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February 2016

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HONOURS AND AWARDS
Gala Dinner 2016

SATURDAY
28 MAY 2016

19:00 – 00:00

The Midland Hotel
Peter St, Manchester

Dress code: Black tie

The BDA's annual Honours and Awards Gala Dinner celebrates the achievements of individuals within UK dentistry. The Association's highest honours and awards will be presented by colleagues from associations representing dental care professionals.

This prestigious event will be held at the Midland Hotel as part of the BDA's flagship Conference and includes a three course meal, the awards ceremony and after dinner entertainment. It is not only a great opportunity for the team to come together and celebrate professional achievements but is also a fantastic way to mark the end of the 2016 British Dental Conference and Exhibition.

BOOK EARLY to avoid disappointment - places are limited.

Ticket price: £85 (inc VAT)

You can book your ticket as part of your Conference and Exhibition registration or by calling

0844 3819 769

Buy nine tickets and get the tenth one free.

Email **bda@delegate.com** or call **0844 3819 769.**

Offer not available online.

BDJ InPractice

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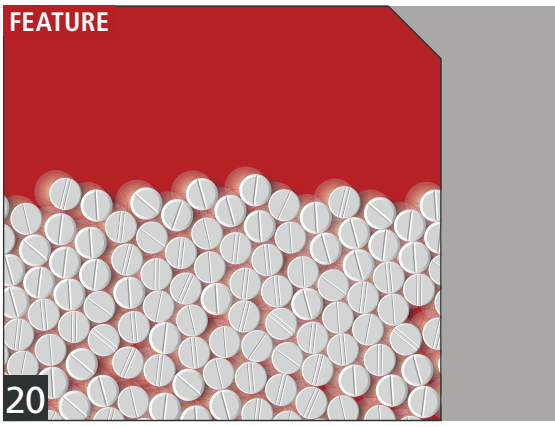

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BDA

IMMUTABLE LAW #4 OF PRACTICE PERFORMANCE

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STAFF RETENTION

Show us the money, say staff

Practices thinking of offering perks rather than cash to retain staff should think again, research suggests.

Most staff believe workplace perks are pointless and would rather have a pay rise or a bonus, a survey of 2400 UK workers by job-site CV-Library has found.

Although almost one-quarter of staff (24.3%) said they were provided with workplace perks by their employer, 24% of them said they would rather have the money and a further 48.8% only rated their perks as "OK". Given the choice, 84.5% of employees would rather have a pay rise or bonus than workplace perks.

But if forced to pick a perk, most would choose to have more time off (40.8%) or something practical that saved them money, such as a gym membership (17.1%).

And over one-half of employees (50.8%) believe perks are "just a fad" and would rather see the money!

But some businesses seem to be getting it right: one in five staff who received perks in the office said they were happy with the benefits on offer.

"When run effectively, workplace perks can go great lengths to creating a happy and productive workforce," founder and managing director of CV-Library Lee Biggins said.

"However, it's important that perks aren't used as a replacement for fair salaries and bonus schemes." (But see also page 14).

PEC elections results

The following members have been elected to the BDA's Principal Executive Committee (PEC).
North East: **Paul Blaylock** (re-elected)
Northern Ireland: **Philip Henderson** (re-elected unopposed)
South West: **Nigel Jones** (re-elected)
Yorkshire and Humber: **Mick Armstrong** (re-elected unopposed)
UK-wide: **Paul Woodhouse** (newly elected)

The PEC is the BDA's governing body and comprises 15 members in total. There are annual renewal elections for one-third of members.

Sugar-monitoring app

Parents can now download a free app to help them monitor their children's sugar consumption.

To download the Sugar Smart app, go to https://itunes.apple.com/gb/app/change4life-sugar-swaps/id1015850256?mt=8 or https://play.google.com/store/apps/details?id=com.PHE.SugarSwaps

Delays to DBS checks

A backlog of 68,000 cases in the Metropolitan Police Service (MPS) completing Disclosure and Barring Service (DBS) checks could impact dentistry.

Fewer than 45% were completed in the target of 60 days, with some taking up twice as long, and the average is about 75 days, the DBS says.

MPS has implemented a recovery plan that includes recruiting more staff, prioritising certain cases and escalating very urgent work.

If an application has been with the MPS for 60 days or more, an applicant can check on the progress of their application using the DBS tracking service at https://www.gov.uk/disclosure-barring-service-check/tracking-application-getting-certificate or call the DBS on 03000 200 190 and they will contact the police to ask for the application to be prioritised, but this request may still be refused.

