DENTAL TRIBUNE

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News in brief

New chairman

Paul Kendall (right) the outgoing chairman of the National Association of Specialist Dental Accountants (NASDA), is thanked by his successor, Nick Ledingham, who presented him with an electric golf caddy and a framed certificate. Paul established NASDA; Nick congratulated him on his achievements.

New site

After a transitional period of running on two websites, GDPUK e-mail discussion group has now moved to its new site at *www.gdpuk.com* New web software allows members to enhance their thoughts with images in postings, excellent for clinical topics. GDPUK welcomes new members from the whole dental team.

Dentist fined

The General Dental Council has successfully prosecuted Stuart Folland at Bristol Magistrates Court for the illegal practice of dentistry. He had carried on working despite being removed from the register for non-payment of the annual fee. He was fined £400 and was ordered to pay the GDC's costs of £1,548.

A bit odd

A cooperative network of GPs has won a three-year contract to deliver a dental advice and triage service across southeast London between 2008 and 2011. The South East London Doctors' Cooperative has introduced a dental triage service whereby patients called an advice line, answered by the dental nurses who then deal with the patient appropriately. But PCTs are supposed to contract with dentists not doctors – a bit odd?

Race for life

Five nurses and receptionists from a Cromer, Norfolk, practice will be taking part in the annual Race for Life at the Norfolk Showground. The 5km run, which takes place at 280 venues across the UK on May 3 and 4, is the biggest women-only fundraising event in the country. More than 665,000 people took part last year, raising £40 million for Cancer Research UK.

www.dental-tribune.co.uk

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Mastering the art of clinical photography can improve the quality of your dentistry, say Jay Padayachy and David Bloom

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New guidelines on antibiotics for 'heart' patients

Ever since most of us qualified, we have asked standard medical history questions to try to identify those who might be at risk of infective endocarditis as a result of invasive dental procedures. Most of such patients are now accustomed to receiving prophylactic doses of antibiotics such as amoxicillin before treatment.

Now it is time for change. The National Institute for Health and Clinical Excellence (NICE) has issued a new clinical guideline on this issue. This recommends that antibiotics to prevent infective endocarditis should not be given to adults and children with structural cardiac defects, who are undergoing dental and a number of non-dental interventional procedures.

The 2008 NICE guideline is based on the best available published evidence and a consensus of multidisciplinary, expert opinion within the Guideline Development Group (GDG). The guideline concludes that there is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE and that the clinical effectiveness of antibiotic prophylaxis is not proven.

The evidence also suggests that antibiotic prophylaxis against IE for dental procedures is not cost effective and may lead to a greater number of deaths through fatal anaphylactic reactions than not using preventive antibiotics. NICE has also issued the guidance in a patient-friendly form for the general public; this may be useful when explaining the new protocol to patients. The new guidelines are also summarised in the new edition (No 55, March 2008) of the British National Formulary.

In a revised position statement, Dental Protection advises its members that dentists working within an NHS contract are required under the terms of their contract to observe the guidance of NICE when writing prescriptions. Clinicians working privately may not have a contractual obligation to follow this guidance, but they would need a very strong justification for choosing not to do so. Dental Protection has also issued a most useful set of answers to frequently asked questions for its members.

Antibiotics now redundant for endocarditis prophylaxis

The chief dental officer for England has stated, 'I am delighted that NICE have produced definitive guidance on this complex issue. This will ensure that dentists can give consistent and evidence based advice to their patients. We will work with NICE and other professional bodies to ensure that this advice is disseminated to the profession so that dentists will be in a position to start applying this guidance immediately.'

The British Dental Association's (BDA) scientific adviser, Professor Damien Walmsley, told Dental Tribune that the association welcomed the new guidance that clarified best practice and places the UK as a leader in this area.. BDA members (including Professor David Wray and Martin Fulford) had been on the reference group and they were able to brief the Health and Science Committee and in turn the Executive Board on this issue.

Some disquiet had been expressed by dentists about how to deal with a situation where the patient's cardiologist recommends that antibiotics should continue to be prescribed despite what the guideline says. Professor Walmsley said that the new guidelines applied to everyone working in the NHS and they were now the definitive guidance. He also pointed out that there were several well respected and eminent cardiologists on the reference group.

