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August 2015


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**References:**
1. Bleeding Index Reduction DOF 1 – 2013 (LAEBBA0001), 50.9% reduction in whole-mouth mean Bleeding Index at 4 weeks.
2. DOF 2 – 2013 (UNKPLT0006).

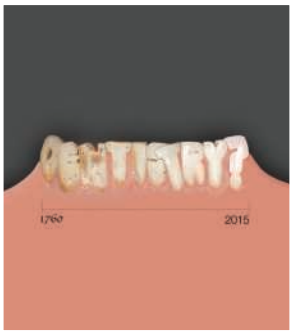
UK/LI/14-3436

**Advanced Defence against gum disease**

# BDJ InPractice

## AUGUST 2015



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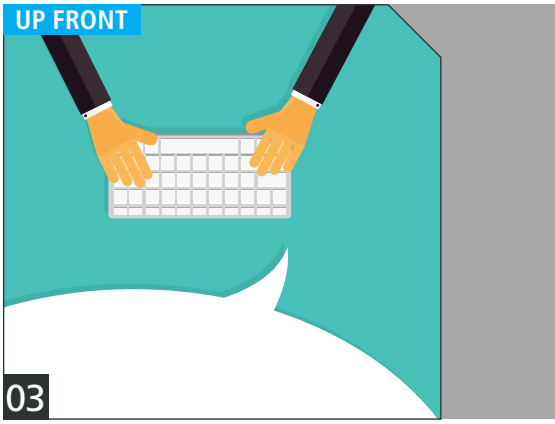




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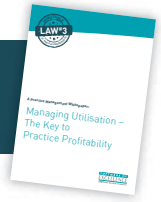


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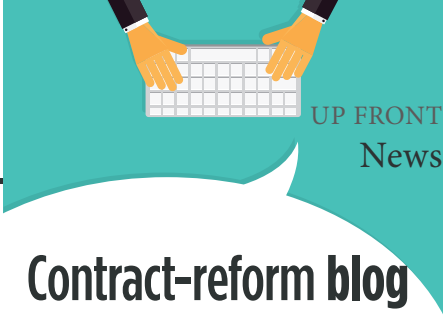



# Complaints-deluge **impacting** indemnity fees



FOUR MAIN DRIVERS (see **below, right**) are fuelling a "deluge of complaints and claims" against dentists, which is having an impact on indemnity fees.

At their root lies rising patient expectations and shortcomings with the current regulatory and legal structure, the Dental Defence Union (DDU) has said.

"Complaints to the General Dental Council (GDC) have increased by 110% since 2011 and we are also seeing clinical negligence claims inflation rising at 10% per year," head of the DDU Rupert Hoppenbrouwers has said.

"While dental claims are traditionally seen as low value, this is no longer the case and our highest amount paid out in compensation to an injured patient in the last five years, together with the patient's legal costs, was over £240,000.

"This trend is not due to a fall in dental standards, which remain high. Very few dental professionals are found by the GDC to be impaired and currently over half of dental negligence claims are successfully defended by the DDU. But the increasing demand for our services inevitably has an impact on the indemnity fees we need to charge dental professionals."

"There are some potential remedies on the horizon however, such as more emphasis being placed on resolving complaints locally and more information being made available for patients as to where to best direct their complaints," Rupert Hoppenbrouwers continued.

"In addition, we have been active in raising the need for the necessary reforms to be made to improve the GDC's fitness-to-practise procedures and we are hopeful this will be achieved.

"There have already been legal reforms to make the fees claimant's lawyers can charge in personal injury cases more proportionate to the damages received by the patient and further proposals to cap fees have just been announced. *See also page 7.* ◆

## Complaints drivers

- Patients often complain to the GDC because they want an explanation of what went wrong and an apology, without first making a complaint direct to the dental professional who may be able to resolve their concerns
- The GDC currently cannot filter out the less serious complaints from those that potentially raise more serious issues about fitness to practise
- The availability of "no win no fee" arrangements for clinical-negligence claims
- The increasing number of cosmetic procedures, which may be expensive for the patient and come with higher patient expectations

## Career advice at #AskBDA

MEMBERS WHO ARE either newly qualified or beginning their careers can get expert-panel advice on careers, starting out and going into practice in a live Twitter-based, question-and-answer event using #AskBDA in September.

Panel member and BDA director for Wales Richard Birkin said: "We know from meeting with FDs, VDPs and other young dentists that the first few years of practice is a time when they need our support most. Whether it is how to write a CV or should I do DCT we want to help."

The Q&A will take place between 12.30pm and 1.30pm on Tuesday 15 September 2015. It will be hosted by @TheBDA. ◆

## Contract-reform blog

MEMBERS WITH NHS practices in England are urged to read a Q&A blog about contract reform and its prototypes at https://bdaconnect.bda.org/qa-contract-reform

Among the issues addressed by Department of Health (DH) deputy director responsible for dental-contract reform Peter Howitt in response to questions by General Dental Practice Committee (GDPC) chair Henrik Overgaard-Nielsen's are capitation and units of dental activity (UDAs).

"The DH position is that going from a 100% activity contract to a 100% capitation contract is very risky and disruptive – you switch from one set of perversities to another," Howitt says.

"A blended contract gives the best of both worlds, rewarding preventative continuity of care and appropriately reimbursing essential treatment."

And on UDAs he suggests a change of name.

"One of the things we will look at during the prototypes is a new and better approach to activity categorisation. It would obviously be helpful to signal the break from the past by scrapping the UDA label. We are open to suggestions for new names." ◆

## Heat-wave tips

SEVEN TIPS to help small businesses overcome the challenges of very hot weather have been suggested by the Federation of Small Businesses (FSB).

- Explore the possibility of flexible working: for example, avoiding travelling during rush hour.
- Where appropriate, Provide air-cooling devices.
- Make sure shade is available: this may need blinds or reflective film.
- Allow additional breaks.
- Provide extra water coolers to help staff stay hydrated.
- Where possible, relax dress codes.
- Have specific precautionary measures for employees particularly at risk from heat.

STAFF PAY

## Small-firms pay guide

OFFICIAL workplace-conciliation service Acas has published a new online guide, *Help for small firms: handling pay and wages,* (see www.acas.org.uk). It goes through the basics on all matters related to pay and the legal rules on staff pay.

Intended to head off any problems or disputes arising over pay, it covers the steps employers and managers should consider when handling staff pay. Issues include: pay systems based on hours worked or performance; wage slips; and the deductions that can be made. Potential pitfalls, such as setting up pay for new employees, overpayments and sickness and holiday pay, are also covered.

Dentists may find the Acas information a useful add-on to the BDA Advice *Employee pay and awards* (see www.bda.org/advice), which guides you through issues to consider when developing competitive rates of pay and fair reward packages. This links through to the periodic survey conducted by the BDA Research Team that analyses actual dental care professional (DCP) pay rates. ◆



## Highest academic headcount

FIGURES PUBLISHED BY the Dental Schools Council show an increase in the number of clinical academics employed by UK dental schools, to a total of 592 full-time equivalent (FTE) clinical academics, a highest-ever headcount of 990. Of these, there were 383 FTE professors, senior lecturers and lecturers; and 291 FTE senior clinical teachers, clinical teachers and researchers.

There have been year-by-year increases in the number of senior clinical teachers and clinical teachers since the role was recognised as a clinical academic pathway with an emphasis on teaching rather than research. This accounts for nearly 90% of the expansion of the clinical academic team, from 471 FTEs in 2007 to 592 FTEs in 2014 (up 24%). Just 14% of senior clinical teachers, clinical teachers and researchers hold full-time contracts with their university, compared with 85% of professors, readers/senior lecturers and lecturers.

There is, however, another trend in the profile of academic dentistry: research-focused clinical academic pathways are increasingly top heavy. The number of professors has increased steadily to its highest of 118 FTEs in 2014; and 79% of professors and readers/senior lecturers are aged 46 and over.

And the rise in the proportion of women entrants to UK dental schools is beginning to change the number of women dental clinical academics. There is near gender parity at clinical lecturer and clinical teacher roles to 40% women overall, up from 32% ten years ago. But only 18% of professors are women and while this is an improvement on 11% on 2004, it shows that change at the top of academic dentistry is more gradual. Just 22% of the clinical academic team is of Black and Minority Ethnic (BME) origin compared with 44% of the dental-student population.

Chair of the Dental Schools Council Professor Callum Youngson said: "There is a risk that the pipeline of early-career, research-active, clinical academic dentists is not sufficient to replace the potential loss of expertise at the top. Long-term planning is required to address this as well as effective promotion to young dentists of the unique value of becoming a clinical academic.

"Through finding new ways of working, dental clinical academia has been resilient to increased pressures put on higher education institutions in recent years and in the near gender parity at a majority of levels we have much to be proud of."

The survey is at: http://www.medschools.ac.uk/SiteCollectionDocuments/DSC-survey-2015-web.pdf ◆



MUST-HAVE DEVICE

## Half of homes turn to **tablets**

TABLET COMPUTERS HAVE become must-have devices in just five years – more than half (54%) of UK homes now own one, up from just 2% since 2011, according to Ofcom research.

They are particularly popular among people aged 35 to 54: two-thirds of this age group (64%) have a tablet.

The trend looks set to continue: 21% of households currently without a tablet told Ofcom they were likely to get one within the next 12 months.

Seven in ten (71%) children aged 5 to 15 had access to a tablet at home by the end of 2014, up from just over one-half (51%) in 2013.

And many children do not even have to share a tablet with their parents. One in three children (34%) aged 5 to 15 have their own device, up from one in five (19%) in 2013.

Tablets are also helping to drive the use of apps: 86% of adults who go online on a tablet were using apps at the end of 2014, particularly for news headlines. But when searching for information, the browser still prevails: 61% of app users mostly use a browser to find the information they are looking for. Only 25% use an app.

And while more than one in three adults (37%) use a tablet to go online at home, only 15% take their tablet with them when out and about – away from home, work or their place of study.

Apple's iPad, launched in the UK in May 2010, and Android and other tablet devices, are helping to shape the way we surf the Internet and communicate, Ofcom says. ◆

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# Switch off for a proper holiday

HOLIDAYS ARE NOT nearly as relaxing as they should be, research has found.

Three in five (61%) employees work while on annual leave: up from 54% in 2013. The study of 1000 UK workers and managers, by the Institute of Leadership & Management (ILM), also found that nearly three-quarters (73%) are stressed ahead of their holidays, with 68% staying late at work the day before. Almost one in five (18%) return to work more stressed than when they left. And more over one-half of workers (54%) have annual leave left at the end of the year: 42% of managers actually have to encourage their staff to take a break.

Modern technology may be to blame for workers not making the most of their annual leave. The poll found that the 61% felt obliged to work on holiday. This is a possible side-effect of modern technology, which means workers are contactable anytime and anywhere: 64% read and send emails during their time off, 28% take business phone calls, and 8% go into work.

Part of the reason 18% came back from holiday more stressed than when they left may be because 81% of staff are faced with overflowing email inboxes on their return.

