PracticeFocus
quarterly magazine of the ADAM ■ spring 2012

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PracticeFocus

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editorial

by **Jill Taylor**

The next three months are set to be a bustle of excitement for the ADAM team.

Entries for the ADAM Awards have now been received and the judging panel was delighted with the extremely high caliber of entries. If you've missed the deadline this year don't despair, we will be running the ADAM Awards again in 2013 so there is plenty time to start building your portfolio in preparation.

We have our 'Working smarter not harder' workshop on Friday 30th March in Manchester, which looks set to be a fascinating day. I am hopeful of leaving the workshop filled with inspiration and ideas to bring back to my own practice to share with the team.

In April we will be at the BDA Conference again in Manchester. Members of the ADAM team will be available on Stand D43 for the entire three days so do please drop by and say hello. You can read about the ADAM-hosted presentation on page five of this issue – we hope to see you there.

May is ADAM Conference month and with the programme now finalised we are very excited. With such a wealth of knowledge and expert advice on hand, this is your perfect opportunity to join us and learn from some of the industry's best. The programme has been designed around our theme of, 'The Nuts and Bolts of Running a Successful Practice'. We look forward to seeing you at the Majestic Hotel, Harrogate in May. Don't forget that our early bird offer ends on March 14 so make certain you book before then!

General dental practices can be quiet at this time of year so we need to be proactive in searching our opportunities. What can we all do to generate additional business? For the very first time our practice participated in a small wedding event themed as a 'Girls Styling Day'. Our dentist was a speaker and we had a great day chatting to prospective brides, their families and other members of the wedding party. As this was a first for us we learned a lot by attending and will definitely do it again. It was very low cost and apart from some time and effort on our part, we had nothing to lose and everything to gain.

We would love to hear from you. Have you done anything like this before and if so would you do it again? You can contact any of the ADAM team via email, Facebook or twitter. Don't be shy, get in touch and let us know what's happening at your practice.

I look forward to meeting you in Manchester or Harrogate.

contacts

Practice Focus is the official magazine of the **Association of Dental Administrators and Managers** (formerly the British Dental Practice Managers' Association or BDPMA), 3 Kestrel Court, Waterwells Drive, Waterwells Business Park, Waterwells, Gloucester GL2 2AT.
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adamnews&information

Don't miss ADAM's powerful one-day workshop

There is still time to join a powerful one-day workshop in Manchester in March, sponsored by The Dental Business Academy – that's half price for members!

- ***Where?*** Victoria & Albert Marriott Hotel, Manchester
- ***When?*** Friday, March 30th
- ***What time?*** 09.00 – 17.00
- ***How much?*** £75 for ADAM members, non-members £150 including breakfast rolls and buffet lunch

The workshop ***Working smarter - not harder*** gives you the chance to join up with colleagues, take stock and re-think how you manage your team and prepare for the challenges of the next 12 months.

This exciting workshop will be designed and delivered by some of the UK's most experienced dental practice experts. As practice owners and managers, The Dental Business Academy knows what it takes to run all sorts of dental practices in today's world. They also have a vast amount of experience setting up programmes for practice managers and other team members throughout the UK, from 'lunch and learn' to degree level study.

The day will cover:

- how to prepare for CQC inspections
- learning the best business planning skills
- building a high-performing team
- creating and perfecting the patient journey.

- Email: **Jan@thedentalbusinessacademy.co.uk** for more information.

ADAM seminar at BDA Conference – 'Don't drop the client baton'

ADAM will be hosting a special seminar at the 2012 British Dental Conference and Exhibition in Manchester on Friday April 27.

Delivered by Simon Hocken, GDP and Director of Coaching, Breathe Business, the seminar is titled ***50% of your new patient enquirers don't become patients! How do you ensure you don't 'drop the client baton'?***

The seminar, which will take place from 4.45 to 6pm in Charter Room 2, will be chaired by ADAM President Jill Taylor, who will also join Vice-president Hannah Peek at stand D43 for the duration of the three day event. This is a great opportunity for members to meet Jill and Hannah, so please make sure you drop by.

The BDA event runs from April 26 to 28 and one-day tickets cost £90 or £150 for two or three days. This will give you full access to all sessions.

- Further information and registration information is available at **www.bda.org/conference** or by calling **0870 166 6625**.

Resuscitation guidance

A reminder of how we should resuscitate a collapsed individual has been updated by the Resuscitation Council (UK).

The main summary says the following changes in the basic life support (BLS) guidelines have been made to reflect the importance placed on chest compression, particularly good quality compressions, and to attempt to reduce the number and duration of pauses during chest compression:

- When obtaining help, ask for an automated external defibrillator (AED), if one is available.
- Compress the chest to a depth of 5–6 cm and at a rate of 100–120 per min.
- Do not stop to check the victim or discontinue CPR unless the victim starts to show signs of regaining consciousness, such as coughing, opening his eyes, speaking, or moving purposefully AND starting to breathe normally.
- Teach CPR to laypeople with an emphasis on chest compression, but include ventilation as the standard, particularly for those with a duty of care.

- For further information visit **www.resus.org.uk/pages/GL2010.pdf**

Last chance for early bird tickets to ADAM Conference

We hope you were delighted to read the news in January's e update that treatment co-ordination expert Laura Horton will be speaking at the ADAM Conference in Harrogate in May.

Laura worked in practice for 13 years and has an unrivalled passion and enthusiasm for treatment coordination. In mid 2008 Laura left her full time PM position and has been successfully implementing the treatment coordinator role into dental practices across the UK ever since.

Her parallel session on the Saturday will help delegates understand the role of a TCO and how to develop a customer-focused approach to gain competitive advantage.

Early bird tickets for the ADAM Conference on May 18 and 19 are available until March 14 – so please email denise@adam-aspire.co.uk or call 01452 886 364 now! For members prices start at just £64 for Friday, £120 for Saturday or £165 for both days.

Tickets for the ADAM Gala Dinner and Awards Ceremony cost £45 and include a three-course meal and two glasses of wine. This is your opportunity to be part of the very first ADAM Awards, kindly sponsored by Denplan, which promises to be a great night.

- For more information visit **www.adam-aspire.co.uk**.

Private dental complaints up by 24 per cent

The Dental Complaints Service (DCS), which deals with complaints about private dental care, has revealed a 24 per cent increase in complaints from 1,180 in 2009/10 to 1,559 in 2010/11.

Of the 1,559 complaints it received in between May 2010 and the end of April 2011, 67 per cent were resolved within a week – a record it's very proud of. The statistics have been revealed in its Annual Review, which is now available online at **www.gdc-uk.org**

The DCS, which was set up by the General Dental Council in 2006, provides a free, impartial service for patients and professionals to help resolve complaints as quickly and satisfactorily as possible for both parties. When a complaint can't be resolved with the help of a DCS complaints officer a panel meeting will be held. Twenty-three of these have been held in the 12 months to the end of April 2011. Three trained volunteers (made up of lay and registrant members) help both parties bring the complaint to a close without the need for costly legal proceedings.

Head of the DCS, Hazel Adams said: "We're working hard with professionals and the public to ensure we're able to provide one of the best complaints handling services in the UK. We are committed to being fair and impartial and we do not take sides."

The DCS is keen to raise awareness of its role with the public and earlier this year produced a leaflet aimed specifically at patients. *'Making a complaint about private dental care'* aims to guide patients through the process of raising an issue and the steps the DCS can take to help them reach a solution with their dental professional. Copies can be ordered online at **www.gdc-uk.org**

Dentists victims of double standards, says BDA

Dentists have been the victims of a double standard in the way they have been treated in relation to Care Quality Commission (CQC) registration, the BDA has told the National Audit Office (NAO).

In a submission to a NAO study on CQC, the BDA has expressed disappointment that while the obvious problems confronting CQC meant that registration of general medical practice has been delayed; registration of general dental practice was forced through despite the profession's warnings. The submission also argues that assurances dentists already regulated through NHS contracts with Primary Care Trusts and Performer Lists would automatically transfer to CQC registration were not fulfilled. It also reiterates the BDA's view that the regime has failed to live up to the criteria the profession set for it; that it should be non-duplicative, proportionate to risk, tailored to the sector, not disruptive of resources and involve the minimum possible bureaucracy.