NICE's summary of the guidance is reproduced on page 2 of this issue, but readers may find it useful to look at the full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) which can be found at: *www.nice.org.uk*

National Institute for Health and Clinical Excellence: prophylaxis against infective endocarditis

Summary and list of all recommendations on antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures – issued March 2008

Adults and children with structural cardiac defects at risk of developing infective endocarditis

Healthcare professionals should regard people with the following cardiac conditions as being at risk of developing infective endocarditis:

- acquired valvular heart disease with stenosis or regurgitation
- valve replacement
- structural congenital heart disease, including surgically corrected or palliated structural conditions, but excluding isolated atrial septal defect, fully repaired ventricular septal defect or fully repaired patent ductus arteriosus, and closure devices that are judged to be endothelialised
- previous infective endocarditis
- hypertrophic cardiomyopathy

Patient advice

Healthcare professionals should offer people at risk of infective endocarditis clear and consistent information about prevention, including:

- the benefits and risks of antibiotic prophylaxis, and an explanation of why antibiotic prophylaxis is no longer routinely recommended
- the importance of maintaining good oral health
- symptoms that may indicate infective endocarditis and when to seek expert advice
- the risks of undergoing invasive procedures, including non-medical procedures such as body piercing or tattooing

Prophylaxis against infective endocarditis

Antibiotic prophylaxis against infective endocarditis is NOT recommended:

- for people undergoing dental procedures
- for people undergoing non-dental procedures at the following sites:
  - upper and lower gastrointestinal tract
  - genitourinary tract; this includes urological, gynaecological and obstetric procedures, and childbirth
  - upper and lower respiratory tract; this includes ear, nose and throat procedures and bronchoscopy.

Chlorhexidine mouthwash should not be offered as prophylaxis against infective endocarditis to people at risk of infective endocarditis undergoing dental procedures.

Infection

Any episodes of infection in people at risk of infective endocarditis should be investigated and treated promptly to reduce the risk of endocarditis developing.

If a person at risk of infective endocarditis is receiving antimicrobial therapy because they are undergoing a gastrointestinal or genitourinary procedure at a site where there is a suspected infection, the person should receive an antibiotic that covers organisms that cause infective endocarditis.

Overview

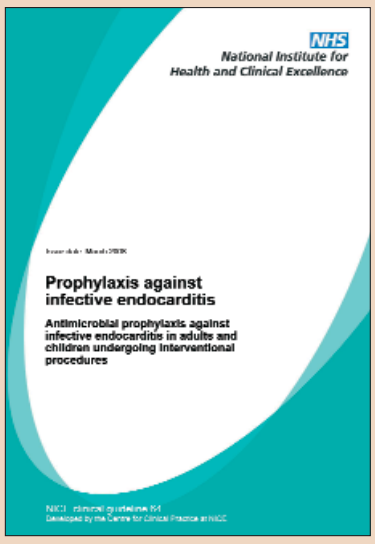
Antimicrobial prophylaxis against infective endocarditis in adults and children undergoing interventional procedures

Infective endocarditis (IE) is an inflammation of the endocardium, particularly affecting the heart valves, caused mainly by bacteria but occasionally by other infectious agents. It is a rare condition, with an annual incidence of fewer than 10 per 100,000 cases in the normal population. Despite advances in diagnosis and treatment, IE remains a life-threatening disease with significant mortality (approximately 20%) and morbidity.

The predisposing factors for the development of IE have changed in the past 50 years, mainly with the decreasing incidence of rheumatic heart disease and the increasing impact of prosthetic heart valves, nosocomial infection and intravenous drug misuse. However, the potentially serious impact of IE on the individual has not changed (Prendergast 2006).

Published medical literature contains many case reports of IE being preceded by an interventional procedure, most frequently dentistry. IE can be caused by several different organisms, many of which could be transferred into the blood during an interventional procedure. Streptococci, Staphylococcus aureus and enterococci are important causative organisms.

It is accepted that many cases of IE are not caused by interventional procedures (Brincat et al. 2006), but with such a serious condition it is reasonable to consider that any cases of IE that can be prevented should be prevented. Consequently, since 1955, antibiotic prophylaxis that aims to prevent endocarditis has been used in at-risk patients. However, the evidence base for the use of antibiotic prophylaxis has relied heavily on extrapolation from animal models of the disease (Pallasch 2003) and the applicability of these models to people has been questioned. With a rare but serious condition such as IE it is difficult to plan and execute research using experimental study designs. Consequently, the evidence available in this area is limited, being drawn chiefly from observational (case–control) studies.



The rationale for prophylaxis against IE is: endocarditis usually follows bacteraemia, certain interventional procedures cause bacteraemia with organisms that can cause endocarditis, these bacteria are usually sensitive to antibiotics; therefore, antibiotics should be given to patients with predisposing heart disease before procedures that may cause bacteraemia (Durack 1995).