Both the MPS and the DBS have apologised for the delays and are working "tirelessly together to improve processing times for DBS checks as quickly as possible," according to the Gov.uk website.

The Care Quality Commission (CQC) checks for DBS certificates in two circumstances in dentistry.

A CQC-countersigned enhanced DBS check must be available when applying to become a provider. An individual must have one, as must all partners in a partnership and any registered managers. The nominated person in a limited company must also have an enhanced one, but that does not need to be CQC-countersigned.

These enhanced DBS checks would be required if, for example, a dentist decided to incorporate and change from being a sole trader to being a limited company or if a short-term partnership was set up to transfer the NHS contract from a seller to a buyer. Essentially, any change of "legal entity" needs them.

The CQC will return any application forms if the enhanced CQC-countersigned DBS check number on it is over six months old.

The second circumstance is where the CQC checks a practice's "effective and safe recruitment" system. CQC-registered providers are responsible for carrying out DBS checks on their staff where applicable and, from the BDA's interpretation of the 2014 Regulations, staff who undertake any clinical work must have an enhanced one and non-clinical staff a standard one.

RECRUITMENT

Firms missing business benefits of local volunteering

Nearly two-thirds of workers would prefer to work for companies that support local volunteering, a survey has found. And further research has highlighted the business case for employer-supported volunteering (ESV).

They found that 81% of those who took part in volunteering reported increased community awareness, 65% saw increased communication skills, and 59% reported an increase in confidence. But, although 65% of respondents would be more likely to work for an employer who encouraged and promoted volunteering, 39% said their employer did not support it.

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A lack of mutual understanding between firms and charities about the costs and benefits involved is the main barrier to ESV, the research by the professional body for HR and people development, the CIPD, and the National Council for Voluntary Organisations (NCVO) also found.

"What we're unfortunately seeing from this research is a lack of understanding from many employers about why volunteering is important, and a lack of communication between charities and business about how they can work together," Katerina Rüdiger, Head of Policy Campaigns – Community Investment at the CIPD, said.

Volunteering could deliver business benefits by both helping organisations build relationships within their local communities and by giving employees the chance to build new skills and capabilities that they could then transfer back to their day jobs, she added. Executive director of volunteering at NCVO Justin Davis Smith, said: "Employer-supported volunteering could potentially offer huge benefits for the voluntary sector and businesses alike – however, this research shows that without clear communication around expectations and the resources involved, many of those benefits could be lost. We need to recognise that volunteering isn't free – there is a cost to the charity in terms of staff time, resources and supervision – yet the right kind of volunteering could outweigh those costs tenfold." ◆

New Year's Honours

Five dentists have been recognised in the 2016 New Year's Honours list.

Margie Taylor, the Chief Dental Officer for Scotland, was appointed a commander of the Order of the British Empire (CBE), for her services to dental health in Scotland.

Christine Goodall, Senior Lecturer and Honorary Consultant in Oral Surgery at Glasgow University's Dental School, was appointed an Officer of the Order of the British Empire (OBE), for her services to violence protection and victims of crime.

Eric Rooney, Consultant in Dental Public Health at Public Health England and Deputy Chief Dental Officer England, was appointed a Member of the Order of the British Empire (MBE) for services to dentistry.

Jane Davies-Slowik, Associate Dental Dean at Health Education England, West Midlands, and a special-care dentist at Wolverhampton NHS, was also appointed MBE for her services to improving oral health of disadvantaged people.

And **Ashley Lupin** from Canterbury, Kent, has been awarded the British Empire Medal (BEM) for humanitarian services to medical training in Uganda. ◆

Don't risk a pensions fine

Small and micro employers must act this year to meet their new workplace pensions duties or risk a fine, The Pensions Regulator has warned.

All such employers should have received a letter from it telling them when their automatic-enrolment duties begin and reminding them to act.

But research shows that smaller employers are likely to leave things to the last minute, leave it too late or not take action at all. Such failure to act risks fines, the Regulator says.

"We are concerned that a minority of smaller employers are leaving things too late and struggling to comply on time," executive director for automatic enrolment Charles Counsell said.

"We are helping employers avoid this by alerting them in good time to their duties and giving them the tools they need to meet them."

Employers who have not already done so should begin planning by using the Regulator's online duties checker, which is part of a new online step-by-step guide: http://www.thepensionsregulator.gov.uk/en/employers

The checker tells employers specifically what duties apply to them and this means the Regulator can send them information suitable for their circumstances.