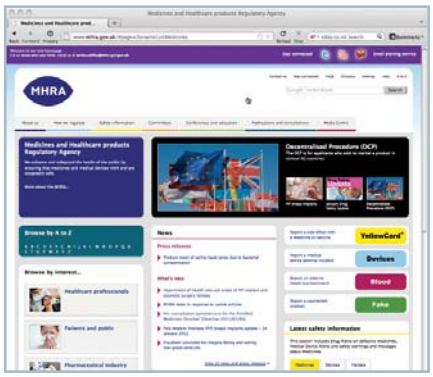
Looking forward, the submission calls for a more formal and publicly available agreement between CQC and the General Dental Council on the delineation between the two organisations' duties, arguing that the current lack of clarity serves only to damage the credibility of CQC with the profession even further. It also argues that CQC's performance would benefit from the injection of some dental expertise into its ranks, calling for the uncertainty facing Dental Reference Officers to be resolved by having their roles transferred to the CQC. Furthermore, the BDA's response criticises the failure of CQC to take on board the profession's concerns in the past and stresses the need for more effective dialogue going forwards.

John Milne, Chair of the BDA's General Dental Practice Committee, said: "Dentists have been very badly abused by both the way CQC regulation has been applied to them and by the double standard apparent in the way that what we were told was an unalterable timetable in relation to dentistry was very quickly delayed for our medical counterparts. The way this has been done serves only to reinforce some dentists' impressions that they have been used as guinea pigs for an ill-conceived and badly-executed extension of regulation.

"The real damage has been done and the BDA awaits an apology from Government for the mishandling of this episode. What's important as move forward is that CQC starts to make progress towards improving the situation. The BDA is calling for a clearer understanding of CQC's role and operations, a desperately-needed injection of some genuine dental expertise into its work, and a more effective dialogue with the profession."

MHRA launches new web home page

MHRA has launched a brand new home page for its website, which went live in January 2012.



The new home page presents all their latest information, including safety updates, in a clear, user-friendly fashion. There are clear ways to navigate to whatever information you need from the website and links to browse through sections. Visit **www.mhra.gov.uk**

Destination Manchester for practice managers

All roads lead to Manchester for practice managers and administrators this April, with the 2012 British Dental Conference and Exhibition taking place at the city's Central Convention Complex from 26-28 April.

With practice managers firmly at the heart of practice life, you're sure to find interest across the wide range of lectures, seminars, interactive sessions and demonstrations on offer, but with so much to choose from we think there will be some unmissable sessions that you'll want to put in your diary now.

Top of the list is sure to be a special seminar hosted by ADAM entitled ***50% of your new patient enquirers don't become patients! How do you ensure you don't 'drop the client baton'?***, Simon Hocken, GDP and Director of Coaching, Breathe Business has now been confirmed to deliver the session, which will be chaired by Jill Taylor, President, ADAM.

Further expert advice will be on offer at the ***Practice matters*** seminar at which five speakers with experience in estates, legal advice, financial advice and accountancy will discuss practice value, tax, incorporation and tendering.

All those looking to boost their practice's profit margin should make a note to attend ***Practice productivity, profitability and performance – using management data to enhance your practice***. At this session Brian Weatherley, the Managing Director of Software of Excellence, will examine how accurate data and the use of Key Performance Indicators (KPIs) can affect and improve practice profitability.

Delegates looking to gain some cross-industry expertise should not miss ***Avoiding complaints through enhanced customer care*** when Sarah Dunning, Training Manager with Virgin Limited Edition, will provide useful insights into the psychology of complaint handling and how team involvement in customer care can help prevent complaints.

And that's not all.

A major draw for many administrators and managers will be the ***Training essentials theatre***. Located in the exhibition hall, the theatre will offer a full programme of 30-minute lectures covering a wide variety of subjects including preventing complaints, business planning and profitability, successful communication, marketing strategies, and record keeping.

Also not to be missed are the opening ***keynote speakers***: eminent brain scientist Professor Susan Greenfield and the Friday ***government address*** by Minister for Health, Earl Howe.

Of course, the event offers far more for attendees than lectures and seminars. Make the most of your time at the event and visit the ***extensive exhibition*** to meet suppliers from across the industry, discuss your purchasing needs and maybe negotiate a great deal! Would you like to book an appointment with one of the exhibitors? New for 2012 is the online exhibitor meeting system. This will ensure you can fit practical discussions into your busy schedule. Your association, ADAM, will also be there, so make sure to pop by stand D43!

Last but not least an exciting programme of ***evening entertainment*** including Thursday night drinks in the exhibition hall, a Friday night party with top tribute band 'Killer Queen' and a black-tie gala dinner on Saturday will provide plenty of opportunities for networking and socialising.

Not yet booked your tickets? With less than two months to go, why wait? One day tickets costs just £90 or £150 for two or three days. This will give you full access to all sessions and offers fantastic value for all DCPs including practice managers and administrators.

- Further information and registration information is available at **www.bda.org/conference** or by calling **0870 166 6625**.

BRITISH DENTAL CONFERENCE & EXHIBITION 2012

A treatment coordinator can add great value

Laura Horton has been working with dental practices and successfully implementing the role of treatment coordinator (TCO) for over three years.

You may have read her articles in journals, heard her speak, or interacted with her via social media, discussing the role of the TCO, but in this issue of *Practice Focus* she writes directly to ADAM members, outlining her top tips to ensure the role is a success in your dental practice.

In addition to assisting dental practices to implement the TCO role, Laura works alongside existing TCOs, helping them to develop and hone their skills. She has had the opportunity to observe many TCOs and in this feature she provides her take on the top five mistakes that TCOs make and the detrimental impact they can have on the practice.

1. Lack of understanding about the role

Often existing team members are 'promoted' to a TCO. Great! They are already part of the team, familiar with the practice's systems and protocols, and know many of the patients. But that isn't enough! All too often practice owners and management aren't aware of what the job entails. A specific job description and relevant training are often not provided leaving the new TCO feeling demotivated and the practice wondering why results are not improving.

The TCO role, when used properly, is a new 'arm' of the dental business and it is essential that focused training is undertaken.

There are four main aspects to the TCO role:

- Seeing new patients' (NPs) for initial consultations before they see the dentist.
- Seeing NPs for free of charge consultations - this is a taster session for patients who can experience the practice, confirm solutions to problems and then go on to see the dentist if they are keen to know their suitability for a specific treatment.
- Helping dentists with the non-clinical treatment planning process - organising paperwork, consents, estimates etc.
- Participating in treatment presentations – being with the dentist and patient when the treatment options are explained.

Often TCOs are asked to help patients fill in their initial medical forms or explain the treatment plan to the patient – but the role can be so much more than that.

2. Lack of organisation and communication

You have to be an organised person to do the TCO role – everyone is depending on you. Being 'on the ball' is an understatement. There is no room for bad days!

Systems need to be implemented and everyone has to know their responsibilities. The TCO must ensure that everyone else within the team is organised, so communication is essential. A lack of focused meetings with team members means everyone may be working hard but often pulling in different directions.

An organised and fluent TCO ensures streamlined processes that promote a superb patient experience. A great TCO changes patients' tired and worn perceptions of dentistry. Organisation and communication skills are paramount. The result of little or no organisation or communication is stress – not just for the TCO but the entire team. It's like a domino effect and before you know it, the entire team is at odds with each other!

3. Having unstructured conversations with patients

Training existing TCOs is always more difficult because they have become stuck in their ways and often those 'ways' are not right. Often their approach in one to one patient consultations (particularly initial and free consultations) is unstructured resulting in the patient taking the lead – a scenario you definitely want to avoid!

The problem when the conversion is not structured is that it does not follow a path to success or win-win approach. You can end up going round in circles wasting valuable time and not achieving your goal of converting your patient to schedule an appointment. The TCO needs to be in control at all times and yet still achieve a win-win outcome for the practice and the patient. When you don't have set questions that follow a natural order you can end up in a muddle. There is a correct time and place for the discussion of money, treatment options, how the patient 'feels', what their goals are and so on, and following a structured pathway is more likely to result in success than a haphazard approach led by the patient.

– with the right approach

4. The TCO is talking too much

If the TCO is talking too much they are being interesting not interested.

The main objectives of the TCO in the new patient consultations are to provide outstanding customer service, build a solid relationship with the patient and build value in the treatment in relation to the fee. But how can you build relationships when you are doing all the talking?

Many TCOs have witnessed dentists giving long, detailed and sometimes boring explanations of treatment so they fall into the trap of doing the same thing. It's hard when you move into this role if your background is dental nursing as you may have been listening to this type of communication for some years. I had!

Talking non-stop doesn't put you in control, doesn't change the NPs perception of dentistry and doesn't build relationships either! Let's put it this way, if the dentist's traditional approach was successful the TCO role would never have developed.