For prophylaxis to be effective, certain requirements must be fulfilled: identification of patients at risk, identification of the procedures that are liable to provoke bacteraemia, and choice of a suitable regimen. There should also be a favourable balance between the risks of side-effects from prophylaxis and development of the disease (Moreillon et al. 2004). Underlying these principles is the assumption that antibiotic prophylaxis is effective for the prevention of IE in dental and non-dental procedures. However, many researchers consider this assumption to be not proven (Prendergast 2006), which has led to calls to significantly reduce the use of antibiotic prophylaxis in this setting. This shift in opinion is reflected in national and international clinical guidelines for prophylaxis against IE. Guidelines used to recommend antibiotic prophylaxis for IE for patients with a wide range of cardiac conditions be given for a range of interventional procedures, both dental and non-dental. They now tend to recommend that only those with one of a small number of high-risk cardiac conditions should receive antibiotic prophylaxis when they undergo a limited number of specified dental procedures.

Throughout the history of prophylaxis being offered against IE, professional organisations have sought to clarify the groups of patients that are considered to be at risk of IE and the procedures (dental and non-dental) for which prophylaxis may be considered. The Guideline Development Group (GDG) used the decision making and conclusions of relevant national and international guidelines to help inform its own decision making. This decision-making process has been important because, for many of the key clinical questions covered in this guideline, there is no evidence base that would meet rigorous quality criteria. Four clinical guidelines on the prevention of IE are discussed in subsequent sections: American Heart Association (AHA) 2007 (Wilson et al. 2007), British Society for Antimicrobial Chemotherapy (BSAC) 2006 (Gould et al. 2006), European Society of Cardiology (ESC) 2004 (Horstkotte et al. 2004) and British Cardiac Society (BCS)/Royal College of Physicians (RCP) 2004 (Advisory Group of the British Cardiac Society Clinical Practice Committee 2004).

The recommendations of these four guidelines, and where reported the rationale for their recommendations, have been considered by the GDG in the development of this guideline. However, it should be emphasised that the GDG has based its recommendations on an independent consideration of the available clinical and cost-effectiveness evidence and, where appropriate, expert opinion. The guideline developers have also sought to make the rationale for their recommendations as transparent as possible, set out in the relevant 'Evidence to recommendations' sections.

This clinical guideline aims to provide clear guidance to the NHS in England, Wales and Northern Ireland regarding which dental and non-dental interventional procedures require, or do not require, antimicrobial prophylaxis against IE. In contrast to other recently published national and international guidelines, it explicitly considers the likely cost effectiveness as well as the clinical effectiveness of antibiotic prophylaxis.

In summary, this guideline recommends that antibiotic prophylaxis solely to prevent IE should not be given to people at risk of IE undergoing dental and non-dental procedures. The basis to support this recommendation is:

- there is no consistent association between having an interventional procedure, dental or non-dental, and the development of IE
- regular toothbrushing almost certainly presents a greater risk of IE than a single dental procedure because of repetitive exposure to bacteraemia with oral flora
- the clinical effectiveness of antibiotic prophylaxis is not proven
- antibiotic prophylaxis against IE for dental procedures may lead to a greater number of deaths through fatal anaphylaxis than a strategy of no antibiotic prophylaxis, and is not cost effective.

Given the difficulties in relative risk definition, a simple classification of conditions into either groups at risk and not at risk was undertaken.

The full report (CG64 Prophylaxis against infective endocarditis: NICE guidance) and guidance for patients can be seen at: *www.nice.org.uk* DT

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Is the answer the £1 UDA?

Michael Watson looks at the controversy over units of dental activity (UDAs) and suggests a fundamental rethink on the issue.

When the concept of the £1 UDA was first put to me by an economics expert, my first reaction was to suggest that she take a little more water with it. After all much of the controversy over UDAs centre around their low value especially after a tendering process and concern about what might happen after 2009. But as she explained the concept I warmed to it.

But first let us look at the background. At this time of year the media runs stories about dentists running out of UDAs and spend more time with their golf clubs or on exotic foreign holidays, leaving patients in the lurch. As an aside we might question why this is a story, if dentists have worked hard to achieve their targets, surely they deserve some relaxation.

Nevertheless there are sections of the media that disapprove of dentists enjoying themselves and the department of health says that they should manage their workload evenly throughout the year. Some PCTs are in a position to offer some additional UDAs on a temporary basis to ensure continuity of services.

So where does the £1 UDA fit in? Under this suggestion all UDAs would be valued at £1. In an average contract this would mean about £7,000 of the contract value would be accounted for by UDAs. This would be the maximum that could be clawed back for failing to reach the target, although in reality such clawbacks would be far less.

The rest of the contract value would be paid for the other services that the practice must provide. For instance nearly half used to pay overheads, such as staff wages, rent, equipment materials and office expenses. These must be paid whether or not the practice achieves its UDA target. It is iniquitous that this element of the contract value is subject to clawback when the payments have been made.