Meanwhile, only 28% of those surveyed reported that they had had arguments with friends and family about their working on holiday, down from 37% two years ago. Considering the increase in those working through their holidays, this seems to indicate that it is fast becoming the norm to be constantly switched on, the ILM suggests.

ILM chief executive Charles Elvin said: "It is crucial that people are able to make the most of their time off work to fully relax, reflect and recharge. This allows them fresh perspective and energy to tackle their work on return from holiday.

"Finding work-life balance is easier said than done.

"But organisations can foster positive work environments by encouraging staff to use their full holiday allowance, hand over responsibilities to co-workers in the lead up to leave and have face-to-face meetings on their return." ◆

PAPER FREE

# SMEs increasingly opting for paperless

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NEARLY ONE-HALF (48.7%) of small and medium-sized businesses (SMEs) could be paperless by the end of 2015, a survey suggests.

Of these, 30% believed that they could go paperless at some point this year while 18.7% said they were already embracing an electronic way of working.

Only a few showed animosity to such a change: 6% said that they didn't want to go paperless.

So, many organisations are now recognising the paperless office as a realistic goal and a benchmark for efficiency, provider of document-management solutions Margolis, which conducted the survey, said.

The survey also found increasing use of the cloud by SMEs and a growing dependency on being "connected" both at work and at home.

More than one-half of business owners (56%) said they used it daily or more often.

Margolis director Richard Shaw said: "We are pleasantly surprised by the openness that we have seen from the businesses surveyed.

"The results show a much greater awareness of the advantages that paperless document management and storage can provide.

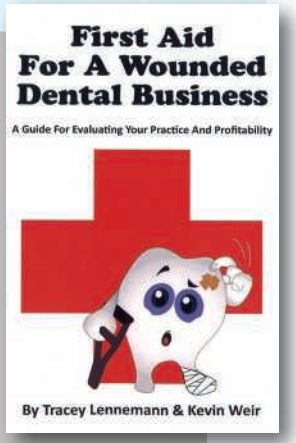
"Typically, there has been a great deal of reluctance towards the paperless office, due to the logistics involved, but that resistance seems to declining."

See also: www.bda.org/bdjinpraticeonline *Rules for going paperless* January 2015, p26. ◆

BOOK REVIEW

# Worth a check-up

**First aid for a wounded dental business – a guide for evaluating your practice and profitability**
Tracey Lennemann and Kevin Weir
CreateSpace Independent Publishing, 2014
ISBN: 978-1-49480-789-4
£19.99




The format of this paperback is similar in style to the famous John Cleese *Video Arts* training films, which were fairly ubiquitous in the 1970s and 80s, writes BDA Librarian **Roger Farbey**. Set in Louisville, Kentucky, the narrative takes the form of a fictional dentist (Dr Andre Townsend) who, finding his practice is in serious trouble, attempts suicide. He then is "referred" by the police who rescue him, to a financial "specialist" (Dr Joe Dirkers) who is also, rather conveniently, an emergency-room doctor. This is where the leitmotif of the book is repeated incessantly, using a constant, and rather irritating, first aid and emergency medicine set of metaphors.

So the book begins with *The Collapse* and is succeeded by chapters such as *Assessment – where are you wounded*, *Triage*, *Stop the bleeding*, and so on, until we get to the punning *The pulse of the business*, *Diagnosis* and, finally, *Physical therapy*.

Leaving aside the tedium of this metaphorical device, the book is actually quite effective and invokes some sensible ideas: such as, what expenditure can be cut and what should not be cut in a budget (marketing and technology should not be sacrificed). There is also a fair bit dealing with financials such as variable costs and revenue and gross profit ratios.

Chapters end with bullet-point checklists. Although not unique it is worth a quick check-up. For more: www.bda.org/booknews ◆

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# New indemnity-cover rules

by Ulrike Matthesius,

Education Adviser at the BDA. She helps members with queries on educational and regulatory matters including General Dental Council registration, standards, and continuing professional development

The General Dental Council (GDC) is currently in the process of formalising the legal requirement for all its registrants formally to declare that they have appropriate indemnity cover. The need for indemnity has, of course, long been an ethical requirement.

Now it is enshrined in legislation: the *Healthcare and Associated Professions Indemnity Arrangements Order 2014*, which last summer provided for the necessary changes to the *Dentists Act*. This new law says that every registrant in all health professions has a duty to hold, and to declare that they hold, the appropriate indemnity cover and to comply with their regulator's rules for proving that they hold suitable cover.

## Individual registrants

So, soon, each registrant will be required to declare that they have appropriate indemnity. It is expected that the GDC will introduce the requirement for all *new* applicants for registration from August or September 2015. For *currently* registered dentists, the indemnity declaration will be part of the renewal process for January 2016, and for currently registered dental care professionals (DCPs), for August 2016.

A standard wording has been written, which is the same for all regulated healthcare professions: "I have in place, or will have in place at the point at which I practise in the UK, insurance or indemnity arrangements appropriate to the areas of my practice." Registrants will be asked to make this declaration by ticking an appropriate box. Without this tick, a registration or renewal will not be progressed. Professionals who do not work clinically will, however, be able to make a declaration saying that they do not need indemnity because of their non-clinical scope, by ticking a box that says: "I do not need indemnity".

## GDC annual checks

A percentage of declarations will be audited each year. This means that, if you are selected for audit, you need to send in a copy of the relevant certificate. You do not need to send any documentation at the time of your declaration: this will just become a part of the registration-renewal process each year.

> "A percentage of declarations will be audited each year. This means that, if you are selected for audit, you need to send in a copy of the relevant certificate."

## Electronic renewals

The GDC is increasingly moving towards online processes and therefore it advises that the easiest way to make the declaration will be through its eGDC platform. It has said that all registrants will be actively encouraged to use this system for their declaration.

## Cover for the practice team

Practice owners who provide indemnity cover for their DCPs will need to provide the policy and its details to each individual who is covered. It is important that they see it. DCPs have to be able confidently to make their declaration and provide the paperwork if asked.

Watch out for DCPs accidentally ticking the wrong box. Where employers pay for their team's indemnity the DCP should not mistakenly tick the box for "I do not need indemnity" because they are not paying for it personally. Since DCPs have a clinical role, they must tick the "yes" box to stay registered.

## If your indemnity cover stops

If a registrant no longer has indemnity cover, they will need to tell the GDC. This does not mean that a registrant needs to tell the GDC of a *change* of indemnity-cover provider if the cover provided by old and the new policies is unbroken. The key issue is that a registrant is covered for the whole time they are practising. But if you are told by your indemnifier that your cover is being stopped and you do not have a new policy in place, you must stop practising on the relevant date and tell the GDC, which will expect you to tell it of the new cover once obtained before you begin to practise again.

## GDC web information

The GDC website (www.gdc-uk.com) has further information in the *Indemnity* section, which can be found under *Standards* on the *Dental professionals* pages. ◆

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Principal Dentist,
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Sunderland

# What is a dentist for?

by Stephen Hancocks

Stephen is editor-in-chief of both *BDJ* and *BDJ In Practice*

In dentistry, we are blessed (or perhaps cursed) with a very broad definition of our scope of activity, namely: "Any such treatment, advice or attendance as is usually performed or given by dentists." Enshrined in all *Dentists Act*s to date, it could almost be said to give us *carte blanche*. If we do it, then it is dentistry.

So, when Jimmy (that is Professor Jimmy Steele CBE to you and me) posed the question *What is a dentist for?* in his *BDA/BDJ Anniversary Lecture*, the answer should presumably have been: "for performing dentistry". That might be well and good, but what type of dentistry is needed, and who, apart from ourselves, decides on that?

Professor Steele's lecture, *Oral health and the British. Oral health care in a changing world* might not have grabbed you as a must-see event yet it attracted a full audience on one of the hottest days of the year and is available on the BDA website to BDA members with an attendant one hour's worth of CPD (www.bda.org/anniversarylecture). I urge you to view it because, apart from being a personal *tour de force*, his presentation provides a fascinating journey from the origins of dental disease in the UK through to a brilliant summary of where we are now and on to speculation of where we might go in the future – what is a dentist for?

## Caries, caries, caries

Caries is arguably the most significant of the oral diseases with which we deal on a daily basis. Periodontology is important, too, but caries has provided us, and continues to provide us at least for the time being with most of our workload. In tracing the history of caries in the UK, Professor Steele looked back to the arrival of tea and the habit of adding sugar. Genteel as it seemed then, perhaps in contrast to today's more-universal habit of sipping fizzy drinks with its equally disastrous consequences, the seeds were sown for what was to become an epidemic.

With the development of the industrial revolution came the need to provide the calories for concerted muscle power. And *cheap* calories came from sugar, fueling not only commercial output, but also caries in the working population. This situation continued for many years against a background of there being no comprehensive oral care for the vast majority of the population coupled with a low expectation of oral health and, indeed, general health.

## Advent of NHS dentistry

At the advent of the NHS there was, therefore, a huge backlog of disease, which needed treatment. Indeed, so extensive was the task that no one even thought to quantify it. It wasn't until 20 years later that someone had the bright idea of assessing the problem, when the first *Adult Dental Health Survey* was undertaken in England and Wales, in 1968. Now, infamously, it revealed that 37% of the adult population over the age of 16 years was edentulous. Remarkably, as these surveys have continued every ten years, the most recent, in 2009, showed that the same oral state had fallen to just 8% of the adult population, a truly huge fall in caries.

It was really this caries epidemic that defined the dentist's approach to dentistry (what a dentist does) and, in turn, it was this that also defined society's approach to dentists and dentistry. But, as he has said before, Jimmy's summary of this is that caries was essentially an epidemic that ended in the twentieth century and what we have to do now as a profession is not only to redefine what "we do", but also, in other words, to redefine dentistry.

Jimmy Steele: "the heavy-metal generation"

## Inequalities and specialisation

While noting the fall in caries in general, we also have to interrogate the data more closely because certain cohorts have not benefited equally from the reduction. Those in the lower-socioeconomic groups have seen a far smaller effect and it is this skewed distribution that now presents us with a dilemma: how should services be provided that cater for a population most of whom need health maintenance while a minority need what amounts to old-style treatment approaches. Once again, using epidemiological data to illustrate this, Professor Steele concluded that it just was not possible to "treat this difference away". Treatment alone would not work in solving the problem.

Professor Steele is famed for coining the term *the heavy-metal generation*

to define those groups of older people who had a lot of metal placed in their mouths in the forms of restorations when they were younger and now have a legacy of dental-replacement need as they head into old age while still retaining their teeth. Alluding to this cohort, he suggested that they would need continuing specialised care with an appropriately trained workforce.

## Defying nature

So, aside from these well-delineated areas, what is a future dentist to do? Jimmy suggested that the biological purpose of teeth was to:

- → get their owner to sexual maturity;
- → allow their owner to provide for offspring;
- → bring the offspring to independence; and
- → provide a possible evolutionary advantage a little beyond the years needed for these functions.

