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April 2015

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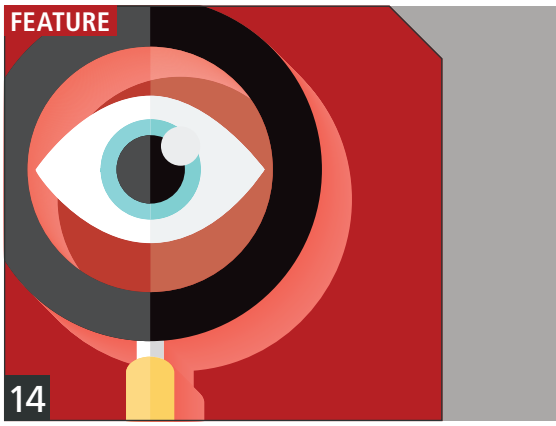

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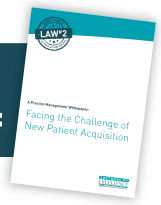

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App for conference 2015

THE BDA IS excited to launch a brand-new event app for conference delegates. The app (see below) is suitable for both Apple and Android devices and makes managing your time and getting around even easier than before. The app is available to download now through the Apple App Store or Google Play: search for "BDA Conference 2015".

The app will help you navigate the venue and exhibition and find conference sessions and exhibitors with interactive maps. Delegates can also sign up to event notifications to receive important messages on event news and not-to-be-missed sessions over the three days of the conference and exhibition.

A personal-agenda feature on the app will allow delegates to browse full programme information covering all clinical, business and core CPD sessions and to add sessions they would like to attend to their own personalised event diary. Exclusive show offers from some of the biggest names in dentistry are also held in the app, ensuring delegates won't miss out on special discounts, promotions and competitions.

Delegates can also add their voice to the event by accessing Twitter and Facebook directly through the app to interact and share views with delegates, speakers and exhibitors.

This year's event will take place from 7-9 May at the Manchester Central Convention Complex with over 100 leading names in dentistry from the UK and Europe presenting.

To register for your place visit www.bda.org/conference or call the registration team direct on 0870 166 6625. ◆

Check the conference website and follow us on twitter for the latest conference news and updates:
www.bda.org/conference | @BDAevents | @BDAconference

England dental charges 2015/16

FROM 1 APRIL 2015, the dental charge payable for a Band-1 course of treatment became £18.80, an increase of 30p. A Band-2 course of treatment now costs £51.30, an increase of 80p. And the charge for a Band-3 course of treatment has increased by £3.50, to £222.50.

Information for patients on dental charges, including a link to the NHS dental-charges poster and leaflet, is available on the *NHS Choices* website. ◆

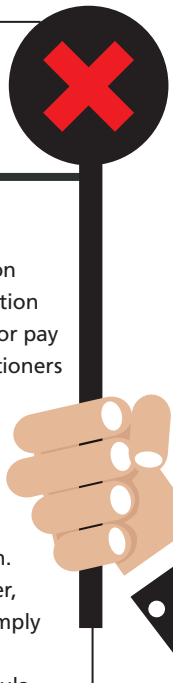
CQC fees stay the same

DENTAL PROVIDERS WILL pay the same fees to the Care Quality Commission (CQC) as they have done in 2014/15 because the cost of their regulation is recovered fully already.

In the summer, CQC will introduce the option for providers to pay by instalments and by direct debit, to help them manage their cash flows.

Also, CQC will publish a calculator on its website this month to help providers work out their exact fees for 2015/16, alongside detailed fees guidance. ◆

DDRB has got it wrong again



BOTH THE APPROACH and conclusions of the Review Body on Doctors' and Dentists' Remuneration (DDRB) in its recommendations for pay awards for general dental practitioners (GDPs) in England for 2015/16 are wrong, the British Dental Association has said.

The DDRB has opted to leave the question of dental expenses for GDPs to negotiation. Rather than negotiating, however, the Department of Health has simply applied a Retail Price Index (RPI) uplift to the review board's formula, producing a 1.34% uplift for GDPs in England.

It has again failed to grasp the 25% decline in real incomes since 2006, the BDA has said, and has called for action on establishing a new basis for calculating dental expenses.

"We aren't surprised by the DDRB's conclusions, but we are unhappy about their approach," former chair of the BDA's General Dental Practice Committee (GDPC) John Milne said.

"The DDRB has backed a low uplift and placed dental expenses on the too-difficult list. So now we have the unedifying sight of the Government stepping in to provide a quick fix as a substitute for meaningful negotiation.

"What we need is a fit-and-proper mechanism for establishing an uplift for expenses, not last-minute improvisation. The disproportionate rise in expenses facing practitioners cannot continue to go unrecognised. It needs proper consideration."

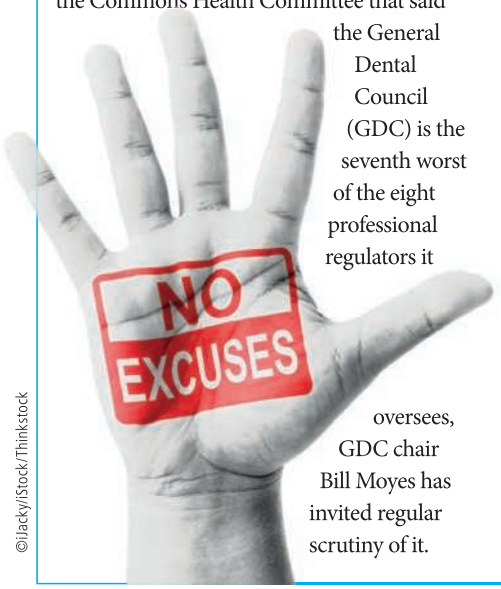
The DDRB has not made a recommendation for employed dentists in England for 2015/16 following the Department of Health's decision last year to implement a two-year pay award. Dentists at the top of their pay scale will receive a non-recurrent uplift, those in receipt of an incremental point will not receive an uplift.

Between April 2006 and March 2013 mean average taxable income for GDPs in England and Wales fell by 24.5%. ◆

GDC SCRUTINY

Annual accountability of GDC

FOLLOWING WRITTEN EVIDENCE from the Professional Standards Authority to the Commons Health Committee that said the General Dental Council (GDC) is the seventh worst of the eight professional regulators it oversees, GDC chair Bill Moyes has invited regular scrutiny of it.



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In supporting this proposal, chair of the BDA's Principal Executive Committee Mick Armstrong said: "These can't just be polite parting words. It is essential now for both patients and practitioners that the GDC is held to account on a regular basis. A one-off will not bring a troubled regulator back from the brink.

"The Health Committee put the regulator under forensic scrutiny, raising real questions about trust, confidence, competence and leadership at the regulator.

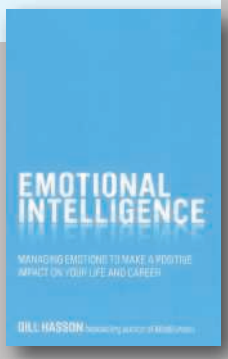
"Important questions were posed, but answers were in short supply. The GDC's representatives demonstrated a shaky grasp of their own numbers.

"They failed to show progress on concrete improvements, and conspicuously failed to take any responsibility for problems of their own making." ◆

BOOK REVIEW

Optimism is infectious

Emotional intelligence – managing emotions to make a positive impact on your life and career
Gill Hasson
Capstone, 2014
ISBN: 978-0-857-08544-3
£10.99



Gill Hasson's message throughout is to turnaround negativity and use it to create positives. She begins by explaining how to understand emotions, discussing – albeit peremptorily – the neurophysiology of emotions, the role of the limbic system and the safety role of emotion – the fight-or-flight response.

The second part of the book deals with managing emotions and in the context of being assertive (or rather, *not* being assertive) she recommends that it is useful to notice how you *feel* about a certain demand or criticism (someone telling you to stop behaving in a certain way). This seemingly obvious exercise is actually very useful because, in becoming detached from the immediate emotion of say, anger or frustration, it can help to clarify what you want to do and analyse your feelings to maintain equilibrium and perhaps *not do* what you might later regret.

Hasson also encourages the reader to recognise the benefits of bad experiences rather than to dwell on their downside. So, for example, not getting a job might have the beneficial effect of learning lessons from the interview, picking up some new information about the job that will be useful in other jobs, or improving interview techniques. She also advocates using a "beginner's mind" by putting aside old prejudices and seeing things anew. Being "nice" also works, since positivity attracts positivity: little things, such as making eye contact, holding the door open for others, and identifying positive people and spending more time with them (since optimism is, apparently, infectious).

The final part of the book puts the theory into practice. How to manage anger is a particularly helpful section. She suggests, when faced with a situation at work where you have been given what, on the face of it, is an unreasonable demand, to try turning it on its head to see the positives. For more about this book: www.bda.org/booknews ◆

GDPC NEWS

GDPC's new chairs

HENRIK OVERGAARD-NIELSEN has been elected the new chair of the General Dental Practice Committee (GDPC). He is based in Fulham, Greater London, where he began an NHS practice in 1999. He previously served as vice-chair.

Richard Emms, from North Yorkshire, and Dave Cottam, from Birmingham, have been elected to serve as the Committee's vice-chairs.

"I am honoured to have been elected as chair," Overgaard-Nielsen said.

"Whilst we need productive working relationships with the Department of Health and NHS England, I am determined to stand up for the profession and to make sure that our views are heard. When it comes to contract reform, we need a faster pace, much more clarity, guarantees that practices will be viable in the transition period, and less interference.

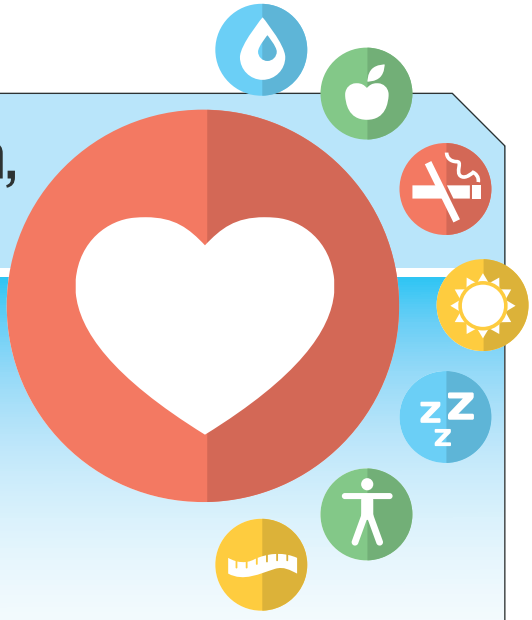
"The Department and Government owe as much to our patients and our profession and I will make sure that the GDPC pushes to make that happen.