The rest of the contract value is a payment to the dentist(s) for keeping the practice open and being available to patients; opening times already form part everyone's contract as it is. The primary care trust (PCT) could agree with the practice a range of services that could be offered, such as a prevention programme, simply to see more patients or patients from specific postcodes.

In coming years the focus of PCTs will have to move away from UDA targets and towards better access to more patients. This is now a national NHS requirement and they will be judged on whether they achieve it. They will not do this by continuing with their current obsession over UDAs.

The £1 UDA does not require redrafting of the regulations and it removes from dentists the threat of clawback. It also allows dentists and PCTs to work together to provide services that are more effective and more relevant to their patients. Not the bad idea I first supposed. DT

Polish dental tourism expands

British-Polish medical tourism provider, StatMedica, has added a new dental clinic in the outskirts of Warsaw to its portfolio. The company now claims to be able to expand on its ability to offer high quality dental care at some of the most competitive prices in Europe, with dental implants starting at £480, crowns starting at £200 and veneers starting at £250. These prices, it says, 'are approximately 70 per cent less than the typical price of treatment in the UK'.

Low-cost flights from cities across the United Kingdom to destinations across Poland and affordable hotel accommodation in Poland ensure that significant cost-savings can apparently be made by travelling to Poland. Alison Hope, director of StatMedica's London office said: 'The cost savings that can be made by travelling to Poland for dental treatment are immense even once you factor in the cost of flights and accommodation'

But BDHF advises against

However the British Dental Health Foundation (BDHF) has backed a 'Which?' report advising against going for medical treatments abroad. It has urged members of the public not to travel abroad for dental treatment after a report by consumer advice group found that almost one in five medical tourists suffer problems after treatment.

The BDHF was speaking after the report revealed that more than a quarter of patients travelling abroad for medical treatment did not feel they received the follow-up care they needed, while a further 18 per cent reported complications. The survey follows a recent warning against dental tourism by the Foundation after a number of callers to its free Dental Helpline service (0845 063 1188) reported that they did not know how to resolve problems that followed dental treatment undertaken outside of the UK .

Dr Carter, chief executive of the Foundation, commented: 'It is a big concern that UK patients are so willing to travel abroad for dental treatment without being fully aware of the risks. Not all dentists are as highly trained as those in the UK, where extensive training and strict examinations are undertaken to ensure they meet the high standards required and this also applies to foreign dentists practising in the UK .

'So called 'dental holidays' are presented as a cheap and hassle free alternative to getting treatment in this country but we know from calls to our Dental Helpline that if things do go wrong then they are anything but, as patients can be left facing all sorts of questions; am I willing to fly back? What are my legal rights as a foreign patient? Am I prepared to go through the courts? Do I have the money required to correct the treatment in this country?' DT

Dentists asking for retired list

The Dental Practitioners Association (DPA) has backed Baroness Gardner of Parkes, who is seeking to amend the forthcoming Health and Social Care Bill to enable retired dentists to stay on the General Dental Council (GDC) Register at a nominal cost and without CPD requirements. The baroness is herself a retired dentist.

During the second reading of the Bill in the House of Lords on March 25, 2008, she said 'This lack of distinction between the honourable and the dishonourable absence from the register is invidious and has upset many dentists... There is a public interest in non-practising dentists remaining on the list, as many non-practising dentists continue to work on boards, trusts, charities and other bodies, public and private. If they claim to have been dentists with an honourable record, it should be verifiable'.

Baroness Gardner is appealing to interested dentists to write to their MPs in April supporting her amendment, which will enable the GDC to set up a separate list for dentists not currently practising. At present, dentists who retire and do not wish to keep up with the requirements for CPD and pay the £438 registration fee are struck off.

'This is what I object to the most', said Baroness Gardner speaking to the DPA, 'You get a letter saying you have been struck off after a lifetime of honourable service. It is the same whether you are a retired dentist or have been struck off for malpractice'. The DPA believes that all dental professionals have a right to appear on the GDC register as a right by virtue of their qualifications—except those who have been removed on disciplinary grounds. DT

DPA's Derek Watson backs call for dentists to remain on GDC list after retirement

Record entries for the student technician award

Rachel's patriotic baseplate design

Congratulations go to Rachel McMichan on winning the 2008 British Orthodontic Society (BOS) student technician award.

Rachel received her award at the Orthodontic Technicians Association (OTA) annual conference in Edinburgh which took place on March 14-16, 2008, from David Bearn, chairman of the BOS scholarship & grants committee.

This year's competition attracted a record number of entries and the judges had a very difficult time selecting the winner.