In essence, since evolution designed our teeth to last just 50 years and we are now living to an average age of 80 years, dentists are being required to help patients defy nature. We are being asked to bridge the gap between evolutionary needs and current social pressures by nursing our patients' dentitions through a modern lifespan. This also includes both function and maintaining patients' aesthetics so that they remain looking young, even trying to improve appearance so they look younger. Perhaps, then, an element of what a dentist is for nowadays is aesthetic dentistry.

Of course, patients themselves also have some part to play in this. Professor Steele questioned if the six-month check-up was originally predicated on fear – fear of pain returning. He also cited US data that showed the drop off in dental attendance in 2009 following the financial crash. This was understandable because the US model is overwhelmingly one of private dental-care provision. Having less disposable income meant that people made choices about where they spent that which remained and, as in the UK, some reined back their spend on dentistry. Significantly, however, in the US the patients have not been returning.

> "Having less disposable income meant that people made choices about where they spent that which remained and, as in the UK, some reined back their spend on dentistry. Significantly, however, in the US patients have not been returning."

Jimmy speculated on this by wondering if, with improving oral health – specifically, declining caries – people were questioning the need to attend. They had delayed attending for, say, a year, and nothing had happened. They were not in pain and had suffered no major oral consequences. So they had left it another year, still without oral consequences, but with financial consequences – they saved money. He thought that this was a trend that we need to be aware of in the UK because it is likely to have greater consequences for dentists' livelihoods than in the USA because it will be taking place against a background of rising numbers of qualifying dentists.

## Future health

While these factors had consequences for oral care and oral-care provision, Professor Steele returned to his original question. If the twentieth-century caries epidemic is over then what is a dentist for? His next suggestion was that dentists would increasingly need to encompass general health. With links between oral health and general health becoming better understood by researchers and the public, patients are likely to expect a greater emphasis on improving health rather than treating disease. But this is a "hard sell" because, while it is difficult to prove prevention, it is easy to quantify treatment activity. Governments are constantly looking for ways to balance the books on health spending and the UK is certainly no exception so that the need to factor in a reduced priority for public expenditure on dentistry was also prudent.

What is future dentistry to look like? Fewer, more specialised dentists? A greater emphasis on state-funded salaried dentists in an attempt to contain the treatment needs of the lower-socioeconomic groups? Fewer practices but with a focus on health and wellness rather than treatment?

## Professional and personal

In conversation after the lecture with two recent graduates I was struck by their reaction. Fully appreciating the educational insight of such an august summary and analysis, they said it had made them think about both the future of the profession and their personal career plans. They both expressed a need to look towards specialisation and gaining a greater sense of the wider role that oral health might play in society in the future.

> "It is becoming increasingly obvious that the end of the caries epidemic will significantly alter the need for, and pattern of, treatment... A substantial proportion of the UK population will not experience caries at all during their long lifetimes."

So, where does this leave us as we weigh up future trends based on detailed knowledge of past activity? Does it help us in answering the question "what is a dentist for?" The overriding message is that whatever a dentist is to be for in the coming years is going to be substantially different from what he or she has been for historically.

It is becoming increasingly obvious that the end of the caries epidemic will significantly alter the need for, and pattern of, treatment. For those currently continuing to battle against caries (and there is, for example, a particular immediate issue on childhood caries) this might seem a ridiculous summation of the evidence. But the charts shown by Professor Steele indicate that a substantial percentage of the UK population will not experience caries at all during their long lifetimes and for those who do experience it the extent will not be anything like it has been in the past – except for those predominantly in the lower-socioeconomic groups.

That the lecture has been recorded and is available to BDA members to view now is of great value in the immediate sense of being informative and providing CPD. In my estimation it will be of huge significance in the future for those looking back to 2015 and observing the points at which the profession had the chance to change its thinking and its modes of operation to address the oral-healthcare needs of the British population. And that is definitely what an anniversary lecture should be for. ◆

## Dental-curriculum problems

As the Dean of Newcastle School of Dental Sciences, Professor Steele was questioned closely about how his vision of the future would affect dental education. In relation to complete dentures, for example, he admitted that he had a dilemma. In a curriculum overflowing with material and pressure to include more and more that is of current relevance, to what extent could it be justified for an undergraduate to spend a lot of time learning to construct full dentures. The answer was probably, by not very much.

Similarly, in terms of entry numbers to dental schools, against the background of the changing nature of disease patterns and the consequent delivery of oral care in the UK population it was increasingly difficult to counter pressure for cutting places. The whole issue of workforce planning is probably more crucial now than ever and yet simultaneously more complex.

# Discuss apportionment in light of fee uplift

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

In exchange for the provision of a surgery, equipment, staff and other services and facilities, self-employed associates pay a monthly sum to the practice owner, which is usually a percentage of the associate's fees. This arrangement, legally labelled a *licence fee*, is commonly also referred to as the *fee apportionment*. The apportionment rate is a key issue for discussion between associates and practice owners. It needs to take account of the level of NHS and private earnings that the associate generates as well as practice costs, including overheads and costs associated with a tougher regulatory environment.

The associate pays to use the practice owner's facilities. But, in practice, it is the practice owner who collects the NHS and private payments earned by the associate. Out of these payments the owner will retain the licence fee owed by the associate as well as deductions for expenses, such as laboratory costs.

Based on the draft associate contracts the BDA has reviewed for members this year, the associate's share of the fee

## Factors to consider

- The associate's performance
- Likely gross fees (in England and Wales this would include the UDA target and the contractual value of UDAs)
- Size and nature of the patient base
- Quality of the surgery and equipment
- Experience and expertise of the dental care professionals (DCPs) who will be made available
- Practice costs and overheads, including staff, equipment, repairs, materials and utilities
- Trends in patient numbers, gross fees and practice costs
- The terms offered at other local practices

apportionment has varied between 40% and 50%. Of course, this is only an indicator derived from the sample of contracts seen and it should be stressed that there is no recommended percentage split.

Exact fee apportionments are a commercial decision for the contracting parties and can be influenced by a number of factors, including the nature of the practice – NHS or private. Each associate and practice owner has to look at their specific circumstances when negotiating the appropriate apportionment for their practice (see box, **above**). The practice owner should review the contract every year and look at recent performance – both of the practice and the associate – and assess the likely impact of changes to circumstances in the coming year.

### How should fee uplift be applied?

Fees in the NHS are looked at by the Review Body on Doctors' and Dentists' Remuneration (DDRB) each year and fees or contract values are generally adjusted upwards. But how, if at all, this uplift should be applied to the associate's earnings it is not necessarily straightforward.

The DDRB uplift is not always intended to boost take-home pay. The reports are often quite specific about how the DDRB has reached its recommendations. Increases may be intended to cover rising practice costs, including staff wages, boost dentists' pay or a mixture of both. For example, in 2015/16, the Department of Health in England announced an uplift on all General Dental Services (GDS) contracts and Personal Dental Services (PDS) agreements of 1.34%. DDRB recommended a 1% increase in the net income of general dental practitioners, the rest of the uplift being intended to cover increases in practice expenses. How to apply this to the associate's earnings needs careful negotiation and a good deal of mathematical analysis. The BDA's General Dental Practice Committee has issued a statement about this (see box, **below**).

With the fee-per-item systems used in Scotland and Northern Ireland the associate's gross fees will increase by the amount of the uplift. In England and Wales, contract values will increase, but this does not have to be passed on in an increased unit of dental activity (UDA) value offered to the associate. In a practice where costs are exerting downward pressure on profitability, it can be uncomfortable for the practice owner to accept that any fee uplift should be passed on to the associate. The other variable that can be adjusted in these circumstances is the percentage apportionment.

Varying the percentage split can help adjust any DDRB increase to fees or UDA rates to help the practice owner to meet practice costs. But associates may be reluctant to agree to any financial changes that they perceive may affect them unfairly: the DDRB has said that general dental practitioners should receive a cost-of-living pay rise so associates would need some persuading to forgo this increase. For both sides, however, actual changes in your practice's performance and costs are more relevant than notional observations made by the DDRB. Both parties should discuss any fee uplift and consider openly the implications on their respective incomes and agree amendments to calculations if necessary. ◆

"For both sides, however, actual changes in your practice's performance and costs are more relevant than notional observations made by the DDRB. Both parties should discuss any fee uplift and consider openly the implications on their respective incomes and agree amendments to calculations if necessary."

## GDPC statement

"The Doctors and Dentists Review Body this year recommended an increase in net pay of 1% for independent contractor general dental practitioners in all countries of the United Kingdom. The award has been implemented by the Department of Health in England and by the Welsh Assembly Government, although they have both abated the amount allowed for staff costs, resulting in a gross uplift of 1.34%. In Scotland, the recommended gross award of 1.61% was implemented. No decision on implementing the uplift has yet been made in Northern Ireland.

"Whilst the DDRB recommendation does not relate directly to the pay of associate dentists, associates might reasonably look to the award for an indication of an expected uplift in their own income.

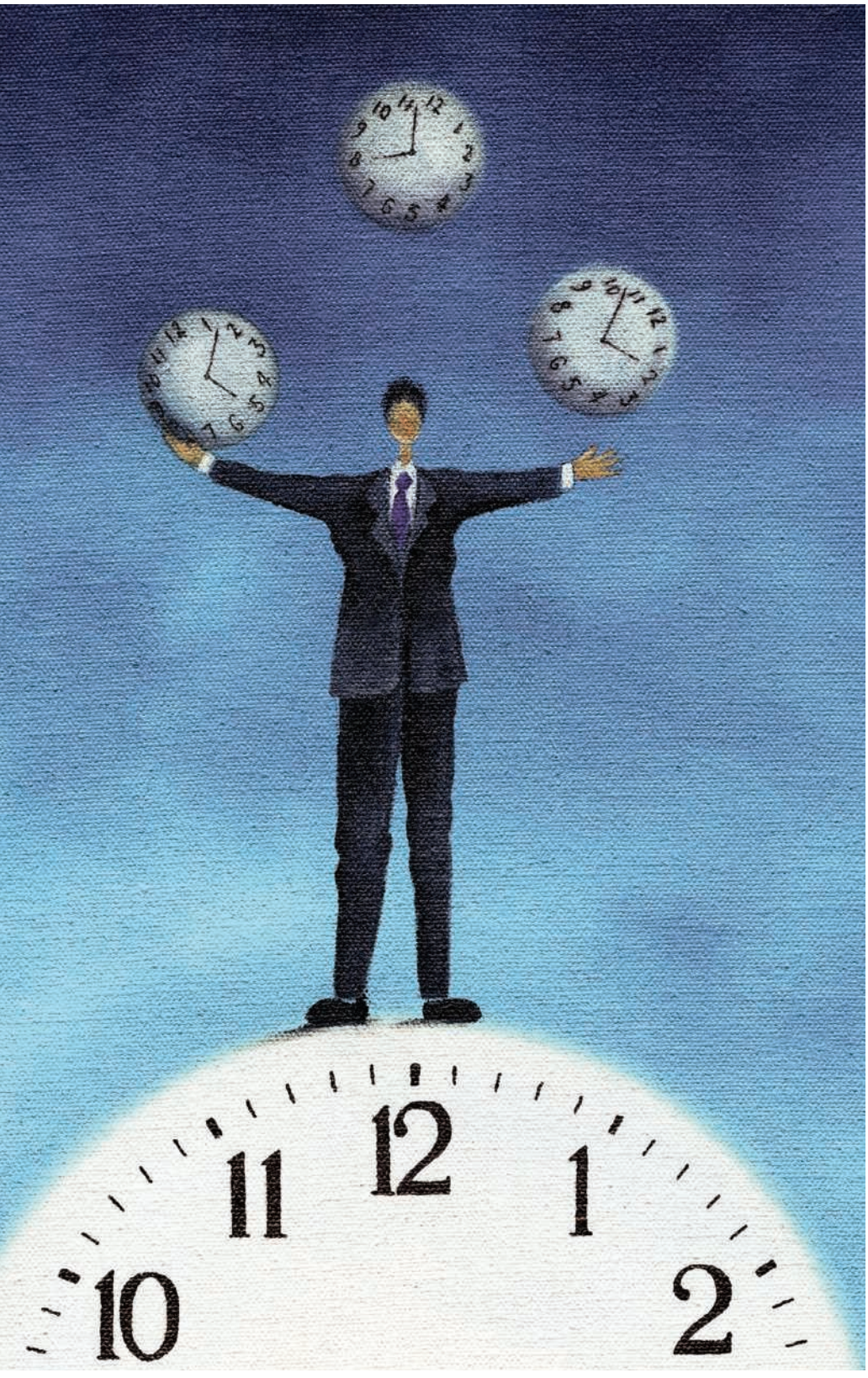
"The GDPC recognises that practice income has been under enormous pressure for a number of years and therefore any decision on pay increases for associates will inevitably reflect local business circumstances, and will be a matter for direct negotiation between the parties.