5. Recommending treatment to patients

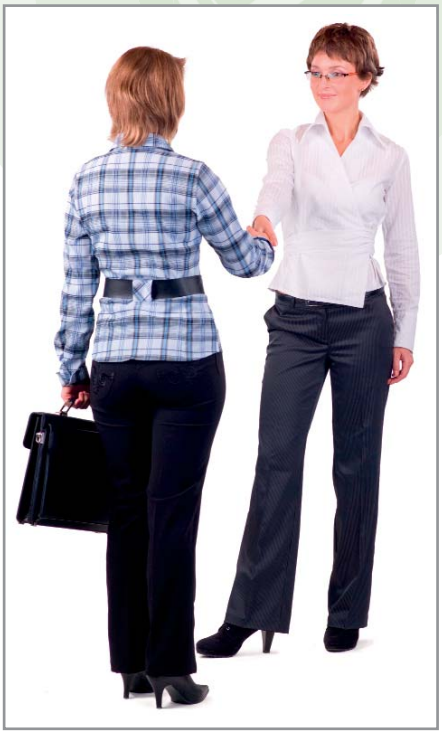
Every time I speak at a conference I mention the fact that TCOs should not recommend treatments and I always have one TCO come up to me and ask me 'but why' at the end!

No TCO in this country can recommend treatment to patients. Firstly during free consultations you are only showing patients the solutions available. If they have a missing tooth the options are: A do nothing B dentures C bridges D implants. If the NP wants to know which option they are suitable for they must have an assessment with the dentist.

If you recommend treatment to patients then you are putting your practice at risk. It is not fair on the dentist or the patient – you cannot promise something when you do not know if it can be delivered. Only dentists can recommend treatment and only after a clinical assessment.

Now I have highlighted the problems, let me give you some tips!

1. Training is essential if you want this role to work in your practice. Don't don't think you can do it alone, that's the long, hard and painful way to implement the role.
2. TCO equals team player. This role has to be undertaken by someone who thinks win-win! Team players want to do the best for themselves, the patients and the practice. They will not let you down so make sure you pick someone with a positive attitude who can communicate well.
3. Learn and follow my six steps to a successful NP consultation. *(see the table below)*
4. Ask open-ended questions when talking to patients about their treatment needs and close-ended questions when you want an answer e.g. do they want to book an appointment to see the dentist?
5. Learn the benefits of all treatments offered at the practice; rehearse the descriptions and benefits while using visual aids too!



About the author

Laura worked in practice for 13 years and has an unrivalled passion and enthusiasm for treatment coordination. In mid 2008 Laura left her full time practice management role and has been successfully implementing the treatment coordinator role into dental practices across the UK, helping them develop a customer-focused approach to gain competitive advantage.

- Visit her website www.laurahortonconsulting.co.uk email laura@laurahortonconsulting.co.uk or contact her directly on 07912 360779.

Six steps to a successful NP consultation

Step	Achieve this by ...
1. Approach	The welcome and rapport you build with your patient
2. Interview	Following the consultation form and process completely, without deviation
3. Demonstrate	Use visual aids to overcome the patient's concerns by describing features and benefits
4. Validate	Using verbal proof stories to show what the practice can do, how your patient will feel, look etc.
5. Negotiate	Ask the patient what would stop them having treatment – what would your patient's problems be?
6. Close	Sum up options and get an answer!

financematters

Tax planning tips for 2011/12

Tax planning before the tax year ends on 5 April 2012 is vital to ensure you take full advantage of available tax allowances and exemptions.

1. Married couples should use both personal allowances and basic rate bands

For the year ending 5 April 2012 all individuals with income of £100,000 or less are entitled to a personal allowance of at least £7,475. Married couples should make use of both spouses' allowances.

The same applies to the basic rate band, which for the year ending 5 April 2012 is £35,000. Where possible use both spouses' basic rate bands before either starts paying tax at the higher rate of 40%.

There are other issues to consider, including anti-avoidance legislation, however this type of planning is legitimate and over several years can save a significant amount of tax.

2. If taxable income is over £100,000 minimise your exposure to the 50% tax rate and loss of personal allowance

If a dentist's income is between £100,000 and £114,950 their effective tax rate might be as high as 60% because of the restriction of the personal allowance.

Planning could include:

- Reducing taxable income by making pension contributions or gift aid donations to charity.
- Deferring income such as dividends or accelerating expenditure such as buying capital equipment. With the 50% tax rate set to stay they should consider the impact on future tax bills.

3. Maximise use of the Annual Investment Allowance of £100,000

An Annual Investment Allowance of 100% of the first £100,000 of expenditure on qualifying plant and machinery (which excludes cars) is available until 5 April 2012 (31 March 2012 for companies). All businesses should, where possible, plan capital expenditure to ensure the maximum benefit is obtained from the AIA before it reduces to a maximum of £25,000 p.a. from 6 April 2012 (1 April 2012 for companies).

Where an accounting date spans the date of the change you need to be careful with the timing of expenditure due to rules regarding the pro-rating of the allowance.

4. Make the most of the Furnished Holiday Letting rules before they change

If you have a furnished holiday home that you let out, either in the UK or EEA, take advantage of the more generous Furnished Holiday Letting (FHL) rules before they change on 6 April 2012.

5. Use your Capital Gains Tax annual allowance

For the year ending 5 April 2012 all individuals have a CGT annual exemption of £10,600 so you should try and use it where possible.

6. Consider Entrepreneurs' Relief

If you are likely to sell a business interest or business asset in the next 12 to 24 months you should speak to your tax adviser to ensure that you qualify for Entrepreneurs' Relief. This relief can save you up to £1.8 million of tax but the rules are stringent so they must be considered well in advance of a sale.

7. Make tax-free investments

- Consider utilising your annual ISA allowance, which is £10,680 for 2011/12.
- Up to £3,600 can be invested into a child trust fund for 2011/12.
- If you have a child under 18 who does not have a child trust fund you could invest up to £3,600 in a Junior ISA.

8. Make use of your Inheritance Tax exemptions

Take advantage of the annual gift exemption of £3,000 where possible. If you have not made use of the exemption in one year, it can be carried forward and used the following year.

9. Plan for your retirement

In the last few years there have been many changes to pension tax relief and more changes will apply from 6 April 2012. You should speak to your financial adviser to ensure you understand the changes and maximise your benefits.

10. Charitable giving

Make sure you complete a Gift Aid declaration for all donations to charity. Ensure your charitable donations are paid by the spouse paying tax at the higher rate so you maximise tax relief.

About the author

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Practice hygiene – opportunity or threat?

There is an old saying that someone else's threat is another's opportunity. This is just the position in which we find ourselves with the increasing stress on dental practice decontamination processes and the inexorable progress towards the 'Gold Standard'.

In order to understand what the drivers are behind this move let's have a brief look at how the creation of HTM 01-05 began because the background may be helpful.

For some years now the accent on practice hygiene has been a major focus of attention driven by the underlying fear of patients acquiring infections in a dental environment. History does not seem to reflect that there have been incidences of infection from general dental sources. However, this may be serendipitous or simply because the blood supply to the mouth and jaws is good enough in most cases to compensate for any hygiene deficiencies – after all mouths are bacteria laden areas before dental treatment.

It all started when the threat of aids being spread emerged and some panic was created because patients of a dentist in America were believed to have been infected with the HIV virus in a practice environment. This was compounded by cases being reported of surgeons being infected when they cut themselves whilst working on HIV infected patients. The truth about the American dental patients will probably never be known for certain but the pundits believe that the dentist may have deliberately infected some patients by introducing his own blood into some injections.

Since all the above occurred there have been other infections which have created outbreaks of mild hysteria. Namely: hepatitis C and vCJD. The science base around the possible spread of these infections from dental treatment, and especially around vCJD, is rather poor but since the spread of Aids from blood products took place in the mid 1990s when the evidence about that was not yet secure, the desire to err on the cautious side has been paramount: hence the creation of HTM 01-05.

In order to achieve the 'gold' standard a separate room, or preferably two rooms, are required to house the pieces of equipment which are believed to be essentials. However, despite all the hullabaloo there is no definitive evidence that vCJD prions can be transmitted through dental treatment nor can they be eliminated by our current sterilisation procedures. And no proper criteria have been produced about the workings of Washer disinfector machines. Bearing this in mind and the pressure to strive for excellence in the process it is surprising that we still hear of practitioners who do not sterilise instruments between patient nor change gloves – so there is still some way to go.