The entrants were required to prepare a removable appliance to a given prescription, and Rachel's imaginative use of colour in the baseplate certainly stood out. The entrants also had to design and produce an appliance to achieve certain tooth movements and present a written commentary on the rationale for the design chosen.

Rachel McMichan receives her award from David Bearn

Rachel's prize was a complimentary conference package to attend the OTA conference in Edinburgh, along with a cheque from the BOS. DT

PCTs fight back on access

PCTs claim more patients getting check-ups

For as long as most of us can remember access to NHS dentistry, or rather lack of it, has dominated the media. This was accentuated by the recent figures showing that since the new contract came in a quarter of a million fewer patients had been seen.

Primary Care Trusts (PCTs) have been pulling out all the stops to try and paint the opposite picture, putting out press releases whenever new practices have been established. The department of health tells us that from this April the focus will be on making sure more people are seen, rather than the current pre-occupation with units of dental activity. In the meantime, here are some stories from around the country.

PCT's dental access pledge

PCT managers have pledged that soon no-one in Burnley and Padiham should be waiting to see an NHS dentist. Thousands of people in East Lancashire gave up trying to find a dentist two or three years ago, amid a number of practices deciding to see only private patients.

But now Burnley MP Kitty Ussher says more dentists are carrying out NHS work and she has received a letter from East Lancashire Primary Care Trust saying that substantial progress has been made in tackling the issue. Trust chief executive David Peat has told the MP it is hoped that everyone currently on their dental access allocation list will be offered an NHS dentist in the near future.

Sheffield PCT invests in services

People across Sheffield are set to benefit from a £400,000 investment from Sheffield PCT in NHS dental practices. The investment is expected to increase access for NHS patients in the city. 17 practices that offer an NHS service throughout the city will be receiving the funding, which will allow them to either to continue to accept new NHS patients if they currently do so or give faster treatment to those patients who are waiting to receive NHS dental care.

John Green, director of dental public health said: 'This is a great opportunity to make sure people don't have to wait too long for dental care, by offering earlier treatment appointments.'

Scarborough in news again

In 2004 Scarborough hit the national media when hundreds of people were filmed as they queued to be put on the list of an NHS dentist in the town. Now, a spokesman for North Yorkshire and York PCT said the current situation was 'very positive' and so far this year 2,189 patients had been allocated an NHS dentist. DT

Westminster week

Prime Minister backs water fluoridation

At prime minister's questions on March 26, conservative MP and dentist Sir Paul Beresford asked Gordon Brown to confirm that he agreed with the need for fluoridation, and would he meet a delegation to discuss the changes needed to implement it.

The prime minister replied that he was personally very sympathetic to what Sir Paul had said and had seen the benefits of fluoridation himself. One reason for the Government putting extra money from the health budget into fluoridation was to encourage that to happen around the country. He added that he would be very happy to meet the proposed delegation. 'It is a good thing for the teeth of the people of this country' said the prime minister

Health questions

Philip Hollobone conservative MP for Kettering had an oral question down for health ministers last month. He wanted a statement on access to NHS dentistry in both his constituency and England. The reply was given by the minister of state, Ben Bradshaw, who said that there had been an increase of seven per cent in the number of dentists in Northamptonshire last year; nationally there were 4,000 more dentists than in 1997, and investment in NHS dentistry has more than doubled.

Mr Hollobone pointed out, however, that according to the latest figures the number of patients in Northamptonshire seen by their dentist has fallen by 13,000 since the new dental contracts were introduced. He also pointed out that Northamptonshire primary care trust (PCT) had yet to undertake a needs assessment of children's orthodontics. The minister urged the PCT to get on and do it. He also said there was now a requirement for all PCTs to increase, year on year, public access to NHS dentists. 'There is no excuse for any PCT, including the hon. Gentleman's, not to improve its results', he said.

A friendly labour backbencher and fellow Devon MP, Linda Gilroy asked the minister to join her in congratulating Plymouth PCT, which a short time ago had 12,000 patients on its waiting list, but had turned things around and now had about 500 patients on it. The minster was happy to do this and also congratulated his own PCT (Exeter), which had halved the number of people on its waiting list in the past 12 months.

However the conservative shadow dentistry minister, Mike Penning, attacked the minister for denying that there was a crisis in NHS dentistry, despite the evidence in the recent Patients Association report. 'Whom should we believe' he asked, 'the Government or the Patients Association'. The minister said he would rather listen to the testimony of MPs, speaking from experience of their constituency, and to the facts.

'Given the introduction of the new contract, and the new investment that is now coming on stream in dentistry, I am afraid I have to tell the hon. Gentleman that not for much longer will he be able to say in the House that NHS dentistry is in crisis', he concluded. DT

USA news round-up

The old saying is that if Wall Street catches a cold, the City of London develops pneumonia. Not always true in dentistry with our two very different healthcare systems, but ideas, materials and techniques do cross the Atlantic. Many news stories from the USA also have echoes in the UK, so here are some that caught the editor's eye.