"However, the GDPC would expect practices to recognise that associate income has also declined significantly in real terms, and to reflect the DDRB award in associate pay wherever possible.

"Associates are encouraged to engage with practice owners to discuss their contractual arrangements in light of the DDRB uplift."

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

# Six steps to



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Now that employees with at least 26 weeks' continuous service have a legal right to make a formal request for flexible working, a practice should have a written procedure it can follow if such a member of staff asks to change their hours. This right, traditionally something an employee could ask for on their return from maternity leave, can now be used by any of your staff. They do not have to be a parent or a carer but are limited to one request a year. You have a legal duty to consider the request and provide a formal response.

Having a written procedure will help ensure consistency in the way you handle such requests (**below**) so the same information is given to every employee and the same factors applied to reduce the risk of any equality claims. Key to your policy is stressing that the right is only to *request* flexible working. You can refuse provided you have looked into their request and you have objective business grounds.

## 1 Outline the right to request

The first part of the policy should explain to employees their right to request flexible

## Your six steps

1. Outline the right to request flexible working
2. Explain how to make a formal request
3. Describe how the practice will consider a request
4. Say how contractual changes will take effect
5. Highlight reasons why a request may be rejected
6. Have an appeal process

# a flexible-working procedure

working. Tell them for how long they must have been employed (at least 26 weeks continuously) and how often they can make a formal request (once a year). Requests could be either to alter their working hours or their working times.

The employee does not need a specific reason for making a request (often requests have been made by those with childcare needs, responsibility for an elderly or disabled relative, or those who wish to do formal studying) and this should not influence the way that you look at the request. Include a statement promising that you will consider all official requests thoroughly and that you will provide a formal response.

## 2 Explain how to make a request

Set out the criteria for making a formal request. An employee must make it clear that they want you to consider a change in their working pattern and say what hours they want to work. A casual verbal request should not be enough: ask them to make a written request. Explain to whom they should address the request: the practice owner, a specific partner, or a practice manager.

Give the employee detailed information about what they should include in the written request. To avoid doubt they should write that it is a formal request. As well as detailing their desired working pattern, they should say when they want the change to begin.

Ideally they should also address the likely impact the change will have on colleagues and the provision of services to patients and suggest how this could be minimised. The more information that they can provide about their personal circumstances and how these balance with practice needs, the more insight it will give you for trying to move forward and find an arrangement that will work for both the employee and the practice.

## 3 Describe how a request will be considered

Your objective in looking at a request for flexible working should be to see if it is possible to accommodate it. You should not be looking for reasons to reject it. Tell the employee who will handle the request and provide the practice's response. Offer to meet to discuss the request. A meeting is not necessary but it is good practice to allow the employee a chance to discuss the situation with you. They can, if they want, be accompanied by a work colleague at any meeting.

> "If you are not able to agree to a request for flexible working you should explain your reasons. Requests should only be rejected on objective business grounds. It helps if your policy provides examples of the circumstances where this could happen."

A starting point in deciding about a request for flexible working is to bear in mind that for dental practices to function you need key employees, such as reception and nursing staff, to work core hours. Their attendance at fixed times is essential for operational needs. You need, therefore, to see if you have enough cover to allow the requested changes. This may include discussing the request with other members of the practice team and that you will do so must be made clear to the employee.

Promise to provide a prompt response. Obviously, it may take time to look into the request in full, so a couple of weeks or a month is a reasonable timescale. If it takes longer, you should discuss this with the employee and explain the reasons for the delay.

## 4 Say how employee's contract will change

Any agreed changes need to be reflected in the employment contract. Confirm the changes in writing with the start date for the new working pattern. Generally, you need to point out that this will be a permanent change to their contract of employment and any subsequent changes, including reverting to their previous hours, would be subject to future agreement. But it is also possible for both parties to agree to the new hours for a fixed period after which the terms of employment return to what they were previously. Alternatively, the changes may be agreed for a trial period, subject to assessing if the changes work in practice.

## 5 Highlight reasons for rejection

If you are not able to agree to a request for flexible working you should explain your reasons. Requests should only be rejected on objective business grounds. It helps if your policy provides examples of the circumstances where this could happen. To cite just a few examples, rejection may be because of the additional costs that would result, not being able to reorganise work among other staff, or the likely detrimental impact of the change on services to patients. Provide a wide range of examples but stress that these may not be the only circumstances where you may be forced to reject a request. In these circumstances, you should offer to meet the employee again to discuss possible alternatives or compromises.

## 6 Have an appeal process

Showing a willingness to think again is an important part of employment-law best practice. Explain, therefore, the arrangements for appeals against your decision. Ask the employee to submit an appeal in writing within a set time, say a couple of weeks. Ask them to say why they believe the reasons given for rejecting the request do not apply in their situation. And promise to give them a prompt written response, again within, say, a couple of weeks.

## All in one place

When developing a procedure, all employees should be consulted. Provide them with a draft and ask for comments. Policies are much stronger if you can show you have had buy-in from your team. A template is available to BDA Expert members. ◆

# Give staff a voice to boost performance

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

Your performance as a capable dentist is intrinsically linked to the performance of your staff. You rely on them to prepare the surgery, ensure that sterilised dental tools are available and dispose of hazardous materials safely. If a staff member fails in their area of work, it has a domino effect on your performance. So, you need to ensure that you continually manage your staff performance and they, in turn, need to understand the standards of behaviour and performance expected of them. Employers have a responsibility to spell out the level of performance they expect from their team. It is a continuing process, encompassing inductions, appraisals, training, coaching, reprimands and praise.

## Have an induction scheme

If you want your staff to hit the performance ground running, you should give new members of staff an in-depth induction. From the outset cover the standards of behaviour and performance required. A well-thought-out induction programme will help the newcomer adjust as quickly as possible to the working environment, reach maximum work efficiency and achieve a high level of performance.

The Workplace Communicator Blog reported, in *Why Induction Training Programs are So Important to Company Success*, that when an induction was provided, there was a 60% reduction in the time it took staff to achieve expected productivity rates. BDA Expert members can access a model *Staff induction training programme*.

> "Recognise and reinforce strong behaviour and performance. Providing informal feedback regularly is paramount. Your staff, like all of us, need to know that their contributions are being recognised and acknowledged."

## Set performance standards

Writing down performance standards helps to set expectations. Job descriptions, practice policies and procedures, and a staff handbook are where you could cover these. Those documents can be used as a reference point to help your staff know what is expected of them.

Standards should be objective and differentiate between acceptable and unacceptable results. The staff member's job description helps establish the performance criteria needed to meet their job responsibilities. Procedures, such as your cross-infection-control policy, lay down steps to be taken when approaching various tasks. And rules, such as ones on the use of mobile telephones, can be included in a staff handbook. Templates relating to some of these issues are, again, available to BDA Expert members.

## Talk to staff

For your standards to be effective, you need to communicate them to your staff. Talking is the key to ensuring staff really have a clear understanding of the standards expected of them and can fully direct their efforts towards achieving specific results. Many practice owners have discussions with their staff throughout the year at one-to-one meetings, coaching sessions and the formal practice appraisal system. If you create a supportive and open environment, everyday conversations about work are invaluable. Your staff may sometimes need to ask you questions or get clarification without fear of recrimination.



Recognise and reinforce strong behaviour and performance. Providing informal feedback regularly is paramount. Your staff, like all of us, need to know that their contributions are being recognised and acknowledged. In a recent conversation with a member (calling about a new employee's probationary period) they told me about how, when a nervous patient attended, the trainee dental nurse built a great rapport with him, ensured the patient was extremely calm and so helped the treatment to be undertaken without a glitch. After the appointment the member made sure that they told her how well she had handled the situation.

A touch more formally, there may be tasks for which you want to coach an employee. When instructing them, demonstrate the task and enable them to practice it. Always provide positive guidance (**right**). Most performance concerns come from marginal errors in work. To make the most from coaching you should focus on behaviours, not personality.

Conversation works both ways. Government advisers David MacLeod and Nita Clarke reported, in *Engaging for Success: enhancing performance through employee engagement*, that employees work best if they believe they have a voice. MacLeod and Clarke said ideally you should create a workplace where: "[the] employee's views are sought out; they are listened to and see that their opinions count and make a difference. They speak out and challenge when appropriate."

## Elements of coaching

- Describe any issue or problem or praise positive performance
- Ask your employee's view on their performance
- Identify the solutions and support available for positive results
- Reinforce your appreciation of any improvements in your employee's work
- Document your discussion and agree any follow-up actions

### Formal feedback

Holding formal appraisal meetings with your employees allows you to assess their performance and potential. And it provides a record of both the employer's and employee's views. Annual appraisals are now a standard management technique. Take time out to discuss the work that has been done and what has, or has not, been achieved.

Appraisals allow both manager and worker to agree objectives, identify training needs and consider future career development. BDA Advice *Managing performance* (www.bda.org/appraisals) provides in-depth guidance on conducting appraisal meetings.

In the end, if an employee is not performing properly you will need to resort to formal disciplinary action but this has to be built on firm foundations. The case of *Janjua v Dr Rashid Ahmad Bhatti Pak Health Centre*, at an employment tribunal, found that a dismissal without any previous discussions about the employee's performance (let alone without any previous formal disciplinary warnings) was unfair.