"We need a reformed contract that can work for dentists and patients in the real world. But this job is more than just about contract reform. We need to represent the profession effectively across the UK and across a wide agenda – we need fair and proportionate regulation, including a GDC that's fit for purpose, we need a system for setting our pay that works, and we need real clarity on what is actually available on the NHS." ◆

GDPC's new top team (left to right): vice-chair Dave Cottam; chair Henrik Overgaard-Nielsen; and vice-chair Richard Emms

DENTISTS' HEALTH

We're in good health, say most dentists



MOST DENTISTS SAY they enjoy "good" health, according to a survey by the BDA.

The research found that dentists are just as likely to rate their health as "good" as the wider adult population. Four out of five general dental practitioners say they enjoy "good" or "very good" health. This compares with three out of four community dentists, who say they enjoy "good health". Younger dentists (under 35 years old) rate their health most highly.

But dentists who say they experience high levels of stress at work are much less likely to say they are in "good health". This is true of both community dentists and general dental practitioners. This link between work-related stress and general health is particularly pronounced among community dentists, with one in twenty saying they were in "bad health".

The BDA research report is available at: https://www.bda.org/dentists/policy-campaigns/research/workforce-finance/gp/dentists-health ◆

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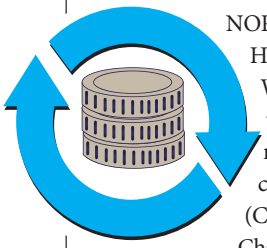
FUNDING

Find funding for CDS, NI



NORTHERN IRELAND HEALTH minister Jim Wells has been urged to find funding for the new contract for the community dental service (CDS) in Northern Ireland.

Chair of the NI Salaried Dentists Committee Margaret McCabe has expressed disappointment that there will be no additional funding during 2014/15 for the proposed new contract because of budgetary constraints.

Members of this group of health service staff have not had their terms and conditions revised since 1987. The BDA says the new contract would cost around £500,000 and would be a relatively small sum in terms of the overall budget.

"We urge the Minister to rethink and prioritise this relatively small amount of funding for this group of dedicated and essential dentists to ensure the future of the service is safeguarded," Margaret McCabe said:

"The CDS is needed by the most vulnerable in our society, and we must ensure that younger dentists see it as an attractive career option, with fair terms and conditions, and one that has comparable pay scales to their counterparts across the UK." ◆

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Participate in **procurement pilots**

ABOUT 200 PRACTICES in Scotland are being urged to participate in government-sponsored pilots of a procurement exercise (called the Analysis of Scottish Dental Accounts) in May. Assessment of it will be based on analysis of their anonymised accounts by corporate financial advisory firm, QMPF.

Practices need to have a 90% NHS commitment and should email info@qmpf.co.uk to express their interest.

There has already been a small pilot exercise and a further 20 practices were approached this month.

The BDA is encouraging practices to participate because it fears that without the robust data on the rising cost of practice expenses the exercise should generate, the Doctors' and Dentists' Review Body (DDRB) will continue to use the out-of-date formula that resulted in the recent mere 1.61% uplift for Item of Services Fees and Capitation and Continuing Care. ◆

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Manifestos dark on dentistry?

by Martin Woodrow,
Director, BDA's Policy and Professional Services

The General Election is just around the corner. By now readers will probably be fed up with talk of "long term plans", "stronger economies", "fairer societies" and "hard working families".

Election campaigns hinge on repetition. Popular policies are distilled into messages, and repeated *ad nauseam*, until – or so the theory goes – the public "get it". They will dutifully pop into their polling station and make their mark accordingly.

And there's no disguising that "health" is a battleground issue. We are receiving assurances from all sides that the "NHS is safe in our hands" as the parties seek to outbid each other on spending.

But where does dentistry sit in that health debate? The simplistic answer is it doesn't. While health sits near or at the top of pile when it comes to issues the public care about, oral health seems conspicuous by its absence.

But the debate is absolutely key to dentistry: you just need to know where to look. We've attempted to look behind the buzzwords and the jargon, at the issues that will shape the future of the profession.

Money

Cold hard cash is the one issue readers will have found it impossible to miss in this election campaign.

Dentistry is, of course, very much a mixed economy between private and public provision. The NHS was protected during the course of the last parliament – certainly in relative terms – and the main parties seem committed to moving forward with something similar. However, it is clear that the service is creaking across the board.

NHS England chief executive Simon Stevens has said that an additional £8bn a year by 2020 is the minimum requirement for the NHS is to continue to meet patient needs and maintain standards of care. Similar concerns have been raised in the other UK countries. The commitments made so far by the main parties do not cover these declared needs. So what will be the consequence? Staff numbers and contractor funding cut? Waiting-times rising? Quality of NHS care deteriorating?

If the future really is so bleak for the NHS will we see a retraction of NHS dentistry and an extension of mixed provision into other parts of the service? Quite possibly, but you certainly won't hear too many politicians having that debate this side of 7 May.

Integration

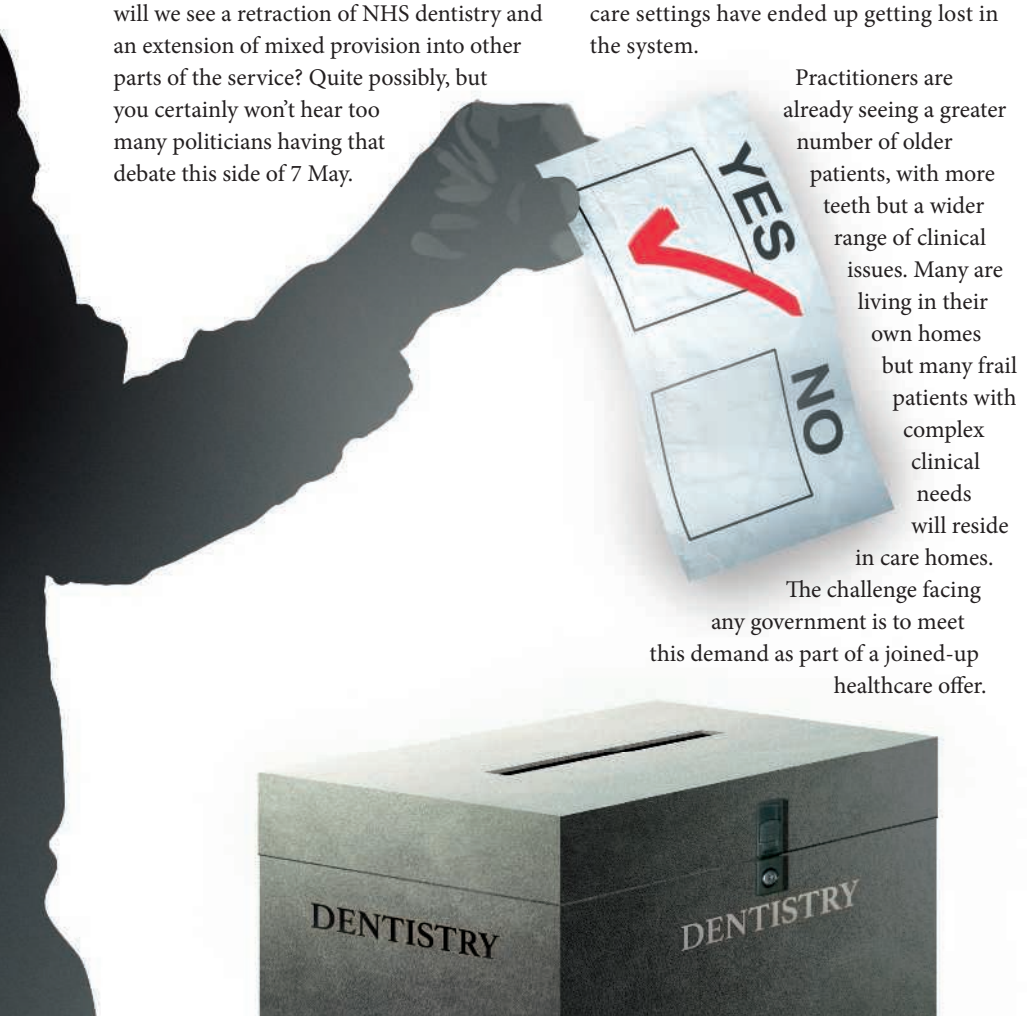
The idea of "whole-person care" is now at the heart of the health debate. The talk is of integration, so healthcare providers and commissioners can better integrate care so services are less fragmented and more accessible to patients.

> "Dental policy has long ceased to be one size fits all. We've already seen what that's meant for the devolved nations, and our national offices and national committees have stepped up to shape very different agendas on pay, practice and commissioning."

But to date that "whole person" doesn't seem to have come with teeth. That needs to change, and as decision-making devolves, we can expect that change to happen.

With an ageing population, it's essential that people with complex care needs can get joined-up treatment, and dentistry must be a part of that mix. Inevitably, patients receiving health- and social-care services from multiple providers and in different care settings have ended up getting lost in the system.

Practitioners are already seeing a greater number of older patients, with more teeth but a wider range of clinical issues. Many are living in their own homes but many frail patients with complex clinical needs will reside in care homes. The challenge facing any government is to meet this demand as part of a joined-up healthcare offer.



The challenge facing the profession will be to make sure its voice is heard in the inevitable integration battle for resources.

Devolution

"Devolution" has become one of the most overused words in the political lexicon. It is pitched as the generous act of handing power down from the desks of Whitehall mandarins to local people, who understand local problems. But is it really that simple?

All the contenders have spelled out their desire to "devolve": but at the BDA we are going to have to fill in the gaps.

Dental policy has long ceased to be one size fits all.

We've already seen what that's meant for the devolved nations, and our national offices and national committees have stepped up to shape very different agendas on pay, practice and commissioning.

Back in Westminster, the Coalition Government has already announced that Greater Manchester would be the first English region to be given control of its health spending. From April 2016 the full £6bn spent there on health and social care will be managed locally.

For some, devolution is the bedfellow of integration: for others, it is where "postcode lotteries" of provision begin. So what will integration and localism mean for dental budgets?

If we're looking at a combined pot, will dentistry become ever more of a "Cinderella" service when it comes to division of resources? It is up to us to establish what works for our profession, and for our patients' oral health.

This debate isn't going to go away. Even if the Manchester experiment doesn't lead to joint health and social care systems across England, there will at least be more focus on integration *within* healthcare. We have what looks like political consensus, and Simon Stevens' five-year plan, with its focus on vertical and horizontal integration, gives a taste of things to come.

Whatever happens, there is every chance we will see clinical commissioning groups taking over the commissioning of dentistry. GPs will be getting their hands on our money. Again the message is clear – dentistry needs to find its local voice.