Grey health

A study by Tefen USA, a management consulting company, warns that 'the approaching onslaught' of more than 70 million aging baby boomers could 'overwhelm' the USA health care system and engulf the economy. A recent report from the Centers for Medicare and Medicaid Services (CMS) predicts that US health care spending will double to just over $4.3 trillion by 2017, nearly 20 percent of the nation's gross domestic product. Tefen warns that CMS' projection could actually be too low because people over 65 face nearly three times as many hospital days per thousand as the general population, and 62 percent of 50-to-64-year-olds have at least one of six chronic health conditions: arthritis, high cholesterol, cancer, diabetes, heart disease and hypertension.

Oral Cancer

Approximately 35,000 Americans are diagnosed with oral cancer each year and nearly 8,000 people died of these cancers in 2007 alone. Early detection is an integral part in battling the disease and can even help identify precancerous cells before they become cancerous. The Pennsylvania Dental Association (PDA) stresses that regular dental checkups play an essential part in the early detection of oral cancer.

No laughing matter

A Long Island dentist has been arrested for inhaling laughing gas (nitrous oxide) for non-medical reasons. Police arrested Dr Norman Rubin and charged him with inhalation of hazardous inhalants, a misdemeanor. They were called to Rubin's office by a patient who found the dentist in apparent distress. Police and emergency medical technicians learned that Rubin had been inhaling nitrous oxide. After being treated, he was arrested.

Independent hygienists

Dental hygienists in the USA may secure right to operate independently. The New Hampshire and Maine state legislatures are considering whether dental hygienists should be allowed to set up their own practices, or at least operate with more autonomy. However retired dentist Ray Jarvis of Rye, secretary of the New Hampshire Board of Dental Examiners, said the board is opposed to any legislation that would let hygienists establish private practices. Jarvis said hygienists must work under dental supervision so serious oral diseases are not missed.

Shop and bleach

Regulators in the States are looking into business that set up in shopping malls and offer tooth whitening. Many not only sell the products but offer customers the opportunity to use them right then and there. Shoppers like them because they are convenient and cheap -- usually about $100 instead of the $500 or $600 charged at a dentist's office. But regulators and dentists have raised concerns about the safety of such practices. Officials say the question that needs to be answered is whether the people at the kiosks are technically performing dental work, which would be illegal. DT

The 10th Dimension—The power of 10…

…a series of articles by Dr Ed Bonner BDS MDent, Sloan Fellow London Business School, practice coach & development consultant

10 things you should know about delegation

1. Understanding delegation

Delegation is a skill essential to any manager and practice owner. Used effectively, it enables expansion of that most powerful and elusive of resources available to a leader – time. There is no other management technique that can buy time as beneficially as delegation. Delegation involves entrusting another person with a task for which the delegator remains ultimately responsible. That person should be able to perform the task using available resources or having the skill, ability and drive to find additional resources if necessary.

Practice owners should delegate stock control

2. Selecting tasks

An example of a delegatable task is stock control. No practice owner should be the one finding out what materials are required, where to get them at the best possible price, and ensuring that the practice neither runs short of nor has a surfeit of necessary materials. An intelligent leader will appoint someone competent to carry out these tasks, and the sole responsibility of the leader is to monitor levels of spending and stock volumes. While someone else is sitting at the computer or telephone doing the ordering, the healthcare professional is either attending to patients, writing reports or letters or reading journals, none tasks which can be delegated.

3. Why delegate?

If you often say 'I don't have enough time', you are badly organised and a poor delegator.

A manager who does not delegate cannot possibly find the time to complete all the tasks that land on his/her desk. Keeping hold of minor tasks impedes your ability to deal effectively with more important issues. A top manager is someone with a remarkably clear desk. Encourage people who claim to be overworked to log their time – analysis of staff work time will invariably reveal spare capacity.

4. Under-use of delegation

Insecure managers who do not delegate underuse employees, which acts as a demotivator to others who know they can do the job at least as well as you but at significantly lower cost. The cost of delegation should not outweigh the costs of non-delegation.

5. What is involved in delegation?

Delegation involves the loss of direct control but the retention of direct responsibility. The basic elements involved in delegation are autonomy and control. When delegating, ensure that the delegate is fully aware of the objectives, which should be stated clearly and concisely. Base the objectives on required outcomes.

6. Accountability

Accountability is at the very core of delegation, so it is essential that delegates know what their responsibilities are. All guidelines should be set in writing, delegation works best when accountability for any particular task rests with one individual.