The Health Centre had ignored not only its own disciplinary procedure, but also all normally accepted good practice for discussing performance with an employee. This case is a reminder of a crucial point: no matter how comprehensive your disciplinary procedure, it will count for nothing unless you tell your staff the performance or behavioural standards you require of them from the outset. ◆

# Stress value to smooth fee

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

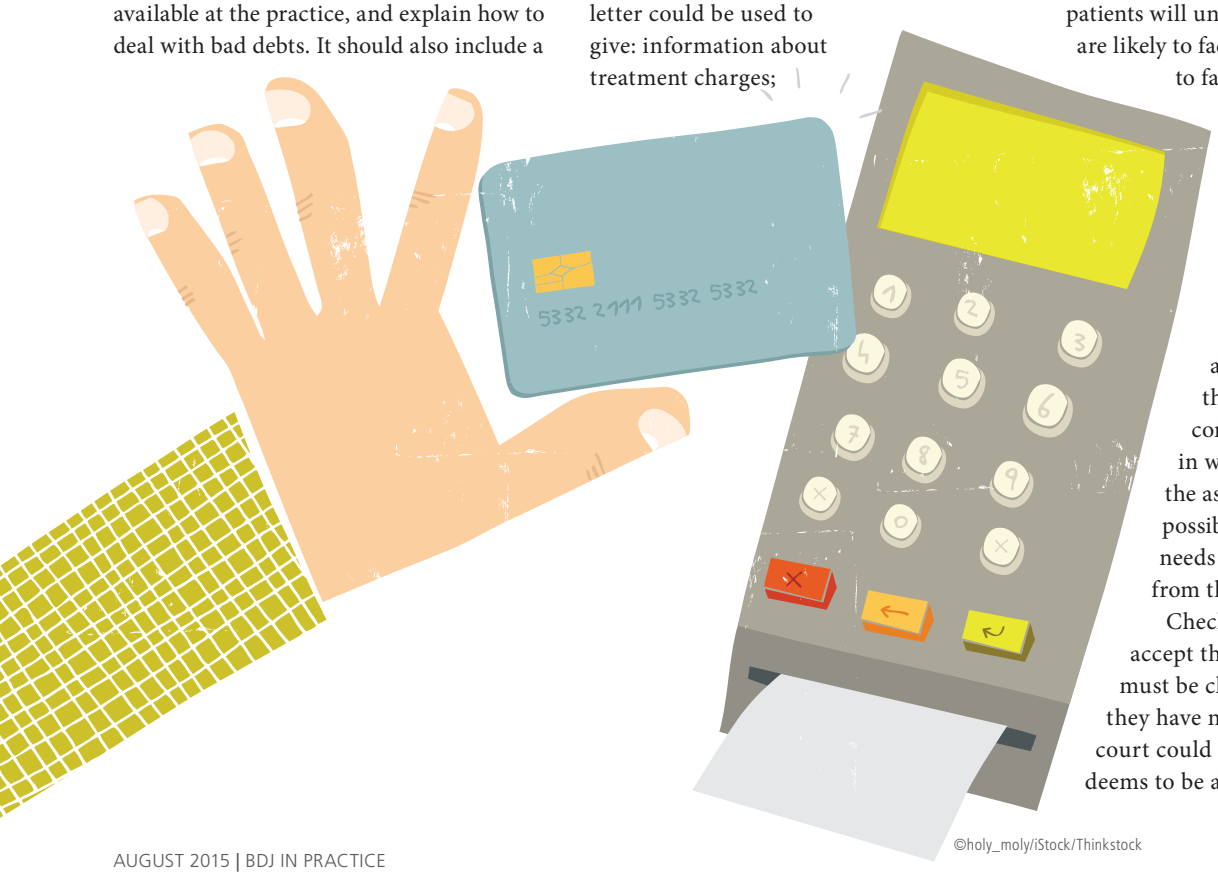
Dentists and other members of the dental team need to feel comfortable about asking patients for payment. Clearly, income is essential for the livelihood of the practice but, as part of good patient communication, collecting fees can also re-emphasise the value for money offered by the practice. Here, a practice policy for fee collection can be a great help. It should establish a formal protocol about when to require payment, list the payment methods available at the practice, and explain how to deal with bad debts. It should also include a commitment by the practice to provide information about costs to patients at every stage of their care. Your payments policy should be understood and followed by all staff. Ensuring timely fee collection is what will keep your business alive.

## Be up front about fees

Patients, too, need to understand your fee-collection policy (**right**). Display information about fees on posters and in a practice leaflet. A new-patient welcome letter could be used to give: information about treatment charges; an indicative price-list; and the payment methods accepted. And remind patients when they make an appointment how fees are collected.

You need to adopt a step-by-step approach when discussing fees with individual patients that follows the patient's pathway. As well as repeating the general information on fees, produce specific treatment plans, estimates and itemised bills; and clearly explain the practice's payment terms. All this is designed so patients will understand what fees they are likely to face and when they are going to face them. Customers (of any business) want to know what they will be paying: nobody likes hidden fees. You and your patients do not want to find yourselves in a dispute over unexpected charges. Treatment plans and estimates continue the process of good patient communication by being clear in what you could provide and the associated costs. If there is a possibility of additional treatment needs or fees, tell your patients from the outset.

Check that they understand and accept the payment terms. Your fees must be clear to be enforceable. If they have not been overtly agreed, a court could instead substitute what it deems to be a reasonable fee, which may

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# collection

not fully reflect your professional time and costs.

A key message here can be to stress quality as well as cost to show that you provide value for money. Value for money is the belief of a buyer that the goods or services they have bought are worth the price they have paid. In dentistry, establishing this link in patients' minds could be done through the attention and empathy you and your team provide during each appointment and by involving patients in their care.

Involving patients, and so allowing them to make informed decisions, is not just good business: it also gels with your ethical commitments, such as the General Dental Council's requirement to "communicate effectively with patients". Encouraging patients to take an active role in their care also goes hand in hand with obtaining informed consent.

> "For one-off treatments or consultations, generally aim to collect the fee at end of the appointment. You or your dental nurse should accompany the patient to reception and ensure that the receptionist has the correct information about the amount to be paid."

## Getting fees paid

Plan how you are going to collect payments: cash, credit and debit cards, or cheques. The Payments Council survey, *The Way We Pay* (2014), found that for spontaneous transactions (non-regular payments, usually face-to-face for either goods or services) debit cards were used for 28% of all payments and credit cards for 8%. Cheques were used for only 1%.

But for higher-value transactions, debit cards were used for 35% of payments; credit cards for 13%; and cheques for 18%. Say clearly which forms of payment that you will accept. (Note: that for NHS fees you cannot add processing fees for debit cards or credit cards to the bill).

For one-off treatments or consultations, generally aim to collect the fee at end of the appointment. You or your dental nurse should accompany the patient to reception and ensure that the receptionist has the correct information about the amount to be paid. But you may decide to vary this depending on the patient's relationship with the practice and the treatment they have just received.

Patients who are undergoing lengthy courses of treatment involving a number of appointments will often be asked to pay upon the completion of treatment. At the penultimate appointment, the patient should be told what the final amount will be and that it should be paid on the next, and last, visit. A final account and a request for payment should then be made at the last appointment. Where revisions to their treatment plan affect the cost, a revised estimate must be issued.

For lengthy or higher-cost treatments, it could be more appropriate to offer patients the chance to pay by instalments over a few months. But if you give this option make sure that you fall within the Financial Conduct Authority's (FCA) consumer credit rules (see www.bda.org/bdjinpracticeonline *Consumer-credit rules relaxed*, June 2015, page 3). And your fee-collection policy should outline any practice rules that you have for allowing payment in instalments.

Before the start of treatment, particularly if laboratory work is involved, you might want to ask for a deposit or part payment of the estimated cost. Your payment policy should describe when a deposit is required: for example, when treatment involves the provision of bridges or dentures. For NHS treatment in England and Wales, the maximum deposit requested can be no greater than the Band-1 charge.

## Keep track of the money

Keeping detailed accounts is vital for the business. Payments should be recorded and proper receipts issued. Regularly check and update payments received against treatments provided and, where necessary, contact those patients who have amounts outstanding to remind them that payment is due and how it can be made. Whenever patients attend the practice, your receptionist should check their record cards for outstanding amounts.

Value for money, patient communication and fee collection sit together. If you provide a good service, demonstrate value for money and ensure patients understand they are receiving value for money, it is likely you will maintain the fee income needed to run a successful business. For more information see www.bda.org/advice for BDA Advice *Fee collection*. ◆

## Patient-guide checklist

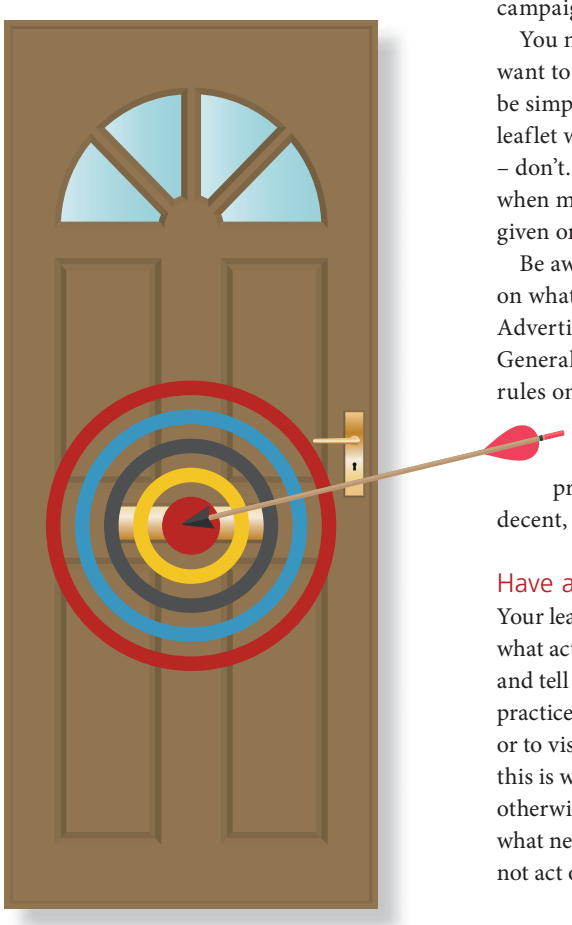
- Give information about fee scales and indicative charges
- Say you will provide treatment plans, estimates, bills and receipts
- List payment methods accepted (cash, cards, cheques, instalments)
- Explain timescales for payment, including terms for payment by instalments, if offered
- Outline the procedure for dealing with outstanding payments

*A model procedure is available in BDA Expert*

# Local leafleting can be cost effective

by John Ling,
the Advice Manager (BDA Expert) at the BDA. He has the Professional Postgraduate Diploma in Marketing from The Chartered Institute of Marketing and is a Chartered Marketer

Leafleting or, as it is sometimes known, a door-drop campaign is, according to the leading magazine for the advertising industry, *Campaign*, one of the most effective ways for businesses to raise awareness in their local area. It is highly effective at reaching many people in a particular area with a simple message or offer. You can reach 16 times the number of people you can with a direct-mail campaign for the same cost – giving you mass marketing, or blanket coverage, at a local level.