Not all firms will have staff who need to be put into a pension scheme but employers still have a duty to tell staff about automatic enrolment and complete a declaration of compliance. Anyone who receives a letter from the Regulator but who does not employ any staff should still act by telling The Pensions Regulator. Failing to do this could trigger unnecessary non-compliance action, the Regulator warns. ◆

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COMPLAINTS HANDLING

Don't risk neglecting social media

Practices need to keep a close eye on, and actively manage, social media to avoid risking damage to their reputations and loss of patients, research suggests.

Social media is now the channel of choice for nearly one in five people wanting to complain about a service they have received, beating other routes such as the telephone, email and face-to-face contact. And one in three says they would move their custom if they received poor service.

The survey of 1000 UK consumers by Echo Managed Services found that 18% of people opt for social media first to voice a complaint or when a complicated problem arises that needs solving.

As many as 14% will turn to it first in a crisis and 13% use it above other available contact channels to request information.

These findings showed that businesses must begin to take social media seriously as a customer-contact channel and ensure that it was joined up seamlessly with other contact channels – or risk a damaged reputation, Echo said.

"Our research findings demonstrate that consumers are willing to use social media for a variety of enquiries – even for complicated ones and to make a complaint," Echo Managed Services head of sales and marketing Chris Cullen said.

The unpredictability of these customer issues and the public-facing nature of social media meant social media should be managed by those with responsibility for customer services rather than for marketing, he explained.

"But what's crucial is that both departments work closely together and not in isolation," Chris Cullen said. ◆

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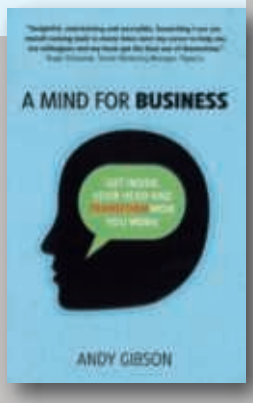
BOOK REVIEW

Well-being's five activities

A mind for business – get inside your head and transform how you work
Andy Gibson
Pearson, 2015
ISBN: 978-1-292-01467-8
£12.99



Gibson's overarching premise is that human beings are the fundamental units of business and the performance of any business depends on the performance of the minds of its staff, writes BDA Librarian **Roger Farbey**.

So his 270-page paperback offers practical advice on various aspects of caring for your mind (his Mindapples thesis, which uses insights from neuroscience and psychology, in a nutshell). Well-being, for example, can depend, he says, on five simple activities: connect with people sharing "quality time"; be physically active; take notice of the world around you; keep learning (since mental challenges are beneficial); and, finally, give, because altruism makes people feel good.

Mindfulness is naturally discussed, but there are whole chapters devoted to other key areas: mastering moods; the drivers to get staff motivated; handling pressure; mind training (to change habits or, more controversially, increase intelligence); making smarter decisions; influencing people; working collaboratively; and thinking creatively.

There is also a one-page *aide-mémoire* recapping: *The 10 habits of a mind for business*. And, unusually, for a book of this type, each chapter is supported by a couple of pages of article references. This book is well-written and attractively designed and ideal for the busy business generation.

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

Internet now jobseekers' favourite

Over one-half (55%) of jobseekers now use the Internet to look for employment and one-third (33%) rate Internet job sites as the most effective channel for finding a job.

Jobseekers 30 or 40 years ago were largely limited to paper media, such as newspapers and magazines, and to introductions from family and friends.

Now, while 36% still use paper media, 33% rely on referrals, and 24% approach a prospective employer directly, at 55% the Internet has become the channel of choice. About 40% of jobseekers used only one channel in their search, and about 25% used two.

The survey respondents also consider Internet job sites and referrals the most effective channels for finding a job: 33% rated Internet sites most effective and 19% said referrals were the top channel, in contrast to the 10% of respondents who still thought paper media was the most effective.

The report's findings make clear that the average users of the key channels have different profiles. The average Internet-job-site user is more educated and younger than the average jobseeker.

These findings from the survey *Job Seeker Trends 2015: Channels, Search Time, and Income Change* of more than 13,000 jobseekers from 13 countries highlights issues that can help employers fine-tune their recruitment and hiring strategies, craft their value propositions for potential employees, and deliver their messages through the channel that best suits their target talent pools. It also presents data that will help jobseekers themselves assess the evolving state of the job-search market, the research's joint-publishers, The Boston Consulting Group (BCG), and Recruit Works Institute say.