Now, it is obvious that for many practices there isn't enough space to create an extra room, let alone two rooms, in which to house a decontamination suite. There may be the possibility of building on an extra room but if the practice is situated on the upper floor of a building or is in leased premises this option might well be eliminated. Then there are the additional costs involved which in times of financial austerity and reduced practice profitability may well stretch the practice's pecuniary reserves beyond their limit.

So what is to be done?

Clearly, if this trend towards decontamination gold standard is to continue – and that seems likely – some of the problems need to be resolved.

One possibility is the creation of some form of central sterilisation unit which is either run on a purely commercial basis or can be shared by several practices in a particular locality. The suggestion mooted by the Department of Health was to transport instruments to a hospital CSU but the turn round times were wholly impractical for a busy NHS practice.

If we are to avoid the wholesale purchase of masses of instrument kits then the turn round times must be quick. This is difficult because of the added time it takes to run instruments through the extended process including washer disinfectors followed by autoclaving. There will also be the necessity to ensure that the correct sets of instruments are returned to the right practice or a disaster in terms of productivity could occur. Imagine the chaos if Kavo handpieces were placed in a practice with W&H connectors. It doesn't bear thinking about – but this sort of error has occurred in hospitals.

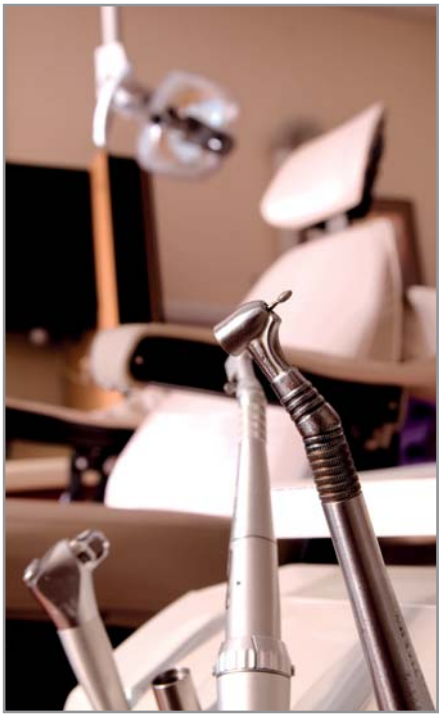
Now, it is well recognised that dentists are very poor at co-operation with their colleagues on any level and pooling resources to create a central sterilisation unit is hardly likely to be an exception. This leaves the way open for others to exploit the situation by creating a decontamination unit which can handle the instruments from several local practices.

Obviously, with the necessity to turn round the instruments in short order there is a limit to how far afield one might venture to collect and deliver instruments and the number of sterilisers and washer disinfectors will also have a major influence on time taken. If there are two autoclaves in use then there will not be the necessity for one cycle to be completed before another can be started; likewise with washer disinfectors. But, careful consideration needs to be given to the type of autoclaves being purchased. There should be at least one which has a vacuum programme so that the less frequently used instruments can be sterilised bagged and these will not need to be re-sterilised for 60 days. This does mean that that a process for dating the sterilised instruments has to be in place and transport of both dirty and clean instruments must be secure to ensure that no inoculation injuries occur and there is no danger of contamination of freshly sterilised instruments. Heat sealed film wrapping processes are more efficient and more cost effective than bagging if there are enough instruments being sterilised to justify the additional set up costs.

Whilst the operatives do not have to be dental nurses they will have to be trained in the processes needed and also supervised to be certain that the process is safe. Written log books of the various stages are essential to safeguard the efficacy of the cycles but, no more so than would be expected in a normal surgery process except that they have to be demonstrable through data logging or print out in order to re-assure the dental practices that they can be certain there are no loopholes in the process. There may be a necessity to bar code instrument packages to ensure traceability but this is not yet certain. However, there must be a fool proof way of knowing which instruments belong to which practice to be certain there is no confusion. Dentists are incredibly possessive about their own instruments and will not accept others even if they are similar.

Transport need not be sophisticated but does need to be reliable to deliver the instruments on time every time.

Having fired your enthusiasm for striding out on your own I need to add in a word of caution. Before embarking on such a project



make sure that all the stages of the process are carefully thought out and that you can secure both the finances and the premises at costs which allow you to charge appropriate fees for your work and also allow you to make an acceptable income.

Approach some of the dental practices in the area who might be struggling to meet the Gold Standard and offer your services together with the necessary assurance about the rigidity of the controls of the process and the charges you deem applicable.(Stress the fact that they will not have to employ additional staff nor outlay for expensive conversions of rooms or build extensions.) If there are some who are willing to take on your services then you can begin the processes of establishing your own Central Sterilisation Unit supplying the needs of local practices.

This short article is not meant to be a comprehensive guide to decontamination procedures nor is it meant to be anything more than a stimulant to possibly satisfying an unmet need whilst giving you some independence by setting up your own business.

- If further assistance is desired please feel able to contact us at: **lester@thedentistrybusiness.com**

Development Focus - Hygiene

Introduction

Welcome to the spring Development Focus. In this issue our spotlight falls on hygiene. Inspired by our attendance at last year's BSDHT conference and recent mystery shopping of hygienists, we have prepared four separate hygiene-related articles to whet your appetite.

Sometimes when you are in the thick of it, standing back and looking at your practice with a fresh pair of eyes can be difficult. Our aim in this feature is to give you recourse to review your approach to the provision of hygiene services to see if you can make any enhancements that lead to a better patient experience, better healthcare outcomes for your patients and additional revenue and/or profitability for your practice.

When undertaking mystery shops of hygienists it is amazing how diverse their approach and standards are. We have come across the best and worst of the profession but how does your hygiene team compare? Do you actually know? Imagine visiting a hygienist with bad breath – it's like buying a car from a salesman who cannot drive! There are hygienists that merely tickle and those that really hurt! Some are keen to provide education while others remain silent.

Do you know what goes on in your hygiene surgeries? When was the last time you observed your hygienists in action to see if they were upholding your brand values in the way they deliver their service? Have you ever undertaken patient feedback specifically on your hygiene service? Do your hygienists work in other practices besides yours and if so, do they return to your practice doing things in a way you would rather they didn't?

We hope you find this feature helpful and it allows you to refine your health-based approach because after all, we are health professionals first and foremost and we must never forget that.

Are you health challenged?

In the last five or six years there has been a real change of emphasis within the dental sector in terms of how it presents itself to the general public. The lines between health and desire, and needs and wants have been blurred. While most practices believe their fundamental service is health-based, their presentation to the general public may suggest otherwise.

In this section we highlight the typical mistakes practices make that blur the lines between a health and a cosmetically focused approach. If you think you are a fundamentally health-based provider then put your practice to the test and see if any of the following relate to you.

1. Practice name – it used to be simple; the practice name was based on where or who you were. Then suddenly the public 'needed' names that were more exciting such as smile, confidence, confident, cosmetic, perfect, spa and studio. All of these words suggest something other than health and if you're not careful, could leave you teetering on the edge of the dental health cliff.
2. Does your website support your supposed health-based approach? So often we see something like this statement from the homepage of a health-based practice: ***We will work with you… whether you're looking for a full smile design, implants, whitening or to simply ensure your mouth is as healthy as it can be.***

   See how health features last and the word 'simply' undermines the importance of health? That means it ranks least in significance. How does your homepage fare – is your health message clear and strong? And on your treatments or services pages do you feature hygiene first or does it come way down the list?
3. Do you send emails, ezines and newsletters with all sorts of promotions that are cosmetically oriented? Why would you continually push whitening when your brand hinges on prevention and health?

4. Do your recall letters castigate patients for not visiting frequently or do they extol the health benefits of regular dental visits in a way that encourages them?
5. Do you proactively sell sundries to your patients because you want to encourage them to properly care for their teeth and gums between visits - or do you forget?
6. Do you spend more time focusing on adult ortho, smile design, facial aesthetics etc. rather than on health?

There is nothing wrong with being cosmetically focused but if your key message is health then SELL health. It is health that people want and it is health that will get them through the doors. And once they are healthy, you can encourage them to enhance their smile with all the cosmetic options you provide.

Take a fresh look at all of your internal and external communications and make certain your message is clear and consistent!

'Children's teeth are being neglected' warns leading dental expert

How does your dental and hygiene care for children fare?

Professor Monty Duggal wrote an article in the Faculty Dental Journal last year saying that 'supervised neglect' was leaving tooth decay untreated in primary teeth – something he described as a 'matter of national shame'.