## Keep it simple

As the name implies, it involves dropping a leaflet or flyer through doors in the vicinity of your practice. Although this sounds straightforward, there are lots you need to consider before embarking on a door-drop campaign.

You need to be clear about what you want to say. Your message or offer should be simple. It can be tempting to cram your leaflet with lots of information or messages – don't. Less is definitely more – especially when many leaflets or flyers are usually given only a cursory glance, if at all.

Be aware that there are restrictions on what you can and cannot say. The Advertising Standards Authority (ASA) and General Dental Council (GDC) both have rules on acceptable advertising (see BDA Advice *Marketing* at www.bda.org/advice). The ASA's and GDC's key proviso is that adverts must be "legal, decent, honest and truthful".

## Have a call to action

Your leaflet should also make it crystal clear what action you want the reader to take next and tell them how to do it. If it is to visit the practice website, to email, to call the practice or to visit the practice, make it obvious that this is what you would like them to do – otherwise you risk them asking themselves: what next? They could then lose interest or not act on what they have read.

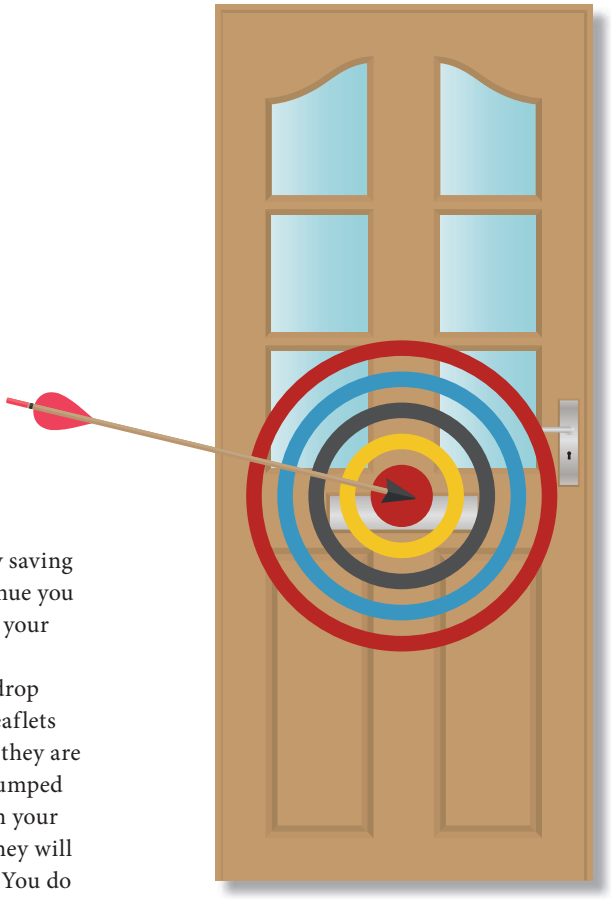
## Don't stint on quality

If you want to portray yourself as a high-quality dental practice, with the highest standards of professional care, then your leaflet or flyer needs to reflect this. Your message can be undermined if the quality of the leaflet does not match what you are saying. Trying to save money on design and printing is likely to be a false economy because sending out a poor-quality leaflet conveys a different image from the one you are trying to project.

So, have your leaflet professionally designed, make sure everything is spelt correctly and neatly formatted, and choose good quality paper. Paper is usually measured in grams per square metre (GSM): ordinary office paper normally has a GSM value of 80. Thicker paper with a high GSM weight is more impressive and, incidentally, easier to post through letter boxes.

The layout and design of the leaflet needs to have impact at first glance. A professional designer and, if you are including images of the practice, a professional photographer, are usually advisable. Also, although it sounds obvious, do make sure any text is legible: carefully consider the font you use, the colour, and make sure your text is not lost among background tints or background images. If your practice has a logo it should be included on your leaflet as it will help people remember and easily identify your practice.

If you are using images in your leaflet you must make sure that you own the



copyright or have permission from the copyright holder to use the image: if not, you could be sued for breach of copyright. Get written permission from anyone, staff or patients, who appear in practice photographs.

> "If you want to portray yourself as a high-quality dental practice, with the highest standards of professional care, then your leaflet or flyer needs to reflect this. Your message can be undermined if the quality of the leaflet does not match what you are saying."

## Target your delivery

Think carefully about whom you want to receive your leaflets. For many practices the answer is simply: "Anyone who lives nearby." For others, it might be more targeted, at "families", or even "affluent families" – in which case you might only deliver your leaflet to particular streets in popular school-catchment areas or large family homes. If you want to sign up patients to a private capitation scheme it would be a waste to print and distribute leaflets to people who will have no interest in what you are offering.

The cheapest way to deliver your leaflets is, in theory, for you or your staff to do it – although going door to door can be a trudge, is time consuming, and any saving has to be balanced against the revenue you could be generating by focusing on your core businesses.

Alternatively, you can pay door-drop delivery companies to deliver the leaflets on your behalf. But make sure that they are reputable – a pile of your leaflets dumped behind a hedge will reflect badly on your image and reputation. Also ask if they will they be delivering just your leaflet. You do not want your message to be lost in a clump of other flyers that are pushed through letterboxes in a bundle. If you need to cover a large area, Royal Mail will deliver your leaflets to the postcodes you specify and may be able to help you identify the postcodes where your target audience lives, although you will pay more for their service and expertise.

## Measure campaign's effectiveness

You will, of course, want to know how effective your leaflet has been. This can be hard to measure. Patients may attend but not just because they received your flyer. There are, however, several ways you can try to measure the effect it has had. One is to compare the number of patients you have before and after the campaign. Deduct from the number of patients you had before the campaign the number of new patients you would normally expect to see over a couple of months. Then calculate how many new patients you have seen in the couple of months after your leafleting campaign. Although a crude measure, it will give you an indication of the success of your campaign.

If you are asking for a response, perhaps for people to email or telephone the practice for more information, you could set up a dedicated email address or keep a tally of the number of calls for information you receive.

Alternatively, just ask new patients how they heard of your practice. Doing this is very important if your leafleting is part, as is generally advised, of a wider marketing strategy.

Sometimes flyers offer potential customers a discount or free gift if they bring the flyer with them, although this can be difficult to do in dentistry. Discounts could be offered on your private fees for certain services or you could offer an appropriate dental product (you need to check the GDC rules on product endorsement, sticking to verifiable facts).

With a little thought and planning, a good design, high-quality printing and a properly targeted campaign, door-to-door leafleting can be a highly effective way to promote your practice to people in your area. ◆

# Income Protection has never been so easy


Lloyd & Whyte

## Get an income protection quote online and receive 20% off your BDA membership renewal when you take the policy out.

We've been working with dentists long enough to know which income protection providers give you the best cover, so we put them all in one place.

What's more we're rewarding BDA members with 20% off their renewal membership when they take the policy out. Full terms and conditions are available on our website.

**Get a quote today by visiting www.lloydwhyte.com/bdaincomeprotection**

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BDA

**What matters to you, matters to us**

**www.lloydwhyte.com**

## Simplify sterilisation tracking

When it comes to efficient tracking solutions for instrument sterilisation, you need look no further than the Steritrak Instrument Tracking system from Carestream Dental.

The web-based, user-friendly program has been designed specifically to help you meet requirements of both the Care Quality Commission and *HTM 01-05*.

The software's ability to gather all pertinent data and automatically generate comprehensive, industry standard reports will simply your daily processes for maximum convenience and peace of mind. It can also be seamlessly integrated within the new CS R4+ practice-management software, which offers further key features to help streamline protocols and analyse practice performance in real-time.

What's more, Carestream Dental is dedicated to the eXceed programme for the provision exemplary customer service every time, so you can be sure to receive all the advice and support you could need.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

## Partial-denture patients almost twice as likely to lose more teeth

Wearing a partial denture almost doubles the patient's risk of losing more teeth than non-partial wearers[1].

Tooth loss can have a profound effect on the lives of patients both physically and emotionally – 45% of patients experience difficulties accepting the loss of their teeth[2]. As their trusted dental professional, your advice can have a huge impact on a patient's well-being, while also helping them to avoid losing more teeth.

Support-denture wearers with the POLIGRIP® Partial Wearer Starter Kit. Designed specifically for new partial-denture wearers, the kit contains a range of materials to help you to explain the process to patients and help them through each step of the denture journey. The kit includes reassuring advice for patients, product samples and money-off coupons.

Request your FREE kits now while stocks last at www.gsk-dentalprofessionals.co.uk

1. Preshaw PM *et al. J Dent* 2011; **29:** 711-719.
2. Davis DM *et al. Brit Dent J* 2000; **188(9):** 503-506




## Raising expectations

Providing a quality service to your patients is a priority for you as a dental professional so shouldn't the service delivered to you be a priority for the supply companies with whom you work?

Delivering complete support and maintenance services from centres located around the UK, the highly skilled team of engineers from Castellini are on hand to provide any advice or technical guidance you may need. They'll even offer training for the relevant members of your team, to make sure they can get the very most out of the new equipment.

So next time you need a new state-of-the-art dental unit, x-ray unit or specialist instruments, look no further than Castellini to receive customer service equal to the high standard of care your patients expect from you.

If you want more information on how to receive Castellini Technical Accreditation, call 08000 933975.

## You'll find a great deal at BDIA Dental Showcase

It's an exciting time for the dental profession, with research showing that nearly 70% of dentists are looking to expand their businesses within the next five years.* This makes attending BDIA Dental Showcase the ideal opportunity to find out what's new in dentistry.

This event is to be held on 22-24 October at the NEC in Birmingham. With over 350 manufacturers and service providers exhibiting you have hands-on access to the latest innovations and can take advantage of a range of exclusive show offers. This is one reason why, last year, 73% of visitors made purchases during, or as a direct result of attending, the event.

There is a lot to learn, too. This year's event sees the introduction of the new Dietary Zone, supported by The Dairy Council, which explores the latest thinking in the links between diet and oral health. Your team can also experience and learn from lively mini-lectures and gain practical business advice that can be taken back into dental practices and laboratories across the country, helping them stay ahead in today's increasingly competitive market.

Sessions include:

- Exploring new horizons – presented by mydentist
- Exciting innovations that will change the way you practice dentistry – presented by DirectaDentist
- Quick, straight smiles from Cast and SmileTRU – presented by SmileTRU/Cast
- Producing and maintaining a perfect finish on anterior restorations – presented by Oral B
- Cerezen clinical-trial overview – presented by CerezenTM
- Better understanding of how banks assess lending propositions – presented by Lloyds Bank
- Ergonomic sitting in dental practice – presented by Salli Systems

Stephen Hancocks from the *British Dental Journal* said: "The BDIA Dental Showcase is a great place to find out about the latest developments that can enhance not only the practice of dentistry, but also the business of dentistry."

The BDIA Dental Showcase is the biggest dental trade show in the UK – so put the date in your calendar and register now for tickets for you and your team by visiting www.dentalshowcase.com

**Healthcare Confidence Index*. Lloyds Bank. March 2015.

## Invest in quality

When it comes to making your practice fit for the challenges of modern dentistry, Tavom UK will make your ideas a reality.