"One of the key capabilities that differentiates the Internet channel from referrals from family or friends is the Internet's ability to process a much higher volume of applications," a BCG partner and a co-author of the report Kazumasa Sakurai said. ◆

MANAGEMENT

3 tips to stop email stress

Checking email outside work hours has been linked to higher levels of stress and pressure. But three simple actions can help combat this (**below**).

The findings are from a report by the Future Work Centre, *You've got mail!*, which polled 2000 people across a variety of industries, sectors and job roles.

Nearly one-half of those surveyed have emails automatically sent to their inbox (push notifications) and 62% left their email on all day.

Those who checked email early in the morning and late at night may think they are getting ahead, but they could be making things worse because these habits are linked to higher levels of stress and pressure, the study said.

"Our research shows that email is a double-edged sword," Future Work Centre insight director Dr Richard MacKinnon said.

"Whilst it can be a valuable communication tool, it's clear that it's a source of stress and frustration for many of us. The people who reported it being most useful to them also reported the highest levels of email pressure!

"But the habits we develop, the emotional reactions we have to messages and the unwritten organisational etiquette around email, combine into a toxic source of stress which could be negatively impacting our productivity and wellbeing." ◆

Stress-busting tips

Early-morning/late-night checkers – put your phone away. Ask yourself if you really need to check your email at these times

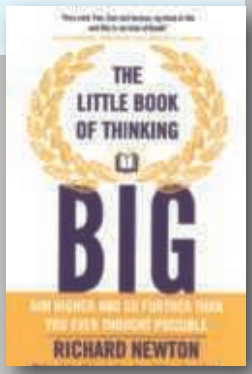
Plan your day and prioritise your administrative work before the priorities of others flood your inbox

Turn off "push notifications" and/or your email app for parts of the day to take control of when you receive email

BOOK REVIEW

Use it or lose it!

The little book of thinking big: aim higher and go further than you ever thought possible
Richard Newton
Capstone, 2015
978-0-857-08585-6
£9.99



Using the sea squirt as a running metaphor, entrepreneur and writer Richard Newton aims to impress upon his readers the fact that you have to use your brain or you'll lose it (the sea squirt eats its own brain, apparently). Similarly, he says, it is necessary to choose the direction in which you swim or you'll be washed up on the shore, writes BDA Librarian **Roger Farbey**.

The book gives the impression of being slight and rather flippant, but on closer examination Newton raises some interesting points including the habits of humans and how negativity can be chronically self-destructive. In the chapter *Change reality...don't deny it* he advises readers that channelling energy into resisting change is usually futile and given the scenario of being confronted with a new and unwelcome change, he offers this solution: Resistance says: "I don't want this". Acceptance says: "Ok, let's work with this." So, Resistance leads to stasis and very often consumes lots of energy to no purpose.

He also quotes a study from Duke University on the futility of being a pessimist: "Optimists and pessimists share the same probability of getting divorced. Optimists are more likely to get remarried."

This relatively short "inspirational" paperback (around a 170 pages but with a fair number of illustrations) is an easy read and definitely not a waste of time.

For more: www.bda.org/booknews

Bank of Mum and Dad funding start-ups

Difficulty in raising business finance is holding back Britain's start-up entrepreneurs in every part of the country and every sector of the economy. To solve this problem, many are turning to the Bank of Mum and Dad, a survey by the Institute of Directors (IoD) has found.

Of the 122 young entrepreneurs surveyed, 39% cite difficulty accessing finance as a barrier to growth. The high cost of finance (33%), business taxes (29%) and personal taxes (26%) were also seen as barriers to success.

More than half (53%) said that it had been money from family members that had got their businesses off the ground; 56% had used personal unsecured finance, like credit cards; and a further 45% had used money from friends.

While money from family, friends, and unsecured loans are the most important sources of finance in an entrepreneurs' early days, private equity, bank and non-bank debt, and private and public sector grants, are all seen as important sources of scale-up finance.

The IoD has called on government to open up the "equity economy" by making it easier for savers to invest in young companies through the Enterprise Investment Scheme (EIS) and Seed EIS and to encourage more people to invest in growing companies to turn Britain's fledgling start-ups into scale-ups.

The survey of 122 members of the IoD 99 network – a group of more than 650 entrepreneurs under the age of 35 – also found that one in five (21%) said the primary reason for their starting their business was to have a "positive social impact"; and 22% said they wanted to work for themselves.

"The last few years have seen exciting developments in alternative finance," IoD deputy head of policy Jimmy McLoughlin said.