Prevention

Prevention is another of the health buzzwords. We all know it's better than cure, but expect mixed signals when it comes to

prevention. They all talk a good game, but no party or government has ever set out anything resembling a coherent prevention strategy.

It's striking, because the lack of that strategy comes with a very real human and financial cost.

We've seen the scandal that one in eight of our three year olds currently experiences tooth decay and it is the leading cause of hospital admissions for children.

So the BDA has been getting oral-health issues onto the agenda as part of the wider prevention debate.

We've been working alongside campaigners to bring oral health into a debate on sugar that focuses on obesity, and a debate on cigarette packaging that focuses on lung disease and lung cancer.

We've had success with plain cigarette packs and huge amounts of publicity on sugar controls, but no major party – yet – has shown a willingness to stick their neck out for it.

Measures such as fluoridation remain politically toxic. It's telling that we've seen progress stymied in areas like Southampton – a key battleground in the May election – while in safe seats like Hull politicians are perhaps prepared to be bolder when it comes to improving oral health.

So whether it's sugar, fluoride – or even a reformed dental contract – we have to show the irresistible logic and concrete gains that come with prevention.

Regulation

It really isn't worth your time searching for regulation on party pledge cards. There don't seem to be many votes in it. But it is on the BDA's agenda, and we are determined to make sure that it is not forgotten.

Regulation remains unfinished business in this parliament. David Cameron once called for action on the "outdated and inflexible" laws applied by our regulators, but that pledge did not secure parliamentary time for new legislation to bring the legal framework up to date.

We've succeeded in getting the problems at the General Dental Council back onto the political agenda.

The dental regulator's first appearance in front of the Commons Health Committee provided vital scrutiny, and we must ensure that it is not a one-off.

Whoever forms the next government we will work to ensure both patients and practitioners get a better deal. ◆

COMMENTARY

More games?

by Mick Armstrong,
Chair of the BDA Principal Executive Committee

Back in February our colleagues at the British Medical Association (BMA) launched their "No More Games" campaign. And it's well worth a look.

A giant jenga set – symbolising the NHS – began appearing on bill boards across London. It was a call to all parties, left, right and centre, to stop using the service as a political football.

Our opposite numbers at the BMA are making a very serious point. But, as dentists, we are in a different place. I'm sure there are some of us who would secretly relish the chance to have the parties lining up to play games with dentistry. Then perhaps we could debate whether or not the sound and the fury made the slightest bit of difference to patient care.

It's an unfortunate fact, when health is uttered by politicians, the implication is it doesn't really mean dentistry. And that's wrong. It's wrong when, in single year, over 25,000 children with decay were admitted to hospitals for multiple extractions.

So politicians don't want to play with us. Perhaps that's because we've been victims of our own success. The nation's oral health is, in many respects at least, in a better place than it's ever been.

But elections brings change. Not just to governments, but to organisations like the BDA that are seeking to make a difference. We want the best for Britain's oral health. We want to see patients and practitioners liberated from byzantine regulation. Reformed contracts that dispense with meaningless targets and put prevention centre stage. And real action when it comes to ending Britain's addiction to sugar.

And if we're going to make any of that happen we've got to look at the game we're playing with the residents of Westminster.

I hope to have the privilege of meeting many of you at BDA conference in Manchester. When I address the hall the day after the vote, opinion polls suggest I won't be able to tell you which party will be forming the next government.

But whoever forms that government we have a job of work ahead of us.

We've been getting our issues onto the agenda. We secured a u-turn on cuts to foundation dentists' pay. We made Westminster wake up to mismanagement at the GDC. A General Election gives our profession a chance to reflect, look back at what we've shown we can do, and to look forward.

> "It's an unfortunate fact, when health is uttered by politicians, the implication is it doesn't really mean dentistry. And that's wrong. It's wrong when, in single year, over 25,000 children with decay were admitted to hospitals for multiple extractions."

The election coincides with just my second conference as BDA chair. I'm old enough to remember Neil Kinnock falling over on Brighton beach during the Labour Party conference, and while politicians and policymakers may be a key audience for the BDA they also offer plenty of lessons on what not to do.

Certainly I can't repeat the mistakes Iain Duncan Smith made in Blackpool back in 2003, as I'm not a "quiet man". But perhaps too often we have allowed ourselves to be described as the "quiet profession".

And in the next parliament we have to turn up the volume. We've already shown what we can do when we pull together. If politicians have been unresponsive to our issues, it's up to us to change that, to set agendas and lead debates.

I don't want Westminster playing games with our profession or our patients. But we've shown that when it comes to change we're ready to play, and to win. ◆

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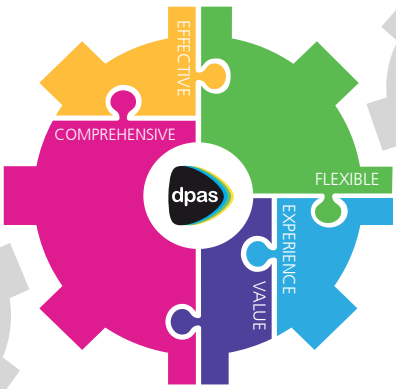

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How to deal with the friends and family test

by the BDA Advisory Team

Practices in England must now provide patients who have received NHS care with a chance to give anonymous feedback about the practice through the *friends and family test* (*FFT*). This became a contractual requirement on 1 April 2015. The *FFT* does this by asking a set question (**right, top**). You can, however, simplify the standard question and responses to be inclusive for patients who may have difficulty with the standard question.

A simpler response scale could just be "yes/no" or smiley faces.

You must also include a second question asking for comments and have a space for the patient to add their views as free text. This question should be general, along the lines of "Do you have any comments about the care you received at the practice?" or "Can you tell us why you gave that response?"

Make patients aware of the FFT

Practices do not need actively to ask all patients to complete the *FFT* but they should ensure that patients know that they can use the test when they want to provide feedback. And patients should be able to provide feedback through the *FFT* at any time.

At the simplest level, you could have a pile of *FFT* question forms at reception with a small "post box" in which to put them. The receptionists could ask if patients want to fill one in, but not at every visit: just when they finish a course of treatment, for example.

The collection method is not prescribed but be wary of using a system that could exclude some patients from responding: for example, online responses only. You can use online forms, text messages or other electronic means but it is suggested that you should only use these in addition to paper forms. But "token-collection" systems, where patients can give a score by dropping a token into a response box without being asked to complete a follow-up question are not allowed.

Submit data to NHS England

From May 2015, practices in England will have to submit monthly data from the *FFT* to NHS England. Data should be submitted through the NHS Business Services Authority (BSA) Dental Portal at www.nhsba.nhs.uk/3300.aspx by the twelfth working day of each month. The first submission deadline is 19 May 2015 for responses obtained in April 2015).

Practices should submit: the total number of responses in each response category, added across each collection method (paper, online, text message, or other); and the number of responses collected through each individual method.

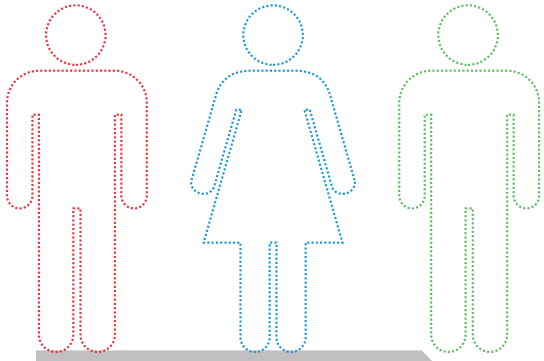
If you have used a simplified response scale, when reporting your data you should evenly allocate both positive and negative responses between extremely likely/likely; and unlikely/extremely unlikely, respectively.

Publication of your data

The monthly data submitted to NHS England will be published on the NHS England website and on the *NHS Choices* website (www.nhs.uk). The NHS England web pages will include comprehensive results for each dental practice (**right, lower**). *NHS Choices* will publish only the total percentage of *extremely likely* plus *likely* responses and the number of individual patients seen in the previous 12 months.

Practices must publish or display their responses. There is no set way to do this: it could be on a notice in the reception area or in a practice newsletter or on your website. As well as the statistical responses you can add the free-text comments, though these must be anonymous and patients must be able to opt out of their comment being published.

See also: www.bda.org/fft ◆



The *FFT* question

In most cases practices should use the standard wording of the *friends and family test* question and offer the set responses.

Standard question
How likely are you to recommend our dental practice to friends and family if they needed similar care or treatment?

Possible responses
Extremely likely
Likely
Neither likely nor unlikely
Unlikely
Extremely unlikely
Don't know

FFT results

The NHS England web pages will include, for each dental practice:

- → the number of responses in each response category
- → the number of responses collected through each collection method
- → the total percentage of "extremely likely" plus "likely" responses
- → the number of individual patients seen in the past 12 months

Dentists get new NHS Pension Scheme

by Joanne McKeown,
the BDA's Pensions and Insurance Consultant. Joanne deals with queries relating to the NHS Pension Scheme, retirement and general pension issues

The *NHS Pension Scheme* changed on 1 April. It is the biggest overhaul for years, with a number of key changes (**left**). The process for the changes began in 2010, when Lord Hutton was responsible for an independent review of all public-sector pensions. The review was commissioned to help ensure that public-sector pensions were sustainable and affordable for a future under the pressure of rapidly rising life expectancy. The BDA and many other trade unions were consulted on the changes and secured many improvements on the original proposals, particularly about the accrual rate and protection arrangements.

CARE

The 2015 scheme is a Career Averaged Revalued Earnings (CARE) scheme. This means you get a guaranteed level of benefit at retirement payable according to a fixed formula: it is a form of a defined-benefit scheme.

Your pension is based on your earnings throughout the whole of your career. The pension you earn each year is based on 1/54th of your pensionable pay in that scheme year. To protect the value of your pay, it is increased by a set rate linked to inflation, currently the Consumer Price Index (CPI). This is known as revaluation. Your historic rates of pay are revalued each year up to retirement or the date you leave the pension scheme. The final pension is then calculated by adding together the revalued pensions earned in each year of membership to work out an average.

Normal pension age

The normal pension age in the 2015 scheme is linked to your State pension age. The Government has plans gradually to raise this age. To find out your State pension age, check the *State pension age timetables* available on the official government website at www.gov.uk/calculate-state-pension.

Protection

Older dentists will remain in the 1995 or 2008 section of the *NHS Pension Scheme* until they reach the normal retirement age, which is either 60 or 65 respectively. You will be protected from the changes if you were aged 50 and over on 1 April 2012 (born on or before 1 April 1962).