7. Choosing the right person

It is very important to choose the right person for the task in hand. The first few times it will be trial and error, but experience brings improved skill assessment and better person selection. Letting go of work gets easier the more you do it. Show faith in your chosen person, even if others have reservations. Do strive to regard your staff as competent people. If you do not trust a member of staff to do a job, it is better not to retain that person.

8. Training

Delegation is an important part of the training process. Consider which skills will need to be developed and taught to enable the delegate to be able to carry out the task successfully. Proper training will motivate the delegate and strengthen their self-confidence.

9. Feedback

Meet regularly, but not overfrequently, for feedback sessions. As a delegation proceeds, you should gradually reduce the frequency of meetings. When discussing progress always use questions in a positive way that is likely to bring solutions to problem areas rather than being overly-critical. Encourage delegates to provide their own solutions.

10. Provide backup

Ensure you provide enough support and back-up to each person delegated a task, especially when things go wrong. Don't use delegates as scapegoats when things go wrong. Establish a culture that recognises success and avoids blame for failure. If delegation is not working, ask yourself: "What am I doing wrong?" DT

Listening to the market

This is the fifth in a new series of articles by Dr Ed Bonner

A modern adage: when you can see a bandwagon, you've missed it!

Market opportunities

Every business (and dentistry is no exception) needs to be able to identify new market opportunities. None can rely nor depend on present products or services, nor on the existing market lasting forever. Many practice owners may think that there are few opportunities to develop and renew themselves regularly, but this simply shows a lack of a strategic overview and a lack of belief in their own abundant strengths. In preparing a marketing plan, we need to listen carefully to what the world out there is saying about itself, about us, and to us. We don't want surprises. We dare not live in that protected cocoon called: 'this does not apply to me, I'm a dentist not a businessman'. Our comfort zone of the past is under siege.

We require information

To understand what our patients/customers want, we need a plentiful supply of timely, accurate information: information about the environment; about how we are perceived by the media and by the public; about government thinking. We need all of this because we need to be able to respond rapidly to current fashions, trends and, not least, prejudices. This information will come from market research, which tends to be an expensive luxury for us. For us, but not for our suppliers, so it is they who will set the agenda for us, rather than the other way round. We thus need to know what our suppliers are thinking about, what our researchers and scientists are doing. We can also benefit indirectly from their education of the public through advertisements. If a major company spends millions on extolling the virtues of their new electric toothbrush, we can sell them like hot cakes because our patients will be asking about them. On the other hand, some professionals may see this as coercive indoctrination where the process moves from informative to persuasive, and they may wish to have no truck whatever with such a process.

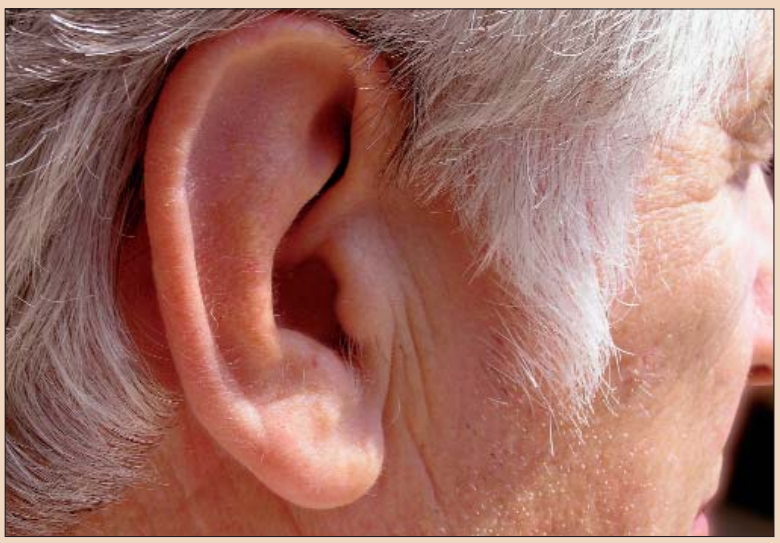
Gathering market intelligence

What dentists can do is involve themselves more actively in intelligence gathering. Market intelligence is everyday information about important environmental events, new laws, social trends, technological breakthroughs, demographic shifts and competitor manoeuvres. From a marketing perspective, the following questions need to be answered:

- What decisions are we regularly called on to make?
- What types of information do we need to make those decisions?
- How do we get the information we need?

We can get this information in a variety of ways: here's 10

- Reading dental journals and magazines from a different perspective
- Attending lectures, courses, seminars and workshops
- Talking to trade representatives
- Government publications
- Through associations/organisations such as CODE
- Reading adverts and advertorials by other practices in local magazines
- New staff employed from other practices – they are competitor ex-employees!
- Listening to our patients
- Watching television and reading newspapers
- Searching the web.