The head of paediatric dentistry at Leeds Dental Institute said that while there was no doubt that the overall caries prevalence in the UK was among the lowest in Europe, the average picture could be misleading and was not a representation of what clinicians were facing daily in NHS practice.

Prof Duggal criticises dentists and parents who believe that primary teeth are not worth repairing and that problematic milk teeth can be left to drop out naturally, adding that it had become increasingly clear that children from deprived backgrounds bore the highest burden of disease.

His hard-hitting opinion is echoed by Helen Rodd, professor and honorary consultant in paediatric dentistry at Sheffield's School of Clinical Dentistry, who says that 40 per cent of children under five had caries, with many coming from very poor or socially disadvantaged areas in the UK.

She says that only 12 per cent of caries are filled, with that number dropping as low as eight per cent in some areas. This differs vastly from the 1980s when around 25 per cent of caries were filled. Dental extractions remain the most common reason for children in the UK to receive an out-patient general anaesthetic, with 23,000 children admitted to UK hospitals each year.

Prof Rodd has also found that x-rays are not routinely taken for children in dental practices and said that although there had been a

55 per cent increase in the use of fluoride varnish applications in the last 12 months, this only represented eight per cent of all children in the UK.

At her lecture at the BSDHT's Oral Health Conference and Exhibition in November she added: "So if your practice offers and applies fluoride varnishes to children and takes regular x-rays, you are in the minority. Very good!" If your practice falls into this category, congratulations – please ensure that you sing about it from the rooftops and reinforce it in your marketing communications.

To fill or not to fill is an area of considerable debate in children's dentistry and opinion remains very divided, with little evidence available to support either an interventive or a purely preventive approach.

A randomised controlled trial, called the FiCTION trial, is currently underway in the UK to determine the optimum outcomes for managing carious primary teeth.

As one of FiCTION's co-investigators, Prof Rodd says it is fantastic that this subject is being treated as a priority by the highest level funding body, the National Institute for Health Research Health Technology Assessment (NIHR HTA) for the NHS.

A UK-wide research team will spend five years assessing the benefits of three different methods for treating tooth decay in primary teeth. These will be conventional fillings; biological treatment of the decay (sealing the decay into teeth with filling materials or under crowns, generally without the need to use injections or dental drills); and using only preventive techniques recommended in national guidance, such as better tooth brushing, less sugar in the diet, application of high fluoride varnish and fissure sealants to stop the decay.

The £2.87million study will involve children aged three to seven who already have decay in their primary teeth but have no toothache or abscesses. Participating dentists will be from general dental practices where children who attend for regular dental care will be invited to take part.

- A call has been made to DCPs to make their voices heard about this issue. For more information about the trial visit **www.fictiontrial.info**

Selling hygiene

For many middle aged and older people, seeing a hygienist is still a relatively new concept. If you have been used to seeing a dentist for everything including your scale and polish your whole life, then the concept of a hygienist would make you feel like you're being fobbed off to someone less qualified. Another way of making money!

If you provide hygiene services you may find that you experience greater numbers of failed to attend (FTAs) appointments and cancellations compared with visits to the dentist. This is usually because patients don't value hygiene appointments. In such cases it is your task to educate patients regarding the vital role played by the hygiene team, how qualified they are and how much better they are than dentists to clean teeth and gums – that is their expertise!

Here are some tips for how you might begin this educational process:

1. Feature case studies and testimonials on your web and in the practice about hygiene treatments and patients' experiences of hygiene. All to often practices focus (again) on their cosmetic treatments. When you consider 89% of the population exhibits symptoms of gingivitis, you are almost guaranteed that people will relate to the experiences of your patients and understand how regular hygiene visits make things better.
2. Introduce a hygiene protocol that ensures a consistent approach to your hygiene. Sell the service, not individuals! You want patients to feel that no matter which hygienist they see, they will receive exactly the same experience and treatment. Confidence in your whole hygiene team gives you maximum diary flexibility and means the patients feel positively about the practice as a whole, not just an individual who they think is outstanding.
3. Make education a big deal so be certain that your hygiene appointment time is long enough for some discussion of how to maintain teeth correctly between visits. Regardless of how much you talk about education, it is amazing how little the general public (your patients) knows about dental care. Download our quiz from the ADAM website and as your patients leave their hygiene appointment ask them to answer the quiz questions and see how educated they are. The questions are very basic so any more than two wrong and you might not be as great as you think at education.
4. Stock a good selection of sundries and have a sure-fire process of recommendation from the hygienists that reaches and is actioned by the reception team.
5. Set a practice target that a certain percentage of your patient base regularly sees a hygienist. By measuring exactly how you fare now and determining a strategy to close that gap, you can identify where issues lie and overcome them to improve the wellbeing of your patients.
6. Provide your patients with information about the hygiene team and their approach. Your key message must be that dentists treat disease but hygienists prevent it. In addition to introducing the team members and their qualifications here are some of the key points you want to get across:

Our hygiene team will:

- Prevent and manage gum disease
- Deep clean your teeth and gums
- Relieve bad breath and bad tastes
- Advise on brushing and flossing techniques
- Recommend inter-dental products for your mouth
- Provide diet and lifestyle advice

Attend the BSDHT Conference

by **Vikki Harper**

I attended the BSDHT conference for the first time in 2011. A practice manager friend and I spent one day there and we were blown away by how much we learned. Firstly, the exhibition was one of the best I have ever attended. A comprehensive contingent of dental providers was on hand to discuss all things health and hygiene based. There was no hard sell, just a keen interest in helping you to promote dental health in your practice. We came away with bags literally stuffed with samples and literature, and our heads filled with ideas for what to change back at the practice.

For family-based practices the range of products from <**brushbaby.co.uk**> was sensational. Providing an innovative range of hygiene products for babies, toddlers and children they represent a fabulous opportunity to communicate and add real value to existing and prospective patients with young children or babies on the way. Then there were the seminars. We learned so much about periodontal disease and the case for filling children's teeth, and the presentation on forensic dentistry was really interesting. We did not manage to book any of the tutorials but will definitely do so next year when we return. Did your hygienists attend the conference? If they did, how did they present back to you? If you did not receive any feedback and you are not able to attend yourself in 2012 then you should definitely set your hygienists some objectives for presenting back to you and the dentists following next year's event. Here are some ideas for what those objectives should be:

- Provide an update on direct access
- Provide an update on current thinking (new concepts and techniques) within the profession
- Provide an update on strategies for advanced periodontitis
- Provide an update on advances in periodontal disease and the impact on systemic health
- Provide an update on new and innovative products for clinical use and sundry sales
- Suggest at least three changes to improve the systems, protocols, outcomes and/or patient experiences at the practice.

PGD template set to empower dental hygienists & therapists

The confusing - and often contradictory - national guidance about administering local anaesthetic and fluoride preparations has spurred the BSDHT to work alongside experts to produce a PGD template that will make life easier for dental hygienists and therapists.

The template will allow dental hygienists and therapists to carry out local anaesthetics and fluoride procedures without having to continually disturb the dentist/s within their practice for written prescriptions or Patient-Specific Directions. That means no inconveniencing the patient who may have to return to the practice and incur extra charges because the hygienist/therapist was unable to obtain a prescription from the dentist immediately. The hygienist or hygienist-therapist is empowered to identify the need for a POM and satisfy that need there and then.

Local anaesthetic and high-fluoride content products, such as varnishes, fluoride supplements and certain toothpastes are classed as Prescription Only Medicines (POMs).

In 2000, changes in legislation allowed certain healthcare professionals to be able to administer POMs in the UK. Although it was assumed that hygienists and hygienist-therapists were included in this group of healthcare professionals, they weren't. This means that hygienists and hygienist-therapists were not legally allowed to prescribe POMs themselves, despite many of them having done so historically.

In June 2010 further legislation led to hygienists and hygienist-therapists in the UK being able to perform these functions as part of their scope of practice in two specific ways, via a Patient-Specific Direction (PSD) or via a Patient Group Direction (PGD).

Patient Group Direction (PGD)

A PGD allows dental hygienists and dental hygienist-therapists to administer POMs to a group of patients via a legal framework without the need for a PSD (or written prescription) from a dentist.

But until July 2012, a PGD can only be applied to patients receiving treatment under the NHS and not to patients receiving private dental treatment. After that date however, both private and NHS practices will be able to use a PGD.

But a PGD is a complicated document that must include a whole raft of information, from details of appropriate dosage and maximum total dosage, quantity, pharmaceutical form and strength, route and frequency of administration, and minimum or maximum period over which the medicine should be administered, to relevant warnings, including potential adverse reactions and details of any necessary follow-up action and the circumstances.