"Businesses can access more sources of capital than ever before and innovations like crowdfunding and peer-to-peer lending are quickly becoming mainstream options. Entrepreneurs see them playing a big role over the next decade." ◆

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BDA
British Dental Association

Making a stand

by Mick Armstrong,
Chair of the BDA Principal Executive Committee

Thursday 12 January was a landmark day for our profession. Hospital dental trainees based in over 50 trusts across England joined their medical colleagues and withdrew their labour.

For 24 hours, during which arrangements for emergency care were still provided, doctors and dentists made their case with the public and the Press on the proposed junior contract.

Our profession has never been involved in industrial action before. Not one of the trainees I have heard from was looking to be pioneers. What united them – and every other BDA member I've spoken to for that matter – is a simple determination to make a stand against a contract that threatens both patients and practitioners.

The British Medical Association has, with our input, been leading negotiations with a government that's consistently proved unwilling to compromise. Industrial action can only be an action of last resort but, having reached an impasse, we resolved to ballot our members. The result was unambiguous.

We received a clear mandate to take action alongside medical colleagues. The hospital trainees at risk are a small part of our health service and our profession, but we all have a stake in this. Many colleagues may have followed this route into their professional lives. Others in general dental practice will know from bitter experience what happens when a government moves to impose a fundamentally flawed contract.

At the BDA, we know that together we are stronger. And today this contract matters to all healthcare professionals.

At the time of writing, the outcome of this dispute is unknown. What I can tell you is that the BDA and our friends at the BMA remain determined to stand up for the next generation.

We won't let this contract put their futures or patient care in jeopardy. ◆

COMMENTARY

Fighting for what's fair

by Sami Stagnell,
an oral surgery specialty registrar and vice-chair of the BDA Young Dentists Committee

In my mind, the *Hippocratic Oath* never felt so forgotten. One might think that this underlying principle and cornerstone should really support any decision-making process in the NHS, but any time spent reading the headlines and healthcare sections of the newspapers (let alone the endless streams of uproar on social media) could make you think otherwise. Let me be clear: it is not the doctors who seem unaware of this founding standard, but rather those in Whitehall.

Day in and day out, we see the heartfelt plea of doctors across the nation and throughout the specialties utter the same dismay at the impact the proposed new junior-doctor contracts will have on their working lives.

We have even seen the Royal Colleges weighing in with their opinions on how dire the outcomes may be for the health service, while the Health Secretary throws flawed arguments back alongside deceptive tales fed to the public about the greedy and lazy professionals who occupy the hospitals (mind you, we apparently only do so between 9am and 5pm; Monday to Friday).

> "Many in the dental profession will have sat by watching this go on before them, unaware that these troubles are really much closer to home than may first be obvious."

Many in the dental profession will have sat by watching this go on before them, unaware that these troubles are really much closer to home than may first be obvious. Some of us, like myself, made the career choice to practice dentistry in the hospital setting.

I know many of the more senior general dental practitioners in practice today spent years in hospital jobs developing their skills and confidence: years before the abolishment of nights and the *European Working Time Directive,* which changed the way juniors now experience hospital life.

I have watched friends and family, colleagues and peers, see what more they can do for people and take brave steps towards becoming dual-qualified, putting lives on hold in pursuit of doing what they love.

These enthusiastic and dedicated clinicians are, in my eyes, part of a bigger family: a family with the patient at the heart of what they do, who go out of their way to do their very best for everyone they care for and where the clock on the wall ceases to exist until the job is done.

This selfless motivation is obvious, even in the way our professions protest: this doctors strike saw only elective procedures abandoned to minimise any impact on patients, leaving us to catch ourselves up on our slightly longer waiting-lists.

Celebrity and public glorification are not common traits in the health profession: we do not expect public parades and applause for our efforts. We do, however, expect to be treated fairly. ◆

COMMENTARY

Unsafe, unfair: the facts on the junior contract

Removal of vital safeguards for dentists and patients

Patients are put at risk when practitioners are overworked and do not get proper rest. Currently, there are limits to prevent employers overworking their clinicians, and there are rules about how much rest and how many breaks doctors and dentists should receive.

The current contract contains a mechanism to ensure that these rules are enforced: employers who do not stick to the limits are penalised financially. The Government wants to remove this safety net but has no real plan to replace it.