Those who were aged 46 and 7 months or over on 1 April 2012 will have partial protection from moving to the 2015 scheme. This covers people born between 2 April

Key 2015 changes

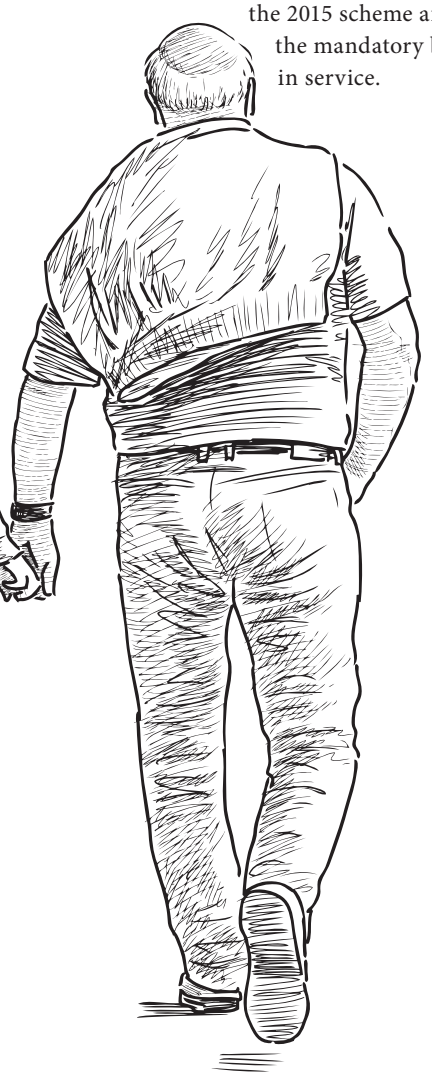
- Dentists born after 1 September 1965 automatically transfer to the new scheme (there is a tapered transfer for those born between 2 April 1962 and 31 August 1965)
- Pensions will be based on Career Averaged Revalued Earnings (CARE)
- An annual accrual rate of 1/54th of pensionable earnings (and there are no maximum years of service)
- The normal retirement age is linked with your State pension age
- To retire at age 65 without a reduction you must take out an Early Retirement Reduction Buy Out (ERRBO)

1962 and 31 August 1965. This tapered protection means that you will not move to the 2015 scheme on 1 April: you will move over at a later date. To find out when you will move to the new scheme, use the tapered-protection calculator on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions/4019.aspx

If you were under the age of 46 years and 7 months on 1 April 2012 (if you were born on or after 1 September 1965) you will automatically move to the 2015 section on 1 April 2015. However, benefits accrued up to the end of March 2015 in the existing sections of the pension scheme will be deferred. Generally, they will be preserved until you reach the normal pension age for that section, either 60 or 65 years.

Rejoining

You can return to NHS work after claiming your pension (though this is subject to a minimum 24-hour break and restrictions on working hours). If your pension is payable under the 1995 scheme you cannot re-join the 2015 scheme if you return to work. If you claim your 2008 benefits at the normal pension age you can re-join the 2015 scheme after the mandatory break in service.



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Contribution rates 2015-2019

These rates apply to England, Northern Ireland and Wales		
Tier	Pensionable pay (whole-time equivalent)	Gross contribution rate (before tax relief)
1	Up to £15,431.99	5%
2	£15,432.00 to £21,477.99	5.6%
3	£21,478.00 to £26,823.99	7.1%
4	£26,824.00 to £47,845.99	9.3%
5	£47,846.00 to £70,630.99	12.5%
6	£70,631.00 to £111,376.99	13.5%
7	£111,377.00 and over	14.5%

These rates apply to Scotland		
Tier	Pensionable pay (whole-time equivalent)	Gross contribution rate (before tax relief)
1	Up to £15,828.99	5.2%
2	£15,829.00 to £21,601.99	5.8%
3	£21,602.00 to £27,089.99	7.3%
4	£27,090.00 to £49,967.99	9.5%
5	£49,968.00 to £71,337.99	12.7%
6	£71,338.00 to £111,376.99	13.7%
7	£111,377.00 and over	14.7%

Early-retirement reductions?

Scheme benefits can be paid out at age 65 (so up to a maximum of three years before your normal pension age), however there would be a proportionate reduction in your pension to reflect that it is being paid out earlier and for longer. If you do intend to retire early, you can enter an agreement to pay extra contributions so that you can retire from age 65 with an unreduced pension. This is known as Early Retirement Reduction Buy Out (ERRBO). The rate of extra contributions payable would depend on your age and the number of years you want to buy out. You need to apply for ERRBO within three months of your joining date. If you apply outside of the three months, your contract would begin from the next scheme year (1 April to the following 31 March) though the extra contributions would be at a higher rate.

Contributions

As a scheme member you pay contributions based on what you earn. The contribution rates for April 2015 to March 2019 have been set (**above**). Employers' contributions, which for general dental practitioners will be from the area team or health board, have increased to 14.3% from 1 April 2015.

Look into further

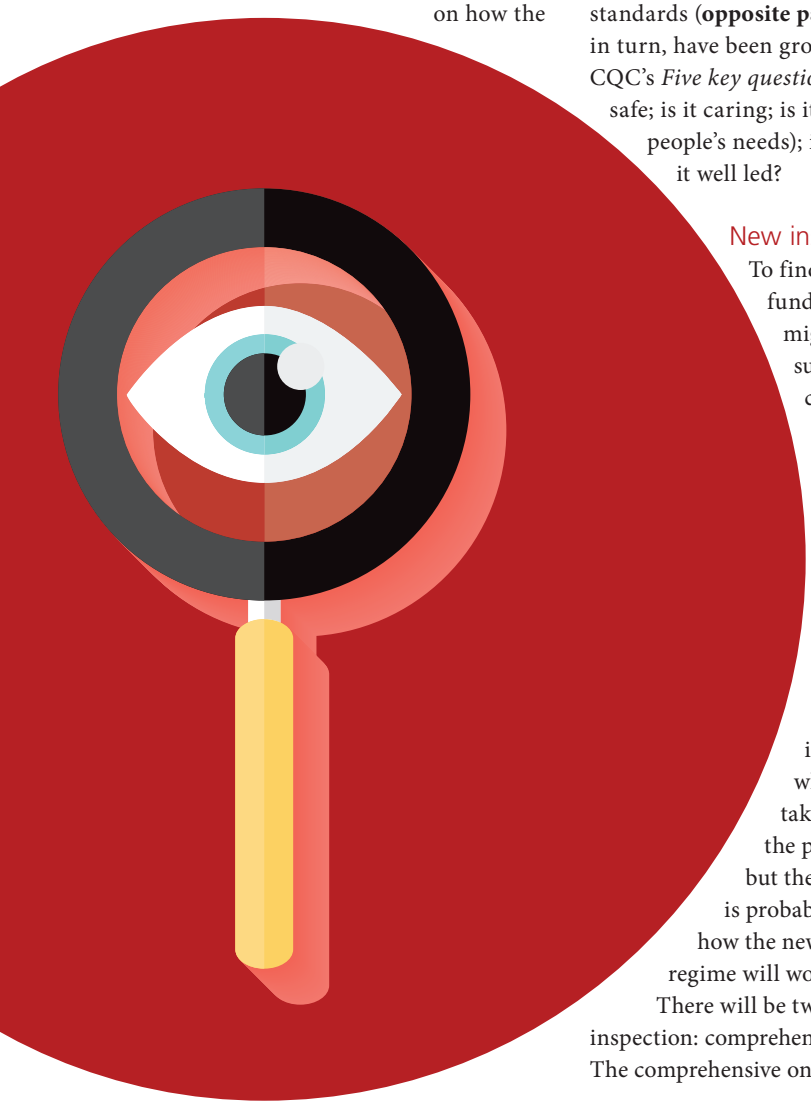
In addition to a retirement pension, the new scheme provides a range of pension and life-assurance benefits similar to the 1995 and 2008 sections. These include: a voluntary early-retirement pension (at a reduced rate to take account of its early payment); ill-health retirement pension; pensions for surviving partners and dependent children; a lump sum payable on death in service; and the option to buy additional pension. Further details can be found on the NHS Pensions website at www.nhsbsa.nhs.uk/Pensions.aspx

The BDA provides information on pensions and insurance, in particular on the *NHS Pension Scheme*. Contact Jo McKeown on joanne.mckeown@bda.org or 020 7563 6897. **Please note**, BDA employees are not authorised under financial services legislation to give independent financial advice. Such advice should be sought from independent financial advisers. See also: www.bda.org/pensions2015 ◆

CQC 11 standards, 5 questions

by Richard Harris, the BDA's Quality and Standards Adviser. Richard advises members on the quality standards and inspection regimes for dental practices

A new set of Care Quality Commission (CQC) regulations (SI2014/2936) came into effect on 1 April 2015. These changes follow a consultation on how the CQC should operate following experiences so far (**opposite page, top**). In essence, the 16 outcomes that the CQC could test during an inspection have been re-vamped and distilled down to 11 fundamental standards (**opposite page, bottom**). These, in turn, have been grouped under the CQC's *Five key questions*: is the service safe; is it caring; is it responsive (to people's needs); is it effective; and is it well led?



New inspections

To find out how these new fundamental standards might be used to assess surgeries the CQC conducted 60 pilot inspections in January 2015, the full outcomes of which are awaited. Nevertheless, enough is known about the proposed system to provide a fairly comprehensive outline: one thing is certain – on the whole, inspections will take longer. Aspects of the process may change, but the system outlined here is probably quite close to the how the new CQC inspection regime will work.

There will be two types of inspection: comprehensive and focused. The comprehensive ones (the vast majority) will be announced two weeks beforehand, will look at all of the standards and might take a whole day.

The focused ones will normally be in response to a concern or will be a follow up after an inspection: these will be more targeted and not look at all of the standards. Focused inspections could be unannounced.

> "There will be two types of inspection: comprehensive and focused. The comprehensive ones (the vast majority) will be announced two weeks beforehand, will look at all of the standards and might take a whole day."

Timetable

For most inspections, the timetable will begin eight weeks ahead of the inspection. For NHS practices, the CQC will contact an area team to discuss who will be involved in the process, how the inspections will be carried out and which practices they propose to inspect. Then, around four weeks before, the CQC will contact the local Healthwatch group.

The reason behind these two points of contact is to gather any relevant information on the practices to be inspected, including any assessments made of – and complaints made against – them. The BDA, in response to the consultation, asked the CQC to request that area teams and Healthwatch do not conduct

preliminary visits to practices to gather the further information.

The CQC has now found that around 20% of dental providers are totally private but it has not yet decided how to gather this additional information for these practices.