The detailed PGD template may be adapted to suit hygienist or therapists' needs and then requires approval at a local level and must be signed by a clinical governance lead, pharmacist, lead dentist and the lead dental hygienist or dental hygienist-therapist.

Contact BSDHT for more information. The document can be used in NHS practices now and in both private and NHS practices from July 2012.

Practice manager to practice champion

Denplan's sales trainer manager, Jo Banks, discusses how selecting a 'champion' can help practice managers ensure business profitability as well as increased patient recruitment and retention.

Denplan's sales trainer manager, Jo Banks, discusses how selecting a 'champion' can help practice managers ensure business profitability as well as increased patient recruitment and retention.

Sales are an integral part of a successful private practice, especially during difficult economic times. The word 'sales', however, is often considered to be a dirty word by practice teams, who feel that their success should be based upon patient health rather than profits.

I believe that appropriate and ethical selling is entirely acceptable in modern practice, as the products and services you offer could genuinely benefit your patients – if only they knew about them! Having a dedicated member of the practice team to act as champion for certain products and services can, therefore, be hugely beneficial for both your patients and your bottom-line.

What is a champion?

A champion is a front-of-house member of the practice team with a strong focus on business growth and patient retention. The role is usually taken up by someone who has the confidence and knowledge to explain to potential patients what your practice can offer them and how they could benefit from the services, payment plans and products you offer – so it's often an ideal role for a practice manager as they can also keep their colleagues up to speed.

Anybody working in this role must be a good communicator, be knowledgeable and be enthusiastic. And by having dedicated members of your team to act as champion, you can see a dramatic uplift in sales to interested patients. In fact, practices with a Denplan Champion often see a dramatic uplift in patients signing up – sometimes by more than 35%! Their knowledge and enthusiasm for the products allowed them to sell to patients who genuinely benefit from them, so it's win-win. Being a champion is, however, a learned skill so it's important to get the right training – something which can often be provided through your payment plan specialist.

Maintaining motivation

When practice teams first introduce a new product or service, they are usually really enthusiastic to demonstrate to their patients just how they can benefit from it. However, teams change as colleagues come and go and the original knowledge and understanding of these services can fade over time.

That's where your champion comes in. By refreshing the knowledge and understanding of the practice team and your patients, champions can breathe new life into services you could have been offering for years. And just because you have always provided something, does not mean that your patients know about it, so you might just be surprised by how much your champion could improve practice profitability. It's also worth asking your payment plan specialist about training courses for maintaining motivation as some could provide this for you.

But don't take our word for it...

To demonstrate how valuable having a champion can be for your practice, receptionist Kathryn talks about her role as a Denplan Champion:

"Practical tips and the exchange of ideas with other champions continues to inspire and motivate me...I keep in touch with them via the Denplan Champions Facebook page so I always have something to contribute at team meetings. The Champions Training handouts are also a great way to involve the whole team and make learning at our team meetings fun!

"To reflect our family ethos, we've adopted 'special occasion cards' which we send to patients to mark a wedding or new baby. We've also welcomed newcomers to the locality by sending a card to the address of a patient we know has moved house, telling them about us should they be looking for a new dentist.

"With assistance from Denplan's Practice Marketing Support we've recently issued a patient newsletter and find that it works very well, generating a good response from patients to special offers and news in general."

Given today's economic climate, it's even more important for practice teams to focus on patient recruitment, contributing to the financial security of the practice, and offering stability for both patients and the practice team. Appointing a champion to encourage growth, (through their motivation and enthusiasm for the products and services you already offer) can not only give your practice team a new lease of life, but can help increase practice profitability long into the future.

About the author:

Jo Banks is Denplan's Sales Trainer Manager, highly experienced in working with dental practice teams to ensure they feel confident in their ability to communicate with their patients and offer them best options for their oral health.

feature

Consent – it's not worth the

by **Andrew Toy** MMedSci BDS MFGDP(UK), Chief Executive Officer of the Dental Business Academy.

Many dentists still think that a patient's signature on a piece of paper saying 'I consent…' means the practice is 'legally' safe. That may have been true in the past, but in today's modern world, a signed consent form is literally worthless. This article will look at the modern meaning of consent and why it's important to your practice. It will also highlight how you can turn your consent process to your practice's advantage.

Why is it important?

The provision of appropriate consent to treatment is becoming increasingly important. Here are a few of the modern developments:

1. **Needs and wants**. Dental practices are providing an increasing number of 'elective' procedures. These are treatments that the patient does not need to have, but chooses to have them because they want them. Elective procedures would include all cosmetic treatments and can also include the provision of implants. If the patient suffers harm from an elective procedure, the practice needs to ensure that its consent process clearly addressed the risks involved. If not, the patient could argue that they wouldn't have had the procedure if they had understood the risks involved.
2. **Ageing population who are keeping their teeth**. The population is ageing and keeping more of their own teeth. This means they have increasingly complex medical and dental needs and, therefore, the type of dentistry we offer them is more complex and specialised. That generally means it's more expensive and more risky.
3. **Lack of trust in dentists**. The public no longer has an automatic trust of professionals, so is more likely to complain to the GDC or think of suing if something goes wrong. In a study of 61 implant treatment cases, Givol *et al*[1] reported that the main causes for lawsuits are actual body injury and major disappointment. They discovered that 95% of errors were due (at least in part) to inadequate preoperative care provided by the dentist, of which obtaining consent is a significant part.
4. **An increase in complaints to the GDC**. Even if the dentist has done everything correctly and by the book, defending yourself against a complainant is enormously stressful, time consuming and expensive.
5. **The CQC**. Elements of the consent process appear in Outcomes 1-4 of the CQC Standards – see Table 1 overleaf[2] This is an area the CQC is likely to take a keen interest.

What is consent?

The definition of what constitutes appropriate consent has changed in recent years. Recent judgements in UK courts have placed a much greater emphasis on dental professionals taking care to *help their patients make the right choice*, rather than dentists making the choice for them. This mirrors social changes, where the public no longer automatically trusts their medical professional, and also expects to be involved in making choices for themselves.

A trusting relationship. It is no longer good enough for the dentist to tell the patient what the dentist thinks they need to know. The simple 'dentist knows best' stance has now evolved into a more complex interaction. The consent process is now described as a trusting, professional relationship in which the dental team:

1. Respects the right of the patient to choose their treatment option, and
2. Gives them the means to make an appropriate choice.

This is the tricky bit. We have to consider whether the patient has the means or ability to consent to treatment. For instance, some adult patients may have language and learning difficulties and not be able to read the documents you have put in front of them. Your consent process has to take this into account and include the use of visual aids and perhaps an interpreter. There is also something called 'Gillick' competency which states that it is possible for a child under 16 to consent to treatment if they are mature enough to do so. Again, this requires the dental professional to make a judgement on the patient's ability to make a choice.

paper it's written on!

Know your patient. To provide the best possible consent process, the dentist needs to consider two phases:

1. Understand exactly what concerns the patient about their mouth (in terms of comfort, function and appearance) as part of a comprehensive dental examination.
2. After the examination, clearly state the 'material risk' for each treatment option offered to the patient ***in a way they will understand***. This means explaining to the patient what risks they may be taking by going through with a particular option, and how this may affect their own lifestyle.

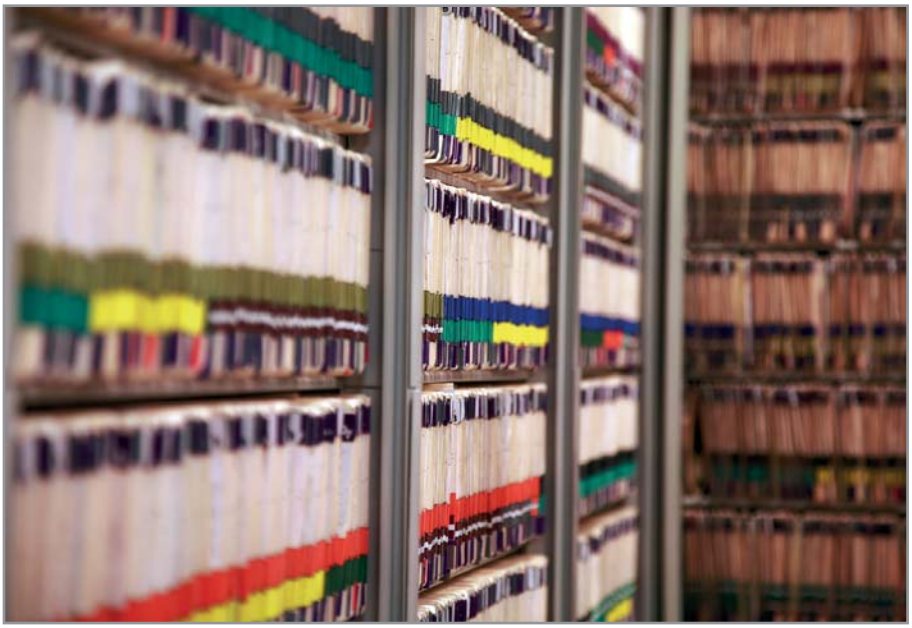
In their publication ***Principles of Consent***,[3] the GDC now expects dentists to *'Listen to the patients and give them the information they need, in a way they can make decisions.'* A dental team member, such as a care co-ordinator, can play a very significant role in ensuring the practice provides a very high quality consent process. The care co-ordinator can spend considerably more time than a dentist gathering information about the patient's dental concerns before the examination. They can also really 'get to know' the patient and build a trusting relationship.