Extension of standard time

Under the current contract, standard time is set as 7am to 7pm, Monday to Friday. Juniors routinely work outside of this standard time to provide patients with high-quality care around the clock. When they do so, they receive a pay premium. This is to reflect the impact that working evenings, nights, Saturdays and Sundays has on personal and family life. The Government no longer intends to recognise the impact of working evenings and Saturdays, and plans to extend standard time to 7am to 10pm, Monday to Saturday.

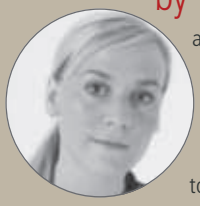
Pay progression

Trainees' pay increases every year in recognition of the experience gained. The Government believes that pay should only rise when a trainee moves to the next stage of their training and responsibility.

This proposal will discourage some people from entering specialist training in the first place; particularly those who wish to have families, because of the financial worries of taking time out of training for maternity leave or to work part time. It will also discourage those already in training from undertaking research or retraining in a preferred specialty.

Insurance – the *must* haves and the *nice* to haves

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

Practices may be offered insurance policies for all sorts of situations these days, but you should think carefully about what cover that you *must* have for your business and what might just be *nice* to have. Some insurances are required by law and some insurances are simply recommended to provide you and your business with some form of protection and peace of mind.

Tailored not generic

Before signing up to an insurance policy, talk it through with the provider. Tell them about your individual circumstances and negotiate cover that insures *you* and *your business* and not the generic business or dental communities. Opting for generic cover may result in you being refused a claim because it does not cover vital aspects of your circumstances.

And when shopping around for insurance, some business owners (dangerously) do not declare certain things to get a cheaper deal. This can completely defeat the purpose of insurance: by not disclosing things, you can void the whole insurance when it comes to having to make a claim. Some insurance companies can be strict about a lack of disclosure when assessing a claim.

The key is to think about why you want to have the insurance: identify the risks that you or the practice could face and decide which are so likely, or would have such a damaging impact on you or your business, that they should be covered. You then need to make sure the insurance you take out is tailored fully to your needs.

With most types of insurance there will be a basic insurance package, a one size fits all. You should view this insurance as the base on which to build. Adding optional extras is likely to increase your premium, but the aim is to protect your practice and livelihood.

And you do not want inadvertently to end up with a policy that allows the insurer not to pay out. Be direct and ask the insurance providers about their terms and conditions and what actions or omissions would void your policy. For example, an insurance company may not pay out under employer's liability insurance if an employee is electrocuted and it turns out you failed to comply with electrical-testing requirements.

"When shopping around for insurance, some business owners (dangerously) do not declare certain things to get a cheaper deal. This can completely defeat the purpose of insurance: by not disclosing things, you can void the whole insurance when it comes to having to make a claim."

Professional-indemnity cover

Indemnity cover is a must for dentists personally. It is designed to offer protection against claims made by dissatisfied patients and having it is a General Dental Council (GDC) requirement. Here, dentists often choose to be protected by one of the major dentolegal-protection societies rather than by a commercial insurer. Check the differences between the indemnity cover offered by the societies and the commercial insurers, especially if you switch from one to the other.

If you establish yourself as a limited company, then you need to have **corporate indemnity insurance** as well as personal professional-indemnity insurance. This is because a patient could sue the dentist personally, the company, or both.

Employers' liability insurance

To cover you against claims from employees who have been injured, become ill or suffered emotional harm while at work, you must have, and display, an employers' liability insurance certificate. This is a legal requirement: you can be fined £2500 for every day you do not hold this insurance.

The cover must be enough to finance compensation that may become payable to a number of employees for a range of hazards. Cover for at least £5 million is the common low end of these insurance policies but many insurance companies often start from £10 million of cover. When discussing the level of cover you might need, be very clear when telling your insurer about the roles that your employees do, the tasks they carry out, and the potential hazards that they face.

The employer's liability insurance certificate that you receive must be displayed somewhere visible to your employees.

Public liability insurance

It is strongly recommended that you have insurance to protect you against claims from the general public for injuries incurred on your premises. Visitors to your premises – family members of patients or delivery drivers sent by your suppliers, for example – could injure themselves while at your practice. People could trip and injure themselves or passers-by be hit by a falling roof tile. Patients who suffer an injury totally unrelated to their dental treatment could also make such a claim.

It is sensible to have cover to protect yourself against such events.

Not all general public liability policies will cover you for accidents concerning pressure vessels. These are specialised pieces of equipment that need special care and which can cause a lot of damage should they explode. You are likely either to need a separate policy or to make sure that this is explicitly covered in your main policy. And here adherence to the manufacturer's instructions and proof of regular servicing is going to be crucial to preserving the validity of the policy.