Listen to the market

The good news is that all the above are within our existing capabilities. The better news is that not one of the above list will cost you a single penny. What will cost you is not to do anything.

Planning from strength

Once we have the necessary information, we can plan either defensively, for example, respond to developing trends, or more offensively, for example, we can be the trendsetters. Put another way, we should ideally be proactive; if not we should at least be reactive. What we cannot be is inactive. Information brings knowledge – knowledge gives power. We can use that power wisely, or we can succumb to others using it for different and perhaps less well-meaning ends.

Since selling his prizewinning dentistry100 practice, Ed Bonner has continued to act as a consultant and practice coach to the dental profession, working with individuals as well as groups of dentists. He can be reached at bonner.edwin@gmail.com DT

Measure for measure

If you want to increase production and revenue at your practice, you need to keep a close eye on your progress and spending, says Simon Hocken

I am still amazed how many clients continue to run their businesses on their bank statements, plus the annual meeting with their accountant. Each month, they roll the dice and take home whatever's left in their business account (and sometimes more). In this article, I want to make the case for a coaching phenomenon; that if you measure your performance you will improve your performance.

Do you measure up?

'Everything You Measure Gets Better' is a coaching phrase that's worth a second look. Here's how it works. If you want to lose weight, weigh yourself often and keep a record. The act of weighing yourself and recording it reminds you and your subconscious that you want to lose weight. If you want to reduce your personal debt, create a spreadsheet that measures your situation and refer to it monthly. Circle a date in your planner when you will update the spreadsheet, look at the result and see the progress.

Keeping a record

If you want to increase the production in your practice, put a notebook in the surgeries of all the fee earners. Then ask all the fee earners (not their nursing assistants) to write down the procedures they carry out for every patient every day, add a value in pounds and then total the figures daily. It's called, 'keeping a daybook' and it's the best way I know of increasing personal 'production'. Computer software can measure the same thing but the outcomes are much better when the fee earners use pen and paper and fill the numbers in themselves.

It's important to fill in the daybook as the day progresses, not at the end of the day retrospectively. The reason for this is that the daybook acts as a 'real-time' record of how the day is going (financially) and if half way through, it's not looking good, it may be possible during the second half of the day to make up some lost ground by changing the focus of an appointment(s).

Attention to detail

In many cases, this small task is all that's necessary to improve the personal production of the dentists and other fee earners and get a poorly performing practice back on track. The very act of measuring focus's your team's attention on what they are doing/not doing and their production improves. I recently worked with a dentist whose daily gross fees increased by a third just by doing this!

The next step in using this tool is to set targets and to measure your situation against a target that represents success, (be it; weight loss, debt reduction or dental productivity!) The trick here is to measure and measure often against a realistic, incremental target. And the next trick is to give yourself/them a reward when you/they reach these targets!

Key performance indicators

I find that I can often measure a dental practice's financial success by using a relatively small number of key performance indicators. I think of them as like a health check. Just like the clipboard that used to hang on the end of a patient's bed, which the Consultant would pick up and quickly see the vital signs and progress of the patient. I have observed that dental principals who have put in place their own version of this "health check" and look at it regularly, often have more successful practices than those that don't.

Setting goals for the turnover of your practice, the net profit it creates and your personal income forms part of your vision for your professional future and should never be left to chance. Measuring your progress against targets is an effective way of making real progress and turning your plans into reality.

Ten things worth mentioning in your practice:

1. Daily production of every fee earner in pounds
2. Daily collection of every fee earner in pounds
3. Total practice sales
4. Total Practice expenses
5. Net profit
6. Cash flow
7. New patients
8. Patient retention (as a percentage)
9. Client satisfaction (using feedback questionnaires)
10. Employee satisfaction (using personal interviews).

Ten things worth measuring in your personal life:

1. Weight
2. Fitness/health
3. Net worth
4. Bank balance
5. Wealth creation activities (as opposed to income)
6. Days off
7. Glasses of water daily
8. Cups of coffee/tea daily and alcohol units weekly
9. Time spent exercising weekly
10. Cholesterol/ blood pressure/ resting pulse rate.

The practice health check

Five key performance indicators for every dental practice.

1. Average daily productivity in '£' of all fee earners (from day book, not from money over counter) graphed each month to show trends.
2. Net Profit of practice as a percentage graphed each month to show trends.
3. Bank account, worst figure, best figure each month, (tracked as a graph).
4. Active patient list size for each dentist, (tracked as a graph)
5. New patient numbers per month, sex, age, location, source.

And I suggest you measure people by what they do, not by what they say they will do. DT

About the author

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