'Getting to know' can also be described as taking a complete 'social history'. It is important to know things like what sort of job the patient does, what sort of recreational activities they enjoy, and their family obligations. Obvious things like smoking and alcohol habits are also important. All of these aspects of a patient's lifestyle need to be taken into consideration when agreeing a treatment plan with the patient.

Once the examination is complete and

Table 1

Respecting and involving people who use the services Clinical Governance	Outcome 1 Regulation 17 (2010)	● Understand treatment choices ● Can express their views ● Privacy, dignity and respect ● Have views considered ● Diagnosis explained
Consent to care and treatment Clinical Governance	Outcome 2 Regulation 18 (2010)	● Patients given time to consider options ● Arrangements made for consent from children ● Respecting the right to refuse or withdraw consent
Fees	Outcome 3 Regulation 19 (2009)	● Complaints procedure meets patient needs ● Registered person investigates ● Record keeping ● Patients made aware of care costs ● Receive a copy of the agreement ● Offer a receipt for money paid
Care and welfare of people who use the services	Outcome 4 Regulation 9 (2010)	● Assessing the individuals needs ● Planning treatment and delivering ● Risk identification and assessment ● Provide safe and appropriate care ● Dealing with foreseeable emergencies



options have been provided by the dentist, the care co-ordinator can ensure the patient receives an explanation of the risks and benefits for each option that suits the patient's learning style and personality. This means the patient will be able to truly understand the options, and their benefits and risks. This is essential to the consent process. A care co-ordinator who really knows and understands their patients will be best placed to help the patient make the right choice for them. Many care co-ordinators find gaining the trust of the patient and helping them choose the most satisfying aspect of their role.

The importance of 'getting to know the patient' in the first phase of an examination cannot be underestimated. There's an old saying that *'the patient will not understand unless they feel understood'*. Giving time and attention to the first phase will make a big difference to the quality of the consent process in the second phase, when the patient needs to understand the options put before them.

So what about the paperwork?

A patient that trusts the practice team is very unlikely to complain to the GDC or try and sue the practice. However, as previously stated, in recent years there has been a trend towards more litigation against dental professionals and the prospect of being sued should not be ruled out at any time. Dentists providing cosmetic dentistry or more complex and expensive treatments are also more likely to be sued.

In the event of any complaint made by the patient to the GDC or through the courts, the quality of the patient records associated with the consent process will have a significant impact on the judgement. In short, as far as the GDC or courts are concerned, *'if it's not written down, it didn't happen.'*

These cases often take several years before a judgement is made, so relying on memory to describe your patient's consent process is not good enough. A practice that takes the time and trouble to complete a full set of records of every patient interaction will be providing their dentist with a robust defence if a patient tries to claim that the care was inadequate in some way. Standards for record keeping have been laid down by the Faculty of General Dental Practice (UK) in their publication ***Clinical Examination and Record Keeping***.[4] Creating clear procedures for your practice to follow during the consent could be one of the best things you've ever done.

Turning the consent process to your advantage

If you really try to simplify it, good consent means:

1. discovering your patient's needs and wants
2. building a trusting relationship
3. using our specialised knowledge to create a list of treatment options designed to meet those needs and wants
4. helping your patients to make the best choice for themselves

Doesn't that sound a lot like an ethical marketing procedure? In a world where there are ever more treatment options and where patients are naturally less trusting, the practice that *invests* in a consent process that is ethically and legally sound will stand out from the crowd.

Invest in your skills. The Dental Business Academy's BTEC level 3 Care Co-ordinator qualification includes the knowledge and skills to help you ensure you have a legal and ethical consent process in your practice. The time and money spent in training the team and developing sound procedures will pay the practice back time and time again. A patient who trusts in the practice will buy from that practice. Good consent is good business!

Conclusions

So, your consent paperwork is only of value if it supports a strong, patient-centred communication process – where patients are provided with a range of options suited to their individual needs. People first, paperwork second.

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News from Saving Faces

Charity helps launch the world's first facial surgery study centre

The Facial Surgery Research Foundation
Saving Faces
research today saves faces tomorrow

Saving Faces and the British Association of Oral and Maxillofacial Surgeons are funding the world's first national oral and facial surgery study centre.

The UK-based centre has the ambitious aim of continuously collecting data on the outcomes of treatment received by every patient in the UK who has a mouth or facial injury or disorder. This will entail scrupulous data collection by UK surgeons and their assistants, consent by people to be followed up over time to determine the long-term results of their treatment, and studying these results to determine best treatment practice.

This huge undertaking will collect information on approximately 200,000 people annually who have treatment of this kind but the effort is set to reap exceptional benefits for patients worldwide.

The registers of British patients are likely to uncover previously unknown causes of some disorders leading to better prevention strategies. S

tudying the outcomes of large numbers of patients having different treatment for the same conditions will also reveal the therapies that produce the best results.

All treatment is relatively successful but these results will consign the less successful treatments for use only when no other treatment is appropriate. This alone will certainly improve patient outcomes throughout the world and the UK surgeons will lead the world in uncovering this knowledge.

A Saving Faces spokesperson said: "All this costs money! The Facial Surgery Research Foundation Saving Faces is funding the centre whilst the UK OMF surgeons are providing the academic input.

"The National Joint Register, a similar undertaking costs more than £2.7 million annually. We think we can run our centre at much less cost - around £500,000 annually - so it's a bargain! But it's still a lot of money, so we need your help."

- To find out more or to donate, visit **www.savingfaces.co.uk**

Put your best foot forward and raise money for Saving Faces

Saving Faces has eight guaranteed places in the BUPA 10,000 in London on May 27, so why not feel like a real Olympian by running the route of the 2012 Olympics Marathon - albeit slightly shorter!

This popular 10k run is suitable for all abilities and you will run past some of London's most famous sights, including Westminster Abbey, Big Ben, St Paul's Cathedral and Nelson's Column, starting and finishing at Buckingham Palace.

- To secure one of the places all you have to do is register by visiting **http://london10000.co.uk/charities/saving-faces** and clicking on the 'Register Today' button or emailing savingfaces@mail.com. Entrants must guarantee to raise £450 each.

Help is at hand for new patients

Saving Faces runs an expert patient helpline that links new patients with former patients who can provide advice and support. Often after being diagnosed patients feel very lonely and troubled. While surgeons can provide the medical and technical information on their condition, there is also a need to just talk to someone who understands. Sometimes patients do not want to show their families how concerned they are and find it useful to talk to someone who has gone through the same traumatic experience.

- Lines are open from 9am to 5pm and if the newly diagnosed patient calls **07792 357972** or e-mails **helpline@savingfaces.co.uk**, the charity will put them in touch with a former patient who understands what they are going through. A message or email can be left outside working hours.

Saving Faces is the only charity in the UK solely dedicated to the worldwide reduction of facial injury, deformity and disease. Its research programmes intend to improve the lives of many millions of face disfigurement victims worldwide and its prevention education aimed at teenage binge drinkers and smokers is already having a major impact.

With our help, Saving Faces will save and improve lives. Millions of oral cancer victims will have essential, tailored physical and psychological support. People under 25 will understand that binge drinking and smoking can result in serious face disfigurement. And the Saving Faces helpline can link new patients with former patients who can provide invaluable advice and support.

Visit **www.savingfaces.co.uk** to find out more.

advertising

Dental Protection

Xtraordinary free membership for all employed dental nurses and dental technicians

With the number of complaints and GDC investigations involving dental nurses and dental technicians on the increase and the fact that 80% of all cases handled by DPL aren't related to clinical negligence having indemnity for clinical negligence alone, simply isn't enough.

