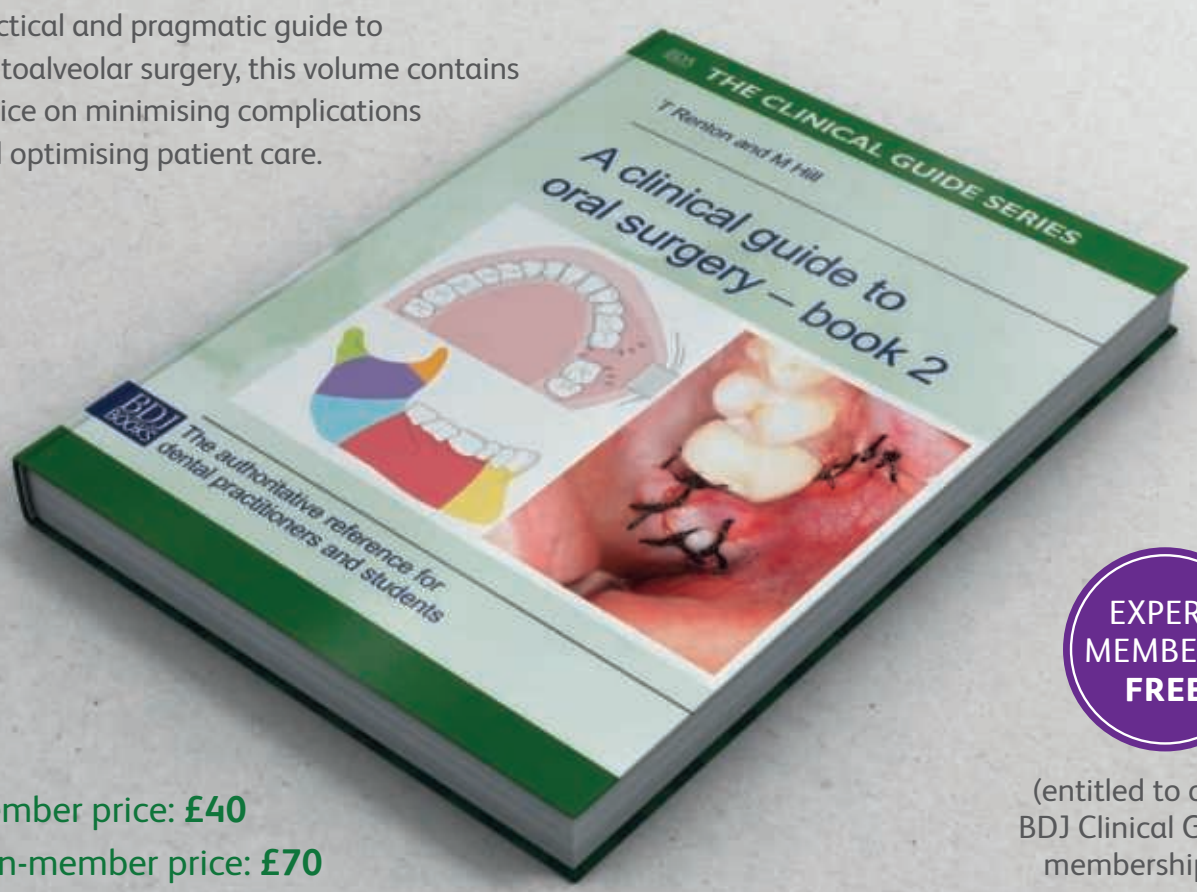

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Happy 60th Birthday

to the High-Speed Handpiece and Modern Dentistry!

60 years ago in 1957, the S.S. White Company introduced the Borden Airotor, the first successful air-driven handpiece regarded as the precursor to the present generation of high-speed handpieces. This revolutionized dentistry making it more efficient, more comfortable and more profitable. This development presented a major improvement from the "belt-driven" handpieces that preceded them and represents one of the most significant leaps forward in the era of modern dentistry.

Real income for dentists steadily increased between 1957 and 2007 through the efficiencies of everyday dental tasks made possible by the Borden high-speed handpiece.

Over the years, high-speed handpieces have gradually been redesigned and upgraded to become the highly accurate and sophisticated tools they are today, further improving practice productivity.

Despite the many technical improvements in the high-speed handpiece and with the practice of dentistry, real income for dentists since 2007 has not kept pace with inflation and has fallen by over 30% - an average loss of £30,000/dentist.

Dentistry as we know it is changing. Surviving in dentistry today requires so much more than just a high-speed handpiece and expertise in dental procedures.

The mindset of "work harder and work more" is no longer a viable strategy. Not only is this a formula for early burn out and lower quality of lifestyle, but our industry, government regulations, and economy are all shifting, making it increasingly difficult for dentists to prosper.

Unless we get comfortable with adapting to change, thriving in change, looking at our businesses differently and acting quickly to correct our course, we will see the end of the independent practice of dentistry in the near future.

Our own pain and frustration, led us to develop The Dentist's Advantage which specializes in providing a membership discount program for dentists.

Members can access benefits and savings from exclusive alliance partners. Partnering with leading businesses, The Dentist's Advantage provides a comprehensive portfolio of the best products and services for members.

We have no doubt every single one of you can find savings through the deals we have personally negotiated on your behalf.

The Dentist's Advantage has negotiated discounts on the things you are already using in your practice to make it more profitable, including:

- Dental Supplies and Dental Equipment
- Dental Lab Services
- Insurances
- Marketing
- Merchant fee savings
- Office Supplies
- Utilities
- Waste Management
- Lifestyle Benefits such as golf, wine, vitamins, Virgin Experiences
- We are also investigating a new all-inclusive online ordering system for you to make your purchasing more efficient, more cost-effective and ultimately keep more money in your pocket.

We want to encourage more dentists to join The Dentist's Advantage. With more members, we will have more negotiating power to lower prices and ultimately make your practice more profitable.

The Dentist's Advantage is a service that provides a link between the independent dentist and top-quality products, supplies and services at a discounted price.

We bring you exclusive products, prices, and services on a day-to-day basis, allowing you to compete with the pressures of dentistry today, empowering you to succeed.

HOW CAN WE DO THAT?

There is power in numbers. **With your help, we can increase our member base, giving us more negotiating power to further reduce your overhead costs.**

TAKE ACTION TODAY!

Join us at:

www.thedentistsadvantage.co.uk

info@thedentistsadvantage.co.uk

phone: 020 7099 2077