Finally, two weeks before the inspection, the CQC will contact the dentist. It will want to speak to the provider (or the registered manager where applicable) to talk through the agenda for the inspection. The CQC will also ask for information on any complaints and a copy of the practice's *Statement of purpose*. Every provider must have a *Statement of purpose* but – because it was not necessary to provide one for CQC registration in 2011 – some practices may have overlooked it. There is an example of it available at www.bda.org/cqc on the BDA's website.

As well as this, the CQC inspector will send the practice posters advertising the fact that the inspection is going to take place and this will be accompanied by a number of comment cards for patients to complete and deposit in a sealed CQC box.

One person, one day

Subject to the outcome of the pilots, the CQC anticipate that most of these comprehensive inspections will be carried out by one person in one day. Occasionally, however, the inspection may involve more people: for example, a dentally qualified specialist adviser. CQC also suggested it may use an "expert-by-experience". These are lay people who have had first-hand experience as patients receiving a particular type of treatment. Note, however, that in response to consultation, the BDA said that specialist advisers should only be used when absolutely necessary and that an "expert-by-experience" should never be used. While lay inspectors who have used a service may be useful to the CQC in looking at some types of specialist care, it is believed they are not appropriate in general practice. Other providers – for example, general medical practitioners and care homes – also do not support their use.

On the day of the visit, the inspector will explain how the CQC regulates, who is on the inspection team and the plan for the day. They will also want the provider to tell them of any concerns they might have about their ability to meet the regulations. Hopefully, you will not have any concerns about your practice and you can also use the

inspection as a chance to share any details on examples of good practice in your surgery.

The inspector will continue to gather views: by speaking to patients and staff; by looking at the complaints; by reviewing the practice's procedures and documents; by looking at the practice premises and its facilities; and by observing processes, for example, the decontamination system. The comment cards will probably be taken away and examined later.

> "On the day of the visit, the inspector will explain how the CQC regulates, who is on the inspection team and the plan for the day. They will also want the provider to tell them of any concerns they might have about their ability to meet the regulations."

The inspector does have the powers – under the *Health and Social Care Act 2008* – to look at patient records. This should not, however, form part of routine inspections.

As the end of the visit, the inspector will discuss their findings with the provider and the staff, so – when the draft report arrives for comment – there should be no surprises in it.

Ten percent

As a policy, the CQC proposes to inspect around one in ten dental practices each year. The profession is not being prioritised because dentistry has proved to be a safe environment, with over 95% of practices meeting all the outcomes under the old system.

Of the proposed 10% to be seen each year, around one-half will be practices where there are official concerns, say from the area team or local Healthwatch, with the remaining ones being randomly selected. See also: www.bda.org/cqc ◆

The first round of inspections

The Care Quality Commission (CQC) – the independent regulator of health and social care services in England – burst on to the dental scene at the end of 2010, with all dental practices in England having to be registered by April 2011. Dentists were asked to make a declaration that they complied with the legislation. There then followed three years of inspections: essentially, the CQC checking up on practices.

There are approximately 8100 dental providers – sole traders, partnerships or limited companies – spread over around 10,100 locations. The CQC undertook 10,900 inspections during that three-year period and finished the vast majority by March 2014.

During this period, the CQC came under huge pressure to reform, both from MPs and the public, and, in June 2013, it published consultation on how it might alter the way it regulates. The BDA, mindful of the experience of practices, made the point that the CQC should ensure that: "Its regulation and inspection regime is tailored to specific sectors that it regulates rather than using a one-size-fits-all approach."

CQC's 11 fundamental standards

- Person-centred care
- Dignity and respect
- Need for consent
- Safe care and treatment
- Safeguarding service users from abuse and improper treatment
- Meeting nutritional and hydration needs
- Premises and equipment
- Receiving and acting on complaints
- Good governance
- Staffing
- Fit-and-proper persons employed

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Daniel Wismeijer

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Julian Yates

From dentate to edentulous - how to overcome common issues when treating the older dentition
Tony Preston

FRIDAY 8 MAY

Restorative dentistry: simple steps to successful outcomes in more advanced clinical cases
Chris Tredwin

Modern technology and endodontic outcomes
Phil Lumley

Digital Smile Design - the emotional connection
Elaine Halley

Implementing ABB (Alignment, Bleaching, Bonding) into general practice
Tif Qureshi

SATURDAY 9 MAY

Preparing for the post amalgam era - resin based composite clinical outcomes and the latest on placement techniques
Van P Thompson

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		**A GDP's guide to orthodontic appliance systems - what's best for your patient** Richard Cure		**Foundations for the future: periodontal issues affecting children and young adults** Wendy Turner
FRIDAY 8 MAY		**A new perspective on dentine hypersensitivity - are you underdiagnosing this condition in your patients?** David Gillam		**Occlusion in everyday restorative dentistry** Kevin Lochhead
		**Engaging and managing dentally anxious children and adolescents in primary care** Carrie Campbell		**Dementia: Understanding how it affects us and the impact it has on our patients and their care** Joanna Millwood
SATURDAY 9 MAY		**Evidence based periodontal treatment: protocols for everyday practice** Ian Dunn		**Sports related dentistry, dental trauma and the endodontic considerations** Lyndon Meehan
		**Early detection of oral cancer** Simon Whitley		**Modern management of third molar surgery** Nayeem Ali

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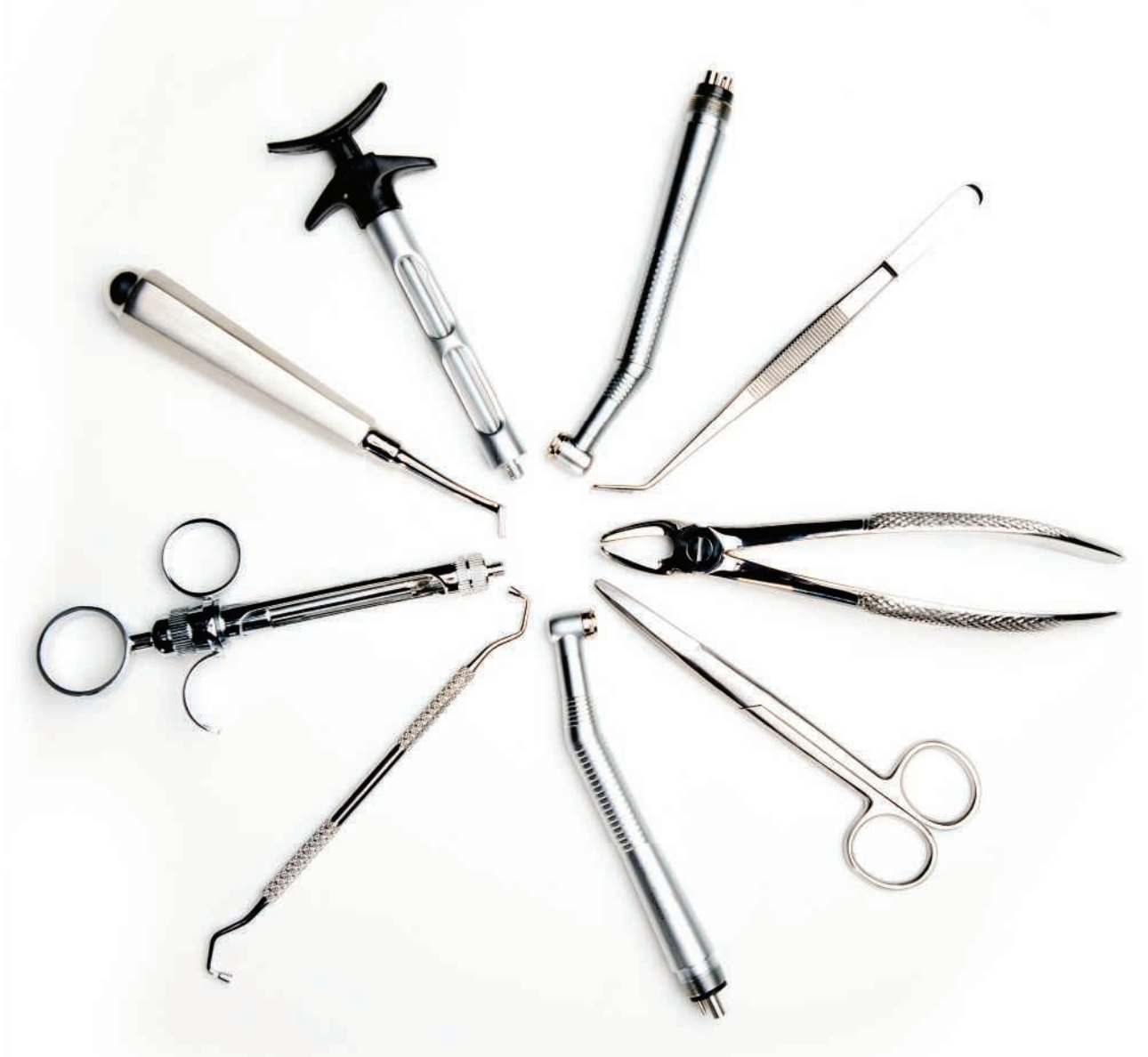

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Image of counterfeit products confiscated by the MHRA.

Rules around agency staff

by Nashima Morgan,
a practice management consultant in the BDA Practice Support Team. Nashima advises general dental practitioners on associate contracts and a wide range of employment and other law

Monday morning your dental nurse telephones to say she is unwell and has been signed off by her doctor for two weeks. You cannot really manage without a nurse all week so have to find someone to step in at short notice.

This is what staff agencies are for. It can help a practice to continue running smoothly if you have researched and lined up a reputable agency that can deliver qualified, committed, agency workers when needed. Of course, you are paying out extra in agency fees and you need to bear in mind the *Agency Worker Regulations 2011* – but the latter are not as daunting as you may think. The regulations grant two types of rights to the agency worker: day-one rights and the week-12 rights.

From the first day

The day-one rights are directly enforceable against the practice owner from the agency worker's first day. It is you, as the commissioning business, who has to comply with these rights and not the employment agency, even though the agency will legally be the worker's employer. Liability for non-compliance, therefore, will rest with the practice owner.

> "The day-one rights are directly enforceable against the practice owner from the agency worker's first day."

The agency worker should have access to the same collective facilities as everyone else in the practice, as if they were directly employed by the practice. This should be on the same basis as permanent staff. Facilities include use of the staff room, car-parking spaces and tea/coffee breaks.

You can only refuse access to facilities if you can objectively justify denying access: cost alone is unlikely to be deemed a good reason. But if something is in short supply,

say you only have two car-parking spaces and these are used by you and your practice manager, then you are justified in telling an agency worker than they cannot use one of the spaces. Also, the rights do not extend to external benefits, such as subsidised membership of a local gym, season-ticket loans for local public transport, and childcare vouchers.