DPL Xtra gives you the peace of mind that all your employed dental nurses and dental technicians have full membership with DPL including additional risks and accountability such as GDC investigations, complaints and inquests.

DPL Xtra

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or call our Membership Helpline on 0845 718 7187

continuingprofessionaldevelopment

Practice Focus is pleased to include a Continuing Professional Development (CPD) Programme for its ADAM member readers in accordance with the UK General Dental Council's regulations and the FDI World Dental Federation's guidelines for CPD programmes worldwide.

The UK General Dental Council regulations currently require all registered UK dental professionals to undertake CPD and provide evidence of the equivalent of verifiable CPD.

Although there is no mandatory requirement for dental practice managers or administrators who are not r egistered DCPs to undertake CPD, the ADAM encourages members to do so as a measure of personal development and professional commitment.

The questions in this issue of *Practice Focus* will provide two verifiable hours of CPD for those entering the programme.

Practice managers wishing to enter the programme can do so by completing the answer sheet on page 25 and sending it (or a photocopy if this is preferred, so as not to remove the page) to the ADAM head office address before **Friday 15th June 2012**.

ADAM members completing the programme will receive a certificate for two hours of verifiable CPD, together with the answers to the questions. Any non-members wishing to undertake the CPD must include a cheque for £15 made out to ADAM.

Aims and outcomes

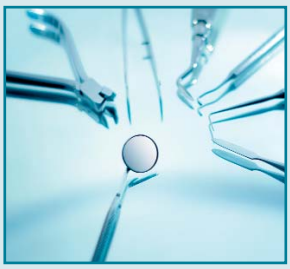
In accordance with the General Dental Council's guidance on providing verifiable CPD:

- The aim of the *Practice Focus* CPD programme is to provide articles and material of relevance to practice managers and to test their understanding of the contents.
- The anticipated outcomes are that practice managers or administrators will be better informed about recent management advances and developments and that they might apply their learning to their practices and ultimately to the care of patients.

Please use the space on the answer sheet to provide any feedback that you would like us to consider.

ANSWERS TO THE AUTUMN EDITION CPD QUESTIONS

1.b, 2.a, 3.a, 4.d, 5.b, 6.c, 7.d, 8.a, 9.c, 10.b, 11.c, 12.d, 13.a, 14.b, 15.c, 16.c, 17.a, 18.b.



1. THE ADAM AWARDS RECOGNISE WHICH MEMBERS OF THE DENTAL TEAM?

A. Managers, administrators and treatment co-ordinators
B. Managers, administrators and nurses
C. Dentists and practice managers
D. Administrators and treatment co-ordinators

2. THE DATES OF THE ADAM CONFERENCE ARE?

A. June 18-19 **B.** May 18-19
C. April 18-19 **D.** May 19-20

3. THE GDC'S LATEST GUIDANCE ON REMOTE PRESCRIBING FOR NON SURGICAL COSMETIC PROCEDURES STATES

A. That it is fine **B.** That it should not be used
C. That it has not reached a decision yet
D. That it is up to the dentist, providing it is ethical

4. IT IS NOT UNCOMMON FOR UNTRAINED TEAM MEMBERS COVERING THE FRONT DESK TO:

A. Undermine your practice brand
B. Undervalue new patient calls
C. Underperform generally **D.** All of the above

5. WHICH OF THE FOLLOWING WERE OFFERED AS TIPS FOR MAXIMISING YOUR FRONT DESK OPPORTUNITIES?

A. Undertake mystery shopping and include additional duties in all job descriptions
B. Choose team members carefully and ensure they are properly trained
C. Don't use the word cover when referring to the front desk because it undermines the importance of the role
D. All of the above

6. SELLING SUNDRY ITEMS IS ALL ABOUT WHAT?

A. Engaging your patients with your expert advice
B. Selling whatever you can to makes lots of money
C. Recommending stock you have a lot of
D. Having a two-way conversation and a. above.

continuingprofessionaldevelopment

7. WHAT MANAGEMENT CHARACTERISTIC IS PRESENT WHERE TEAMS DISPLAY HIGH LEVELS OF MOTIVATION, COMMITMENT AND LOWER STRESS LEVELS?

A. Effective underperformance management
B. Effective performance management
C. A hands-on style **D.** None of the above

8. EFFECTIVE PERFORMANCE MANAGEMENT COVERS:

A. Getting the right culture, managing conflict and being supportive
B. Getting the right culture, creating conflict and being supportive
C. Getting the right culture, managing conflict and being unsupportive
D. Ensuring you measure as much as possible

9. WHICH OF THE FOLLOWING ARE NOT MANAGEMENT STANDARDS FOR DEALING WITH THE PRIMARY SOURCES OF STRESS?

A. Control and support **B.** Relationships and change
C. Demands and role **D.** Control and structure

10. WHICH OF THE FOLLOWING BEST DEFINES CUSTOMER SERVICE?

A. It is part of your product portfolio
B. It is an approach based on having the right culture
C. It comes from your service offering **D.** None of the above

11. ACCORDING TO THE ARTICLE, WHAT IS THE BIGGEST SINGLE REASON WHY BUSINESSES LOSE CUSTOMERS?

A. New competition moves in
B. Existing customers stop recommending
C. One employee exhibits indifference
D. Poor overall service

12. A COMPLAINT PROCESS SHOULD BE?

A. Expedient, fair and effective
B. Simple, heartfelt and effective
C. In duplicate form
D. Determined on a case by case basis

13. IF YOU RESOLVE A COMPLAINT EFFECTIVELY, WHAT PERCENTAGE OF CUSTOMERS WILL RETURN?

A. 50% **B.** 90% **C.** 95%
D. None: once a customer complains there is no hope

14. WHICH CQC OUTCOME SUGGESTS YOU 'MUST ASSESS AND MONITOR THE OUTCOME OF YOUR SERVICE PROVISION'?

A. 14 **B.** 15 **C.** 16 **D.** 17

15. ACCORDING TO THE ARTICLE WHAT IS ONE OF THE BEST WAYS TO ASSESS HOW GOOD OR BAD YOUR CUSTOMER SERVICE IS?

A. Put yourself in the place of another team member
B. Put yourself in the place of a customer
C. Ask your team to complete a survey
D. None of the above

16. WITHOUT PROMPT DIAGNOSIS HOW MANY PEOPLE WITH MOUTH CANCER WILL DIE?

A. 50% **B.** 25% **C.** 80% **D.** 100%

17. WHAT IS THE NAME OF THE CHARITY ADAM IS SUPPORTING FOR THE NEXT YEAR?

A. Saving Mouths **B.** Saving Lives
C. Saving Faces **D.** Saving Teeth

18. WHAT IS THE AIM OF THE CHARITY'S DIAGNOSTIC SERVICE?

A. To speed up the referral process
B. To ensure referral to the most appropriate local surgeon
C. To rapidly reassure those with benign diseases within days
D. All of the above

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CPD answer sheet: Practice Focus Spring 2012

Please PRINT your details below:

First Name* Last Name* Title

Address*

Postcode*

Telephone Email

GDC no.* (if relevant) ADAM Member: Yes No ADAM no.*

**Essential information. Certificates cannot be issued without all this information being complete.*

Remove this page, or send a photocopy to the ADAM at: ADAM, 3 Kestrel Court, Waterwells Drive, Waterwells Business Park, Gloucester, GL2 2AT.

Answer sheets must be received before **Friday 15th June 2012**. Answer sheets received after this date will be discarded as the answers will be published in the **Summer 2012** issue of *Practice Focus*.

Answers

Please tick the answer for each question below.

Question 1: A B C D	Question 2: A B C D	Question 3: A B C D	Question 4: A B C D	Question 5: A B C D
Question 6: A B C D	Question 7: A B C D	Question 8: A B C D	Question 9: A B C D	Question 10: A B C D
Question 11: A B C D	Question 12: A B C D	Question 13: A B C D	Question 14: A B C D	Question 15: A B C D
Question 16: A B C D	Question 17: A B C D	Question 18: A B C D		

Feedback

We wish to monitor the quality and value to readers of the *Practice Focus* CPD Programme so as to be able to continually improve it. Please use this space to provide any feedback that you would like us to consider.

"I enjoy working with DPAS, because they put us in control of our business but are there when we need them. They are the perfect business partner."
Shauna Simpson, Practice Manager, Bedale Dental Practice

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