The beautiful, bespoke furniture looks contemporary and is built to last. You will be providing your team with an efficient comfortable place to work in, which will boost morale, reduce stress and impress your patients.

Tavom UK's design service will allow you to see all the furniture *in situ* before you complete your purchase. The team will find a solution to make the most of your space and create a clean, streamlined environment.

If you want to allow for future expansion, Tavom UK's experts will build this flexibility into your design.

For more information, call 0870 752 1121 or visit www.tavomuk.com

## Develop your business

Lifecycle marketing is a comprehensive approach for helping small businesses expand and grow sales. A customer-centric strategy, it is founded on the idea of sending the right message to the right person at exactly the right time.

The team at 7connections understands the importance of creating and nurturing long-term patient relationships through precisely timed communications and has recently partnered with Infusionsoft to offer even more effective support to practices around the UK.

Together they can help you develop, build, implement and evaluate your marketing strategy to ensure that you use the most effective tools for your business.

For more, call 01647 478145 or email phillippa.goodwin@7connections.com

## Crossing the interdental divide

The Wisdom Clean Between Interdental Brushes are clinically proven (Yost *et al. J Clin Dent* 2006; **17**(3)**:** 79-83 and Petra Ratka-Krüger *et al. Clinical trial of a metal-free interdental brush.* University Medical Centre Freiburg, Germany. Nov 2010) to help your patients safely and gently remove plaque and maintain optimum dental health.

From September, a dentist-surgery pack of Wisdom Clean Between Interdental Brushes will be available through dental wholesalers for you to use on patients. Consisting of a dispenser box with 100 cello-wrapped bundles of each colour of brush, these will provide the ideal opportunity to introduce the products to patients, showing how their oral health can be maintained with ease.

Constructed with latex-free, rubber filaments, they are wire-free and easy to use between tight spaces in natural teeth, under bridges, around dental implants and with fixed orthodontic appliances.

The soft tips gently stimulate and massage the gingiva, minimising trauma and helping to prevent galvanic effect.

For more, visit www.wisdomtoothbrushes.com or call 01440 714800.


# DENTAL SHOWCASE'15

## 22–24 October 2015, NEC Birmingham

## Registration now open!

**• 350+ stands • Discover and trial what's new • Broaden your knowledge**

BDIA Dental Showcase is the UK's leading B2B trade show for dentistry. With over 350 stands and exhibitors, 73%* of attendee's purchase either during or directly after the show. Don't miss out on our exclusive show deals and register today.

**Putting innovation into practice for every member of your dental team**

**www.dentalshowcase.com**

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BDIA Dental Showcase 2015 is organised by the British Dental Industry Association (formerly the BDTA), Mineral Lane, Chesham, Bucks, HP5 1NL Tel: +44 (0)1494 782873 Email: admin@bdia.org.uk
*2014 independent visitor research carried out by Serendipity Sales Solutions

# BDA Good Practice

BDA
British Dental Association

## A framework for continuous improvement

**BDA Good Practice is a framework for continuous improvement that helps you build seamless systems and develop a confident and professional dental team. Our three key principles describe the fundamentals of BDA Good Practice:**

**Systems**

Develop systems to enhance the efficiency of your practice.

**Team working**

Build an enthusiastic, motivated and engaged team and improve practice communications.

**Patient experience**

Create a loyal patient base and drive personal recommendation.

### www.bda.org/goodpractice

All BDA members can now access the BDA Good Practice self-assessment via the BDA website.

Allow four to six months to work through all of the requirements.

Make an application

When your team has completed the practice self-assessment, download, complete and return the application form together with the fees:

- Application fee: £425
- BDA Good Practice membership: £300 (per year)

The application assessment usually involves an on-site assessment by a BDA Assessor. An on-site assessment is a valuable and collaborative experience to help you develop your practice. A summary report is provided.

Advertise

Member practices advertise their team's commitment to working to the BDA Good Practice standard with the exclusive BDA Good Practice membership plaque, member logo and are listed on www.bdasmile.org/gps.

**www.bda.org/goodpractice | 020 7563 4598 | goodpractice@bda.org**

# Dentist to Dentist

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

## Midlands

### NPH REFERRALS
www.nphreferrals.co.uk

Brassey Rd, Shrewsbury, Shropshire SY3 7FA
**Tel:** 01743 244446
**Email:** info@nphreferrals.co.uk

**Dr. Oliver Bowyer BDS MFDS RCS(Eng) MSc MOrth RCS (Eng) FDS RCS (Eng)**
Consultant Orthodontist. Specialist in Conventional and Aesthetic Orthodontics including aligners and lingual appliances.

**Dr.Jeremy Edmondson BDS MSc(Endo) MFGDP(UK) MGDS RCSI**
Endodontics (primary and re-treatments). Removal of fractured files, posts and perforation repairs. Surgical Endodontics. Endodontic Trauma Management. Internal Bleaching.

**Dr.Richard Gatenby BDS MFGDP(UK) FFGDP(UK) Dip Imp Dent RCS(Eng) Dip LM RCS(Eng)**
Implant placement, autogenous bone grafts and sinus lifts.

**Mr.Ahmed Messahel BDS FDSRCS(Eng) MB ChB MRCS(Eng) PGA Med Ed. PGA MLiP FRCS(Eng) OMFS.**
Consultant Oral & Maxillofacial surgeon. Specialist in Oral surgery.

**Dr.James A Russell BDS**
Aesthetic and Restorative Dentistry. Accredited by the British Academy of Cosmetic Dentistry. Complex single and multi-unit aesthetic restorations.

Inter disciplinary treatment planning where required.

Facilities include Cone Beam CT.

261047

### THE PRIORS DENTAL PRACTICE LTD
www.thepriorsdentalpractice.co.uk

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

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

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

**Interests:** Periodontics, Orthodontics, Implants

**Dr Ayodele Soyombo**
**On Specialist List:** Yes, Orthodontics

**Dr Bola Soyombo**
**On Specialist List:** Yes, Periodontics

**Dr O Onabolu**
**On Specialist List:** Yes, Periodontics

209439

## North West

### ST GEORGE'S DENTAL PRACTICE
www.stgeorgesdentalpractice.co.uk

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

261006

## Scotland

### BLACKHILLS SPECIALIST REFERRAL CLINIC
www.blackhillsclinic.com

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

209189

## EDINBURGH DENTAL SPECIALISTS

www.edinburghdentist.com
www.tele-dentist.com

Edinburgh Dental Specialists,
178 Rose Street , Edinburgh EH2 4BA
**Tel**: 0131 225 2666 **Fax:** 0131 225 5145

**Dr Kevin Lochhead BDS LOND, MFGDP (RCSEng)**
**Interests:** Fixed and Removable Prosthodontics, Dental Implants
**On Specialist List:** Yes, Prosthodontics
**Dr Pier Luigi Coli DDS, PhD**
**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)**
**Interests:** Fixed and Removable Prosthodontics
**On Specialist List:** Yes, Prosthodontics
**Matthew Brennand-Roper BDS MClinDent (Pros) MJDF RCSEng MFDS RCSEd MPros RCSEd**
**Interests:** Fixed and Removable Prosthodontics, Dental Implants
**On Specialist List:** Yes, Prosthodontics
**Dr Carol M E Tait BDS, BDS Hons. MSc, MFDS RCSEd, MRD RCSEng**
**Interests:** Endodontics **On Specialist List:** Yes, Endodontics
**Dr Robert Philpott BDS MFDS MClinDent MRD (RCSEd)**
**Interests:** Endodontics
**On Specialist List:** Yes, Endodontics
**Dr Penny Hodge BDS Edin 1982, PhD Glasg 1999**
**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
**On Specialist List:** Yes, Oral and Maxillofacial Surgery
**Prof Lars Sennerby DDS, PhD (Visiting Professor)**
**Interests:** Implant Dentistry, Biomaterials, Bone Biology
**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
**Dr Donald Thomson BDS (Edin), FDS RCSEd, FDS RCPSG, DDR RCR Interests:** Cone Beam CT Imaging
**Specialist List**: Yes, Dental and Maxillofacial Radiology

259506

# North

## IVORY DENTAL PRACTICE

www.ivory-dental.co.uk

108-110 Town Street, Horsforth, Leeds LS18 4AH
**Tel:** 0113 2583349 **Email:** info@ivory-dental.co.uk
Specialist referral practice and CBCT scanner.
Referrals can be made via: www.ivory-dental.co.uk/information-for-dentists
**All** patients delivered back to referring dentist for ongoing maintenance

**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

## SPECIALIST DENTAL CARE

www.specialistdentalcare.com

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

261782

# South East

## WOOD LANE DENTISTRY

www.woodlanedentistry.co.uk

37 Wood Lane, Sonning Common, Berkshire/Oxfordshire, RG4 9SJ
**Tel:** 0118 972 2626
**Email:** info@woodlanedentistry.co.uk

**Claudia Wellmann BDS(Hons)(Wales) MFDS RCSEng MSc (Hons)(Perio)**

**Vikram Chugani BDS (Wales) MFDS RCSEd MSc (UCL)**

**Jessica Lee BDS (Wales) MFDS RCSEng DipDentSed**

**Referrals accepted for Periodontology, Endodontics, Implants, Restorative Dentistry, Oral Surgery and Dental Sedation.**

**On Specialist List:** Yes, Restorative Dentistry and Periodontology

257674

## HARRY SHIERS DENTISTRY IMPLANT REFERRAL PRACTICE

www.harryshiersdentistry.co.uk

28 Harley Place London W1G 8LZ
**Tel:** 0207 580 2366
**Email:** harryshiersdentistry@gmail.com

**Dr Harry Shiers BDS (Lon). MSc. (Implant dentistry) (Eng) MGDS. RCS. (Eng) MFDS. RCPS. (Glasg)**

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

**(Accredited Specialist in Orthodontics).**

**Interests:** Restorative dentistry, Implant dentistry, Cosmetic dentistry, Preventative dentistry, Orthodontics, Periodontics, Peadodontics

**On Specialist List:** Yes, Orthodontics, Periodontics.

252578

## DENTAL SPECIALISTS MK

www.dentalspecialistmk.com

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

209440

## LONDON SMILE CLINIC
www.londonsmile.co.uk

40-44 Clipstone Street
London, W1W 5DW
**Tel:** 02072552559
**Email:** info@londonsmile.co.uk

CT scanner, Digital OPG and Ceph and Zeiss microscope on site.

**Dr Andrew Chandrapal BDS MFGDP (UK)DPDS (BRIS) MClinDent (Pros), GDC-79890**
**Interests:** Prosthodontics, implant supported dentures, complete and partial dentures, restorative dentistry.

**Dr Padhraig Fleming BA BDent Sc (Hons) MSc. (Lond).MFD RCS (Ire)MFDS RCS (Eng). MOrth RCS (Eng). FDS (Orth) RCS CLIT, GDC-82611**
**Interests:** Orthodontics
**On Specialist List:** Yes, Orthodontics

**Dr Daniel Flynn BDentSc MFDS RCSI MClinDent MRD, GDC-100571**
**Interests:** Endodontics, microsurgery
**On Specialist List:** Yes, Endodontics.