Basic employment rules, such as health and safety regulations, anti-discrimination laws and the National Minimum Wage, apply to agency staff as they do to all employees. Agency staff can also claim proportional paid holiday. And details of permanent vacancies in the practice should be circulated to agency workers, too.

From 12 weeks

After 12-weeks working for the same employer and in the same role the temporary worker has the right to equal treatment under basic working and employment conditions. This covers the right to the same rates of pay, including the basic hourly rate and any overtime payments or performance-related bonuses.

It will generally be straightforward to work out if an agency worker has been in the same role for 12 weeks. Breaks for sick leave, jury service, holidays, a planned temporary practice closure (such as at Christmas) would not break the agency worker's continuity. But the breaks themselves would not count towards the 12 weeks.

Continuity will be broken if the temporary employee is absent for more than six weeks between assignments with the same employer or the temporary worker takes on to a substantially different role. For example, if the temporary employee was engaged as a dental nurse and later returns to the practice, but this time to cover the reception, then continuity would be broken.

"After 12-weeks working for the same employer and in the same role the temporary worker has the right to equal treatment under basic working and employment conditions. This covers the right to the same rates of pay, including the basic hourly rate and any overtime payments or performance-related bonuses."

Both the practice owner and the agency could be liable for non-compliance with rights under the 12-week rule. However, the practice owner will only be liable if incorrect information, such as wrong information on rates of pay, is given to the agency.

Agency-worker rights exclude protection from unfair dismissal and redundancy pay. These rights are deemed to be linked to a continuing long-term relationship between employer and member of staff so are not covered by the agency-worker rules.

Maternity leave is a special case. The agency worker is not entitled to maternity leave as such, in the sense that the employer does not have to keep the job open for them to return to. But the agency worker is protected from discrimination on grounds of maternity. She may also be able to claim Statutory Maternity Pay, but it would be the agency that would be liable for this payment if she meets the qualifying criteria.

Spend time on inductions

Agency workers should not be singled out and treated differently. The dental nurse who steps in might only be there for a day but it would be sensible to ensure that somebody, perhaps the practice manager, spends some time as soon as they arrive to introduce them to practice procedures and the practice team.

Give a quick tour of the building, showing the temporary worker the staff facilities and fire escapes. Tell them them about break times and lunch.

You might think this is all a bit too much for someone who might only be at the practice for a short time. But look at the time spent as an investment. The practice might use the agency again and have the same worker assigned it. The next time they will already know their way around. And if you do have a permanent vacancy in the future they might be interested in applying. ◆

Key message

Both the practice owner and the agency could be liable for non-compliance with rights under the 12-week rule. However, the practice owner will only be liable if incorrect information, such as wrong information on rates of pay, is given to the agency. Agency-worker rights exclude protection from unfair dismissal and redundancy pay. These rights are deemed to be linked to a continuing long-term relationship between employer and member of staff so are not covered by the agency-worker rules. Maternity leave is a special case. The employer does not have to keep the job open for an agency worker.

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When no "rights" means it must be done right

by Victoria Michell, a practice management consultant in the BDA Practice Support Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and associate contracts

Arguably the key "right" for a self-employed associate taking maternity leave is for her to be able to return to her role following the leave period. Strictly speaking there is no *right* to return but it would be very unwise for a practice owner to end an associateship for a reason connected to pregnancy or maternity leave because it could be construed as discrimination and lead to liability for sex discrimination. While there is some doubt if an associate could claim sex discrimination here, a tribunal is more likely to find that the associate is protected if a practice blatantly discriminates against a female associate on the grounds of sex or maternity.

Because associates are self-employed they do not have the same rights to maternity leave as employees. The right to time off for maternity leave should be agreed in an associate contract. Associates performing NHS dentistry may claim NHS maternity payments for up to six months (also paternity leave is available for up to two weeks and adoption leave is available on similar terms to maternity leave (see www.bda.org/advice for BDA Advice *Dentists' parental leave and pay*. So understanding the associate's intentions is of major importance to a practice owner to allow them to manage their business. The shorter period of paternity leave may present no greater issues than would a fortnight's holiday: but a longer time off for maternity leave (or adoption leave) is likely to need careful planning.

As soon as possible

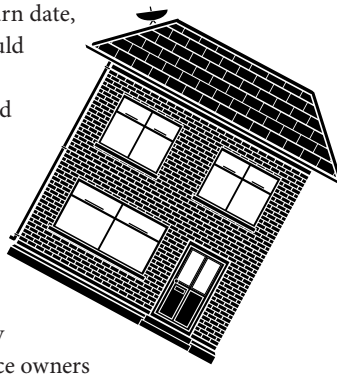
Just like employees, associate dentists and other self-employed individuals should discuss their return to work with the practice owner as soon as possible and provide the practice owner with a return-to-work date. It may not be possible for an associate to decide if they will take the full leave period at this point but an anticipated return date should be given to the practice owner.

The key, as with any aspect of the relationship between the practice and the associate, is that both parties communicate well with each other and in good time.

> "Because associates are self-employed they do not have the same rights to maternity leave as employees. The right to time off for maternity leave should be agreed in an associate contract."

If an associate, during the leave period, wants to return to work sooner, they should contact the practice owner in the first instance. Provided enough notice has been given and the practice owner is not put in breach of the contracts they have with any dentists providing locum cover, the practice owner should accommodate a change to the return date where possible.

The question of enough notice could be hard to quantify – it may be that this should, as with employees, be eight weeks before the earlier return date. But the legal rights for employees, unlike for self-employed associates, are clearly defined: so, another rule of thumb may be the notice period that the practice owner would have to give a locum.



To delay the return date, enough notice should be given before the previously indicated return date. Again, eight weeks is suggested, purely because this matches the rights of employees. The key point is that practice owners need time to organise patient cover if the associate does not want to return on her original date. An associate would not, however, be able to extend her leave beyond a maximum 12 months' entitlement.

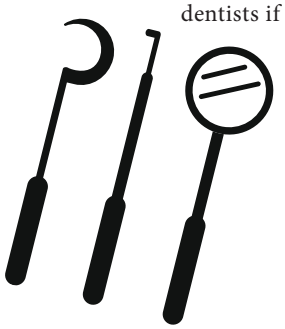
As the date of return approaches, the associate should liaise with the practice owner about the practicalities of her return. Changes at the practice during her absence may mean it is necessary to discuss the services now offered to patients, practice hours, personnel and chairside assistance. Of course, the associate should have been consulted even though she was on leave before any major changes were implemented.

Part-time work and flexible working

Following maternity leave, an associate may wish to return to work part time. Flexibility is common in dentistry and any such request could be easy to accommodate. Specific laws apply to employees when they ask for flexible working, one of these being an obligation on the employer to consider the request and make reasonable efforts to accommodate it. In the case of associates, although there are no legally defined rights, it is important to bear in mind that an unreasonable refusal of a request could allow an associate to raise the issue of unlawful sex discrimination. So, it is best practice for a practice owner to consider an associate's request carefully and take reasonable steps to accommodate it if possible.

> "Following maternity leave, an associate may wish to return to work part time. Flexibility is common in dentistry and any such request could be easy to accommodate."

The practice will need a dentist to provide services for the hours worked by the associate before going on leave. Meet the associate and discuss her request and possible alternatives. See if it can fit in with working arrangements or ask other dentists if they would re-jig their working arrangements



to accommodate the request. If the associate has been covered by a locum, ask them to see if they can stay on and job-share. You could also advertise for a dentist to job-share. This may be the solution for the associate. It may even be the preferred option for all parties because it could allow the practice to secure the services of an additional practitioner who could widen the skill base of the practice and provide greater flexibility around holidays and sickness cover.

When thinking of turning down a request for flexible working, practice owners should ask themselves if they have objective operational grounds for doing so. Although rights for self-employed associates to ask for flexible working are not set out in statute, practice owners throughout the whole maternity process for their associates need to ensure they do not act on discriminatory grounds. So, the best way to show that you are not refusing a request owing to sex discrimination is to show that you have a sound business reason for your decision. One such reason could be that flexible working would have a detrimental effect on patient services and you have not been able to see a way around this problem. See also: www.bda.org/atoz ◆

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Key message

Strictly speaking there is no *right* to return but it would be very unwise for a practice owner to end an associateship for a reason connected to pregnancy or maternity leave because it could be construed as discrimination and lead to liability for sex discrimination.

Don't fear **investment** in **staff training**

by Sabina Mirza, a practice management consultant in the BDA Practice Support Team. Sabina advises general dental practitioners on associate contracts and a wide range of employment and other law

No one walks into a job as the perfect employee, possessing the full set of skills and competencies for it. So you need to train the person to ensure they become proficient and have the skills needed competently to carry out their duties.

As a practice owner, you need employees who can deliver a high-quality service to your patients to ensure your business viability. As a registrant, you are under an ethical obligation to ensure that you work with suitably trained, qualified and competent colleagues, so make sure that your employees comply with, are aware of, and work towards, the GDC's *Standards for the dental team*. An employee-training programme that strikes a balance between your employee's needs and the business's needs, and meets regulatory obligations, will help you thrive.

Makes staff feel valued

From your employee's point of view, the investment of money and time in their training goes a very long way towards their seeing you as a good employer. It says that you value them and are genuinely interested in their future.

When employees feel valued it nurtures a friendly workplace, one to which they want to commit their loyalty and a loyal employee is more productive and innovative. They will go above and beyond their duties set in their job description. For example, such employees are more likely to be prepared to provide cover for absent colleagues.

Feedback from the BDA's online education courses shows the positive impact of training.

"I wanted to take the BDA's radiography course because it would help with my personal development and was an advantage to my department. I wanted to prove to myself and my colleagues that I could do this," one respondent said.

"The oral-health-education qualification has enabled me to be more independent and I feel more confident talking to patients as a result," said another.

Most people turning up to work do so not only for money, but also because they want to feel satisfied in their job. A trained employee is more likely to do a good job and, in turn, feel satisfied and believe that their role is an important one to you.

Adds value and helps retention

One of the main benefits practice owners report about using the BDA Education courses to support their employees in training is that they see a considerable reduction in requests for help, less need for overall supervision and a much more autonomous employee.

"The qualification reassures the patients, reassures me and provides reassurance to the dentist that I am providing the correct facts. The surgery has become more time efficient as we can multi-task between us. The dentist continues to value my contribution," one student said.

On the flip side, a lack of investment in training will decrease the employee's motivation, commitment and skills. Unmotivated employees will not perform well on the job, will not go the extra mile, and may present a careless image to patients that costs you time and money.

> "To make training worth while, it is important first to assess a staff member's training needs and then find suitable courses to fill the gaps identified. This could be done as part of regular appraisals."