Some public liability insurances include cover for **pollution**. This offers protection against claims by any third party that suffers as a result of pollution caused by your practice.

Example of such pollution would be escape of hazardous substances from your practice, such as mercury over a long period of time, or other chemicals in a fire or a flood.

Businesses that carry out any of their activities on the road require **commercial motor vehicle insurance**. This is where a car is used for purposes over and above your normal commute to and from the practice. Within dentistry, this could cover domiciliary visits or simply transporting dental items or clinical waste or ferrying a member of your dental team to another location, a branch practice, for example. Motor-vehicle policies should, therefore, cover staff and any other passengers, equipment, materials and work gear.

Building and contents

Building and contents insurance can protect you against risks to your building or surgery equipment. Get cover against theft, fire and accidental damage, too. You could tailor your policy further: to cover your equipment against natural disasters, electrical surges or power failures, and mechanical breakdown.

If you share your premises with another business, or rent a room to another dentist, tell your insurers because this could affect your insurance cover if you need to make a claim.

Accurately value your practice contents to make sure you get full cover. And check if you would receive new-for-old payments or just for the current depreciated value of any equipment. Consider including your general stock and the dental products you sell when obtaining this type of insurance. **Product liability insurance** can provide protection on any dental products you sell, such as electric toothbrushes. This protection can include safety claims, damage caused by spoilage, manufacturing defects, medical costs and legal-defence costs.

Business-interruption insurance

To cope with financial loss should your practice be unable to operate, consider business-interruption insurance. Although this will seem to cover similar risks to building and contents insurance – for example, fire, flood or power cuts – its aim is to restore the business to the same financial position had the insured event not occurred.

If you rely on a particular person to bring in income – an associate, for example – it is worth looking into **key person insurance** for your business. This covers if they are unable to work because of illness or injury.

Health-related insurances

Think about what could happen if you were stopped from working through illness or what would happen to your dependents if you died. Insurers can offer you various **life, personal-sickness, income-protection and critical-illness insurances** that could give you and your family some peace of mind. If considering income-protection insurance ask about own-occupation cover.

Your pension savings may also provide some help in these circumstances but you would need to talk to your pension provider to find out exactly what benefits would be received. You may believe that they will not be enough for your circumstances so you should also consider insurance cover.

But make sure the insurance policy would pay out regardless of any pensions or other payments you may receive as well. Some policies will not pay out if you are receiving money from other sources to cover your sickness.

Find out if there is anything that would prevent the insurer from paying out. You may need to add to the basic policy to ensure you are covered.

Read the documentation

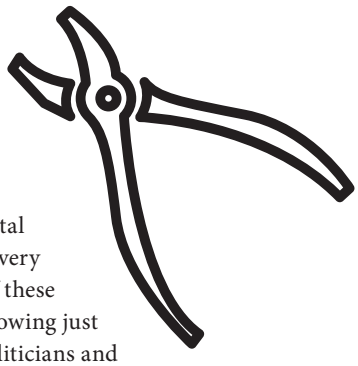
Do be sure to read your policy documentation, whatever insurance you take out. In can be lengthy and complex but there might be loopholes that would affect your cover. If you do not like something in your terms and conditions then you should speak with the insurer to see if there is a way to remove that or to have it covered. Be aware that any change may increase the price of the insurance.

Speak to an expert

Insurance is a specialist area and it is worth speaking to an insurance expert to find out what insurance is appropriate for your individual circumstance. You can contact the BDA's partners Lloyd & Whyte at www.lloydwhyte.com or telephone on 01823 250700. ◆

How did UK dentistry become a charity case?

by Henrik Overgaard-Nielsen,
Chair, General Dental Practice Committee



You may have heard about Claire Skipper before Christmas. The mum from Dewsbury had been in agony with toothache. Unable to find an NHS dentist, and fortified with a shot of whisky, she headed to her garden shed at 3am, and tried to remove the tooth in question with a set of pliers.

Claire's story has been used to explain why a minster town in West Yorkshire has joined a list that includes rural communities in Uganda and Cambodia as recipients of care from the charity Dentaid.

So, on 3 December, Dewsbury Dental Centre opened its doors to the homeless, migrants, low-paid workers and vulnerable adults: basically, to anyone suffering dental pain but who had been unable to get on the books of an NHS dentist. And 17 local dentists and dental students duly offered their time on a Thursday evening to work for this "pay what you can afford" scheme, with treatment provided on a sit-and-wait basis. The pilot is now set for expansion across the UK.