**Dr Hatem Algraffee BDS, MSc, M.Clin. Dent., MRD RCS (Eng), MFDS RCS (Eng), GDC-72250**
**Interests:** Periodontology, gum grafting
**On Specialist List:** Yes, periodontics

**Dr Zaki Kanaan BDS MSc Dip Dsed LFHom, GDC-72312**
**Interests:** Implant surgery, oral surgery, bone grafting and sinus lifts.

263521

## DENTAL SPECIALISTS ST ALBANS

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

239826

## AYUB ENDODONTICS
www.ayub-endo.com

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

230732

## KAIZEN DENTAL IMPLANTS CENTRE
www.kaizendentalimplants.co.uk

191 Parrock Street, Gravesend, Kent, DA12 1EN
**Tel:** 01474 247600
**Email:** info@kaizendentalimplants.co.uk
**Interests:** Dental Implants

**Dr Rik Trivedi BDS (Lon) DipImpDent RCS (Eng) & Associates**

**Excellence in implant referrals**

258516

## TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

## CRESCENT LODGE DENTAL PRACTICE
www.dentistsw4.com

28 Clapham Common, Southside, London SW4 9BN
**Tel:** 020 7622 5333
**Fax:** 020 7720 8782
**Email:** reception@dentistsw4.com
**Specialist Periodontist:** Dr Stella Kourkouta DipDS, MMedsci MR RCS FDS RCS Eng
**Specialist in Oral Sugery:** Dr Fabrizio Rapisarda DDS

We welcome your referrals.

255225

## MHV SMILE CENTRE LTD T/A ASPECTS DENTAL AND REFERRAL
www.aspectsdental.com

Aspects Dental and Referral
38 Benbow Court Shenley Church End, Milton Keynes, MK5 6JG.
**Tel:** 01908 506199
**Email:** info@aspectsdental.com
**Interests:** Periodontics, Endodontics, Implants, Prosthodontics and Dentistry Under IV
**On Specialist List:** Yes
All referrals welcome.

257244

## WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

253003

## South West

### THE CIRCUS DENTAL PRACTICE
www.circusdentalpractice.co.uk

**Paul HR Wilson BSc (Hons) BDS MSc FDSRCPS FDS(RestDent) RCPS GDC No: 72955**
13 Circus, Bath, BA1 2ES
**Tel:** 01225 426 163 **Email:** reception@circusdentalpractice.co.uk
**Interests:** Fixed & Removable Prosthodontics, Implants, Bone Augmentation, Soft Tissue Augmentation, Endodontics, Aesthetic Dentistry, Treatment Planning Assistance, Study Club, Implant Mentoring.
**On Specialist List:** Yes, Restorative Dentistry, Prosthodontics & Endodontics

239371

## East Anglia

### GRANTA DENTAL LTD
www.grantadental.co.uk

**Dr Helen Harrison**
39 Newnham Road, Cambridge CB3 9EY
**Tel:** 01223 461381
**Email:** reception@grantadental.co.uk
**Interests:** TMJ, Occlusion, Splints for pain relief & reconstructive treatment planning
**On Specialist List:** No

237823

### DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

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

**Specialist Referral and Education Centre**

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

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

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

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

**Specialist Periodontist:**
**Trisha Whitehead**

**Specialist Orthodontist:**
**Dirk Bister**

WINNER Dentistry Awards Best Practice East 2014

254718

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British Dental Association

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2015

# Anniversary Lecture

www.bda.org/anniversarylecture | 1 HOUR VCPD

## Oral health, epidemiology and the British way of life

**Professor Jimmy Steele**
Head, School of Dental Sciences,
Newcastle University

The BDA/ BDJ Anniversary Lecture is kindly sponsored by:

HENRY SCHEIN® DENTAL

# Business skills CPD

**Q1:** From when will all currently registered dentists have to make a declaration of indemnity to the General Dental Council?

**A** this month
**B** September 2015
**C** January 2016
**D** August 2016

**Q2:** Which of the following should associate and practice owner take into account when negotiating the appropriate fee apportionment for their practice: a – size and nature of the patient base; b – trends in patient numbers, gross fees and practice costs; c – terms offered at other local practices?

**A** a and b
**B** b and c
**C** a and c
**D** a, b and c

**Q3:** Which of the following statements is *not* true of an employee's request for flexible working?

**A** A request can be to alter their working hours or their working times
**B** The employee must have a specific reason for making the request
**C** Your objective should be to see if it is possible to accommodate the request
**D** Any agreed changes need to be reflected in the employment contract

**Q4:** Which of the following should you do when coaching an employee in a task: a – ask your employee's view on their performance; b – identify the support available for positive results; c – reinforce your appreciation of any improvements in your employee's work?

**A** a and b
**B** a and c
**C** b and c
**D** a, b and c

**Q5:** According to a Payments Council survey, what percentage of higher-value transactions are paid for by debit card?

**A** 8%
**B** 18%
**C** 28%
**D** 35%

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

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

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

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

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

## Need help?

To access *BDJ In Practice* CPD online:

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

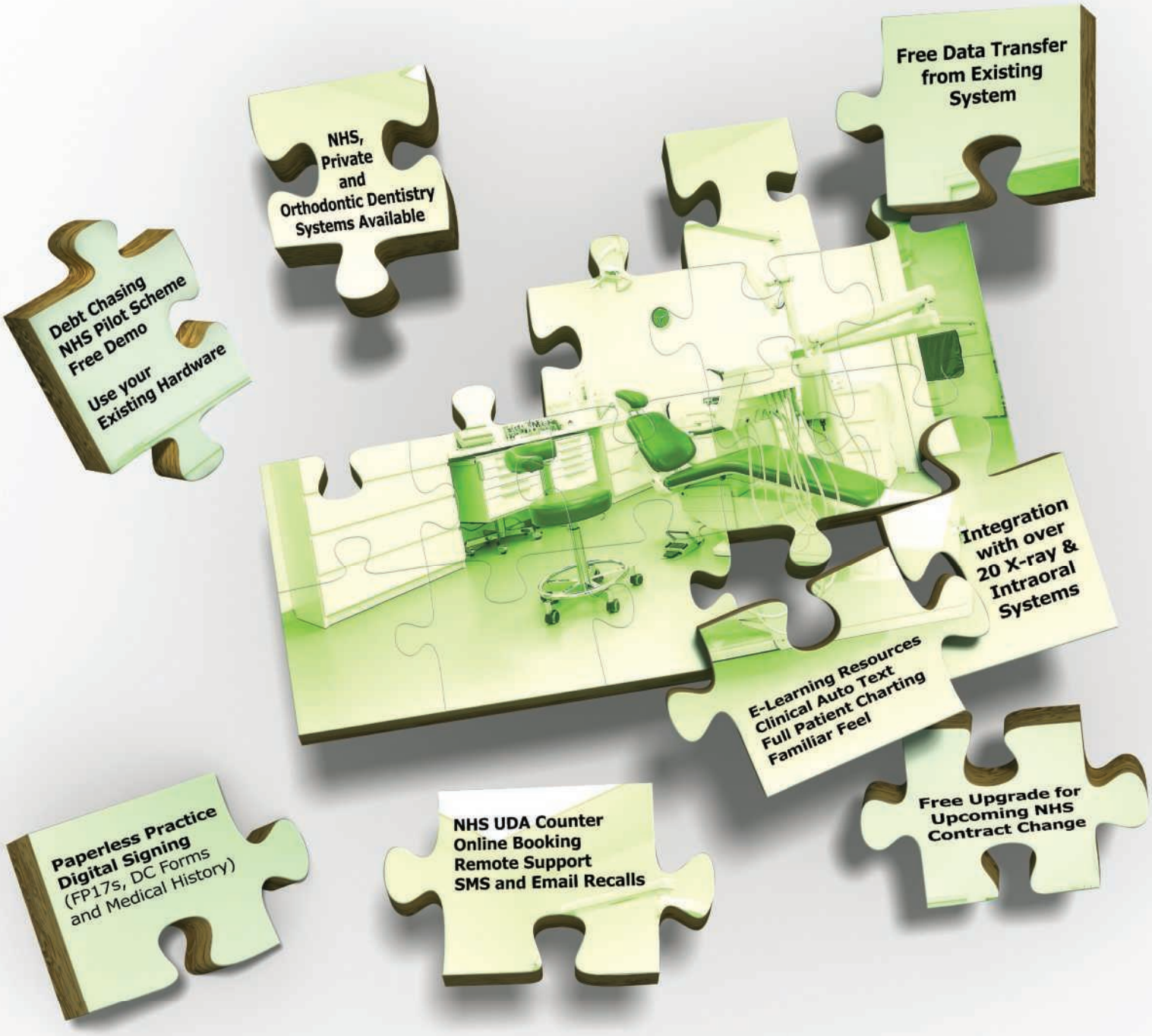
**First-time user:** select *BDJ In Practice* CPD on the front page of the CPD Hub and enrol for the service. You will automatically be taken to the *BDJ In Practice* CPD page.

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

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

For support use: mailto:cpd.hub@bda.org

# Is your practice missing a **vital piece?**

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BHA software

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*Essential software in every professional practice*

## WHAT IS PLANMASTER$^{3D}$?

**Patient education software and so much more...**

- **Animate and explain** exactly what different types of treatment involve simply and effectively with just one click.
- Create fully **personalised 3D animations** for even the most complicated of procedures, which can be clearly and concisely explained to your patients at every stage from the outset until the conclusion of treatment at the touch of a button.
- Easily understandable **treatment plans**, including itemised price lists, generated automatically.
- Available on desktops, tablets and even smartphones **without any installation**.

A case study by Dr. Gabriel Green, DDS, MSc

# HOW DID I DOUBLE MY CONSULTATION SUCCESS RATE?

Over the last few months the number of consultations I have provided has increased dramatically. As of now I need to expend less time and energy in order to elicit a positive and rapid response from my patients, even when the upcoming treatment is complex in nature.

**I've tried it and it works!**

I first started to use PlanMaster$^{3D}$ six months ago, the main goal of which was to increase my consultation succes rate; it aids patients in clearly understanding the treatment they will receive whilst also providing them with more confidence before they take to the dental chair.

**How do I use PlanMaster$^{3D}$?**

I utilise the 'one-click 3D animations' when I want to quickly and simply illustrate a treatment type or demonstrate the differences between various treatment options. More importantly, as an implantologist I like PlanMaster$^{3D}$ due to its capacity to create fully personalised treatment visualisations. My patients are extremely appreciative of being able to see their current dental status, their treatment and the final result; having sent them their treatment plan and quote together with the 3D animation, I very soon receive a reply saying: *'Let's do it!'*

**Unlike others...**

As an open-minded dentist I've tried a lot of different software in the past, but PlanMaster$^{3D}$ is different in many important respects: it exerts a positive, tangible effect on my practice's performance, is very easy to use, requires no installation, I can use it anywhere, anytime and my hands aren't tied as I can use it on a monthly subscription basis.

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