One of the key signs that you are not providing meaningful development is that employees often leave and go work elsewhere, possibly for a competitor. Research (Why top young managers are in a nonstop job hunt) in *Harvard Business Review*, found that lack of training opportunities led to a high staff turnover. Authors Monika Hamori, Jie Cao and Burak Koyuncu concluded: "This creates a vicious circle: companies won't train workers because they might leave, and workers leave because they don't get training."

A practice has to begin the process of recruiting a replacement, which has associated costs and is time consuming.

Think return on investment

The cost of training, especially funding an employee to attend an accredited course, is the biggest barrier to taking up training opportunities. You also have to factor in the employee's missing work time while attending training sessions. But do not only look at it this way: look also at the return on investment.

Online news blog, *The Huffington Post*, (Not investing in employee training is a risky business, 30 June 2014) reported that employees learn: "Real skills, but sometimes those skills are 'soft' and sometimes it takes time for those newly acquired skills to affect the bottom line. Improvements derived from training and development are not easy to track point for point."

But the blog also stressed that many studies had shown a link between training and performance, morale and retention of staff.

This view has been echoed by a delegate on one BDA Education course. "I enjoy learning and want to continue learning. I was not confident to talk to people I didn't know, but since qualifying my confidence has grown. It has enabled me to work more efficiently as a team member, giving good oral-health advice."

Don't fear paying fees

A common barrier to employers funding staff training is the fear that once trained the employee will move on and the practice's investment will be lost. You could agree to pay the tuition fees for an employee but require that the amount can be recovered from the employee if they fail to complete the training course or if they leave the practice (for whatever reason) during the course or within a certain period after finishing it. You would need a separate training agreement signed by the employee if you are to claw back any fees in this way: a template is available for BDA Expert members.

Assess needs first

To make training worth while, it is important first to assess a staff member's training needs and then find suitable courses to fill the gaps identified. This could be done as part of regular appraisals. Draw up a *personal development plan*: again a template is available for BDA Expert members.

Once the training is completed, you should follow up and review it. This will help to show how far an employee has developed in their abilities and knowledge as well as help you to rate the training for other employees. While practice owners will be cautious about investing in an employees' training, the long-term return on the investment does outweigh the initial costs. ◆

BDA courses

- BDA Education offers online courses for dental care professionals (DCPs) in dental radiography (www.bda.org/radcourse) and oral-health education (www.bda.org/ohecourse) leading to nationally recognised qualifications. They are an ideal way to provide flexible training for dental staff, boosting their confidence and providing them with new skills that benefit the practice.
- One successful participant said: "As a result of the oral-health-education course, I am much more confident in everything, not just my ability at work. I am confident in how I integrate with people and feel I am an equal. It has given me such a boost to have achieved something and achieved it well."
- The BDA also offers a range of events from small interactive workshops, to seminars and conferences. Each year it holds events covering all core CPD topics as recommended by the General Dental Council, as well as business and personal development topics as part of the Training Essentials portfolio. To review the list of courses visit www.bda.org/training
- There is currently a "buy one get one free" offer on most Training Essentials courses for BDA members: that is two courses for just £215. Call the Events team on 020 7563 4590 to take advantage of this offer.

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*This offer cannot be booked online and cannot be applied to events already booked or two day courses. For full terms and conditions please visit our website.

A-dec at BDA

A-dec are proud to be supporting the BDA Live Demonstration Theatre and also look forward to welcoming you to stand B70 at this year's BDA Conference and Exhibition.

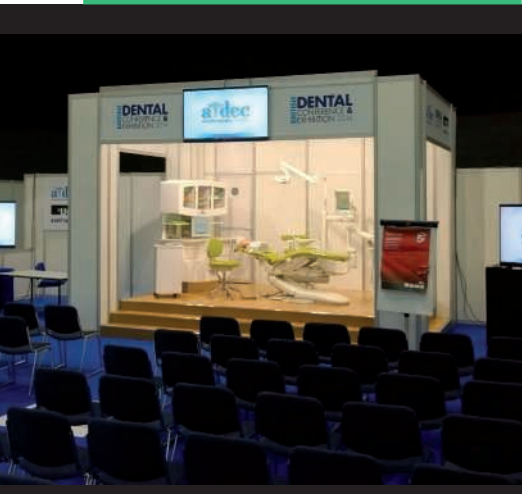
On stand B70 we'll be showcasing our stylish top-of-the-range A-dec 500 dental chair with Red Dot award winning A-dec LED light.

In addition to this we are delighted to be supporting the BDA again with all of the equipment you see on stage in the Live Demonstration Theatre.

Come and join us at the show to see if there is an A-dec dental chair for you. After all, you could spend over 26,565 hours with your chair throughout your career so it needs to be right for you and your dental team.

Our A-dec Territory Managers will be on the stand for the duration of the show offering advice on treatment room design and ergonomic solutions for your practice. Visit them on stand B70 or call 0800 233 285 for more information.

For more information: 0800 233 285; info@a-dec.co.uk and www.a-dec.co.uk



Talk to Belmont

The BDA will provide a perfect opportunity to update visitors on what's new at Belmont. Chances are many practitioners haven't purchased a new chair for a while and will be amazed at how technology has evolved.

Belmont's streamlined equipment, with easily cleanable upholstery that's resistant to both bacteria and staining, will benefit both patient and practitioner.

The former will receive treatment in comfort, while the latter will benefit from improved ease of access as well as keeping the CQC inspectors happy!

For those who wish their surgery was a little bigger, why not take a look at the Cleo, which has a folding leg-rest? Not only does this have a much smaller footprint, making your surgery look bigger and easier to work in, it also has many benefits for the patient. Access is easy: it's just like getting into a "normal chair", which will be a relief to all, especially elderly, disabled or younger patients.

As is always the case, there will also be some tempting offers for those who like what they see and how to benefit from the cost savings available throughout the duration of the show.

Belmont

Oral-B's Test Drive

Oral-B has recently introduced its Test Drive trial programme, which allows multiple users to experience Oral-B power and toothpaste using a shared handle in a hygienic way. Dental professionals will now be able to evaluate the product themselves before recommending it to patients. Patients will also be able to experience the product before investing in the technology.

The new Oral-B SmartSeries electric toothbrush with Bluetooth 4.0 connectivity is another recent innovation. The new toothbrush connects to the Oral-B App, recording brushing activity which patients can then share with their dental professional. Brushing duration, mode and problem zones can all be highlighted and the information easily retrieved.

The mechanical benefits of Oral-B's power toothbrushes complement the chemical efficacy afforded by their Pro-Expert toothpaste.

Gum health through effective plaque control is just one of the many beneficial features of Oral-B's Pro-Expert toothpaste and it's the inclusion of stabilised stannous fluoride (SnF2) that makes the difference.

Stannous fluoride was the first scientifically recognised fluoride and in recent years has been stabilised and combined with sodium hexametaphosphate, to provide additional protection.

Visitors to the BDA are also encouraged to log onto Oral-B's professional website, www.dentalcare.com

Show support for the Ben Fund

Come and have your photo taken on Friday 8 May on stand C45 at the BDA Exhibition. Get into the spirit with your team!

We need fun "I support" photos for the Benevolent Fund's Charity Gallery.

Create a memorable moment with friends and colleagues: photos are available to keep for a small donation.

The BDA Benevolent Fund has been helping dentists in need for over 125 years and needs your help now more than ever. Any support you can give will be much appreciated.

Visit stand C45.

Nuview at the BDA

Nuview is set to exhibit at the BDA Conference and Exhibition in May and is ready to help attendees explore the extensive range of cutting-edge visualisation and magnification solutions available.

Delegates can look forward to demonstrations of the state-of-the-art Carl Zeiss dental operating microscopes and loupes, exclusively provided in the UK by Nuview.

With an extensive range of systems, including the sophisticated OPMI Pico microscope, the convenient TTL Teleloupe and EyeMag Pro loupes, as well as the new EyeMag Light II, Nuview is perfectly situated to provide delegates with the enhanced magnification they need.

Also on show will be the wide variety of alcohol-free infection-control solutions in Nuview's exclusive Continu range.

From equipment cleaners to surface disinfectants Continu aids *HTM 01-05* compliance and is independently tested to exceed European standards.

If you're planning on attending the BDA Conference and Exhibition, make sure you visit Nuview on stand B32 to discover the full range of solutions available.

For more information call Nuview on 01453 872266, email info@nuview-ltd.com or visit www.nuview.co

Cutting-edge solutions from Clark Dental

Clark Dental will be among the leading exhibitors welcoming delegates at this year's BDA Conference and Exhibition, showcasing the latest innovations in the UK market.

Visitors to the stand will discover the new NOMAD® Pro 2 handheld x-ray machine. Delivering images of outstanding quality, it enables professionals to remain with the patient during the x-ray process.

Delegates can also learn about the Sirona ORTHOPHOS XG 3D and the many benefits of a fully digital panoramic OPG combined with the latest 3D technology.

The Clark Dental team will be on hand to demonstrate Schick 33, the latest module in the state-of-the-art Schick Digital Imaging System, offering an industry-leading resolution of 33 line pairs per millimetre. Attendees will also be able to explore the smart thinking Florida Probe, providing real-time audio commentary for periodontal exams.

For more, call Clark Dental on 01268 733146.

Helping you identify Acid Wear

The results of ESCARCEL, the first and largest pan-European Epidemiology study to assess the prevalence and risk factors for Acid Wear, offers unparalleled insights into the condition.

The study revealed just how widespread Acid Wear is in young adults across Europe, with 1 in 3 exhibiting clinical signs. Of particular concern is the evidence that this figure is significantly higher in the UK (**Bartlett DW *et al*.** *J Dent* 2013; **41**: 1007-1013.

Acid Wear is an irreversible condition. The best way to manage it is prevention.

As identification of the early clinical signs is the first step in helping to protect patients from further damage, the BEWE (Basic Erosive Wear Examination) tool can help support your understanding. It can help you to assess patients' level of risk and ultimately aid your treatment decision.

GSK has launched the Pronamel® BEWE and Acid Wear mobile app to help support you in detecting Acid Wear. Use the simple app on the go as an easy reference guide for the background to the condition, the BEWE tool, and tips for patient management. Download the app from the iTunes App Store now, just search "bewe".

Find out more about IAS Academy at BDA 2015

The IAS Academy will be at the BDA Conference and Exhibition 2015.

IAS Academy offers a unique pathway of guided learning and structured orthodontic training for GDPs. No matter your level of experience, there will be an appropriate point of entry for you.

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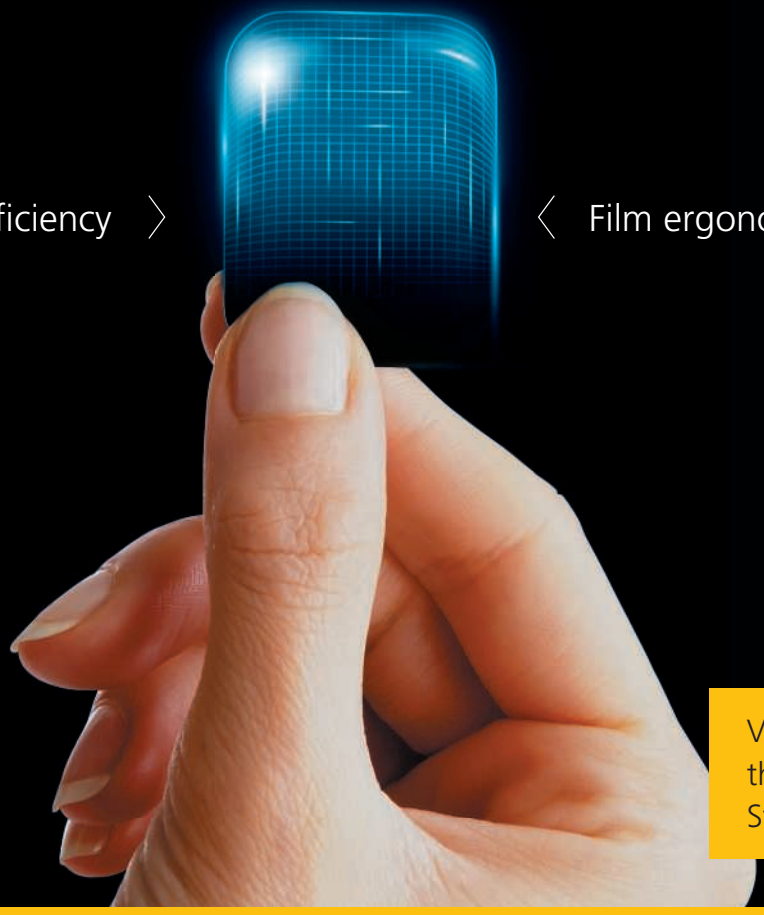

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Interests: Fixed & removable prosthodontics, dental implants **On Specialist List:** Yes, Prosthodontics
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Mr Chris Allan BDS, FDS, RCPS, MRD RCPS Glas
Interests: Fixed & removable prosthodontics, dental implants **On Specialist List:** Yes, Restorative Dentistry
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Interests: Endodontics **On Specialist List:** Yes, Endodontics
Mr Donald Thomson BDS(Hons)Edin, FDS RCS Edin, DDR RCR
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On Specialist List: Yes, Prosthodontics
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Interests: Fixed and Removable Prosthodontics, Dental Implants, Periodontics **On Specialist List:** Yes, Prosthodontics and Periodontics
Dr Fran Veldhuizen BDS, MFDS RCS(Ed), M Clin Dent, MRD RCS(Ed)
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On Specialist List: Yes, Prosthodontics
Matthew Brennand-Roper BDS MClinDent (Pros) MJDF RCSEng MFDS RCSEd MPros RCSEd
Interests: Fixed and Removable Prosthodontics, Dental Implants
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Interests: Endodontics **On Specialist List:** Yes, Endodontics
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Interests: Endodontics
On Specialist List: Yes, Endodontics
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Interests: Periodontology
On Specialist List: Yes, Periodontics
Mr Martin Paley BDS, MB ChB, FFDRCSI, FRCSEd, FRCSEd(OMFS)
Interests: Oral and Maxillofacial Surgery, Dental Implant Surgery, Head and Neck Surgical Oncology
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Dr Gillian Ainsworth BDS Sheff 1996 FDS RCPS Glasg MSc Edin MSurgDent RCS (Ed)
Interests: Oral Surgery, Implant Surgery, Sedation
On Specialist List: Yes, Oral Surgery
Dr Neil Heath DCR(R), BDS, MSc, MFDSRCS, DDRRCR
Interests: Specialist interest in CBCT interpretation and Ultrasound scanning in diagnosis of head and neck pathology.
Specialist List: Yes, Dental and Maxillofacial Radiology
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Specialist List: Yes, Dental and Maxillofacial Radiology

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Orthodontist Dr Sarah Sadek, BDS (Hons.), B.Sc (Hons.), MFDS RCS (Ed.), M.Sc, M.Orth RCS (Ed.)

(Accredited Specialist in Orthodontics).

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Specialist in Oral Sugery: Dr Fabrizio Rapisarda DDS

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On Specialist List: Yes Prosthodontics and Periodontics

253003

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Email: info@thepriorsdentalpractice.co.uk

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

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

Miss Karen Juggins BDS (Hons) MFDS RCS (Eng), MSc, MOrth RCS (Eng), FDS (Orth) RCS (Eng)
Interests: Specialist Orthodontics **On Specialist List:** Yes

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

236739

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

North

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Dr. Sharif Khan BDS (Edin.), M.CLIN.DENT. (Lond.)
Interests: Cosmetic & Implant Dentistry, Advanced Prosthodontics

Dr Meera Aggarwal BChD (Leeds)
Interests: Periodontology

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Dr Shash Bhakta BDS, MMedSci (Rest Dent) MFDS RCPS, MRD RDS (Prosthodontics), PhD FDS (Rest Dent) RCS
Interests: Restorative and Implant dentistry, Endodontics, Fixed and Removable Prosthetics and Periodontics
On Specialist List: Yes Periodontics, Endodontics, Restorative Dentistry and Prosthodontics
Dr Harmeet Dhaliwal FDS (Orth)RCS, MOrth RCS, MDentSci, MFDS RCS, BDS
Interests: Orthodontics **Specialist list:** Yes Orthodontics

255221

TRINITY HOUSE ORTHODONTICS
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Mr Dirk Schuth BDS, FDSRCPS, FDS, RCS (Ed), MOrth RCS (Eng+Edin) MDentSci (Leeds)
Borough Road, Wakefield WF1 3AZ
Tel: 01924 369696

Trinity House Orthodontics
46 Shambles Street, Barnsley S70 2SH
Tel: 01226 770010
Email: thortho@btconnect.com
Interests: Orthodontics – Adult & children, NHS & Private
On Specialist List: Yes, Orthodontics

217672

THE YORKSHIRE CLINIC
www.mydentalspecialist.co.uk

Mr Martin F. W-Y. Chan BDS, MDSc, FDS (Rest Dent) RCPS (Glasg), DRD, MRD, RCSEd.
Bradford Road, Bingley, West Yorkshire BD16 1TW
Tel: 01274 550851 / 550600
Email: info@mydentalspecialist.co.uk
Interests: Restorative and Implant Dentistry, Prosthodontics, Periodontics, Endodontics
On Specialist List: Yes, as above

212838

BDA Good Practice

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Business skills CPD

Q1: Which of the following is true in relation to managing the *friends and family test*?

A Patients should be asked to complete one after every visit

B You must use the exact wording of the standard question

C You must provide a second question asking for free-text comments

D You must display the results of the test at your reception area

Q2: Under the new Care Quality Commission's regime, there will be how many types of inspection?

A One

B Two

C Three

D Four

Q3: How many practices does the CQC propose to inspect each year?

A 5%

B 10%

C 15%

D 20%

Q4: Under day-one rights, to which of the following is an agency worker entitled: a – use of the staff room; b – childcare vouchers; c – proportional paid holiday?

A a and b only

B b and c only

C a and c only

D a, b and c

Q5: Which of the following breaks an agency worker's continuity in the same role under the 12-week rule: a – sick leave; b – jury service; c – holidays; d – a planned temporary practice closure?

A Sick leave only

B Jury service only

C Holidays and sick leave only

D None of them

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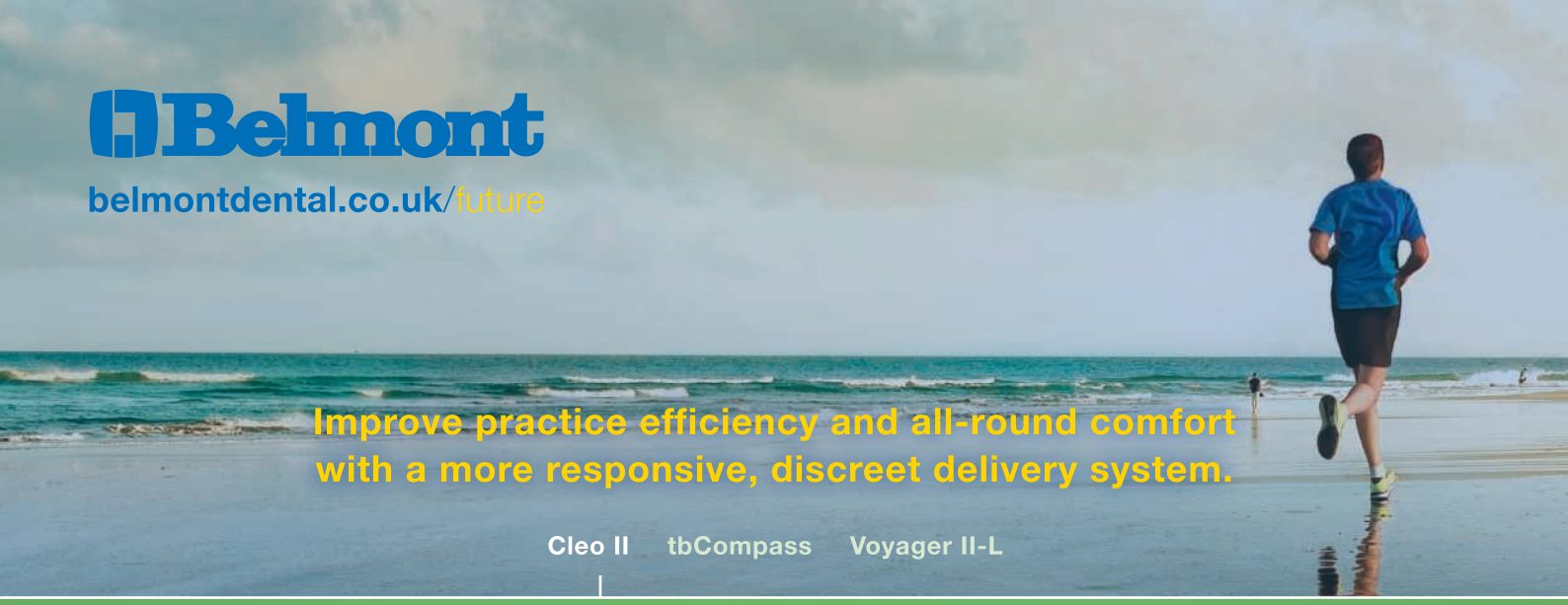

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