Dentaid is doing great work. We should all applaud colleagues who have stepped forward to make it possible. But today we all have to ask some very serious questions. And first on the list is how on earth did we get here?

Britain is the fifth wealthiest nation on earth. We are not lacking when it comes to the people, the skills or the infrastructure. For all the inevitable talk of "Third World Dentistry" that this pilot has generated, it is not the UK's talented and dedicated dental teams that have been found wanting.

> "For all the inevitable talk of "Third World Dentistry" that this pilot has generated, it is not the UK's talented and dedicated dental teams that have been found wanting."

This is all about the funding choices we make and the NHS has consistently decided to set aside funding to provide dental services for just over one-half the population. At local level, health chiefs are failing to commission enough services, particularly in areas of high need. And it is people like Claire who have to live with those choices.

We remain saddled with a rigid target-driven contract system. When targets aren't hit, money clawed back is not reinvested in NHS dentistry. And when colleagues have the capacity to treat more patients, the NHS will not allow them to do so.

So, to the second key question. Do these charity pilots represent a solution?

Charitable provision of dentistry is, at best, a sticking plaster. It is not a plank of a viable dental policy. The very existence of these clinics is showing just how bad politicians and commissioners have been for vulnerable patients in need of treatment, not just in Dewsbury but all over the country.

It is 16 years since Tony Blair pledged: "NHS dentistry for all." It was a good sound-bite but, short of the new contract that dropped a bomb on the service in 2006, causal disinterest in oral health has remained the order of the day in Whitehall.

In April, we will be looking at the 10-year anniversary of that imposed contract. Its stated aims were to improve access and reward preventive work, and it has failed on its own terms.

The Department of Health will say that all is well with NHS dentistry and that, in absolute terms at least, access is on the up since the unfortunate hiccup of the mid-2000s. It has said that services are being commissioned to reach the Claires of this world and that a "reformed" contract is just round the corner.

While more people may be getting access, by almost every conceivable measure oral-health inequalities are growing.

Dentaid's arrival in a West Yorkshire is a timely reminder that we cannot go on as we are. Britain needs effective NHS dentistry. If government wants to see it thrive, it needs a different approach, with proper investment and a contract with a square focus on prevention. And one where those most in need of NHS care are no longer the least welcome.

The alternative is to sit back and let patients pull out their own teeth with pliers. ◆

Say thank you to stop staff exodus

by Graeme Jackson,
Editor, *BDJ In Practice*

Between one-third and over one-half of UK workers plan to move jobs this year, three surveys of staff plans for 2016 have found. All have identified similar reasons behind this potential mass exodus from firms and, crucially, ways to stop it. But handing out pay rises is not the answer, it seems. Instead, firms need to up their management game and focus on the problem of staff feeling undervalued. And when it comes to the job-satisfaction wish-list identified in the survey by pensions- and savings-provider Standard Life, dental practices could already be ahead in the staff-retention game.

According to the *Job Exodus Trends 2016* report from Investors in People (IoP), 49% of UK workers will be looking for a new job in 2016 and one in five is already actively job hunting.

Nearly one-third of them said they were miserable in their jobs owing to a combination of poor management (43%) and not feeling valued (39%).

The survey of just under 2000 employees by the Institute of Leadership & Management (ILM) paints a less-bleak picture: only 32% said they were planning to move on.

But it echoes the staff disenchantment identified in the IoP survey. One-quarter said they were so desperate to leave that they wouldn't stay in their current job no matter what the company offered them.

And in the past 12 months, 34% of employees have been so fed-up that they have left without lining up a new job, according to the ILM.

But pay rises are not the answer. Unsatisfactory pay was only the third reason for unhappiness given in the IoP survey (38% of respondents cited this). And the ILM research found this to be an even lower retention motivator: only 15% said they wanted to move to get a better salary.

Further evidence that pay rises alone would not solve the problem was highlighted in the IoP report. This survey asked respondents to choose between a 3% pay rise, in line with recent UK increases; or a non-remuneration benefit.

One-third (34%) said they would prefer more-flexible working hours to a 3% pay rise. Nearly one-third (28%) said they would rather have a clear career-progression route. And one-quarter (24%) would rather their employer invested in their training and development more.

Career progression was of particular concern to younger workers. Over one-quarter (26%) of 18-24 year olds said they had no clear career progression in their current role.

Again, the survey findings were similar. The ILM research found that 26% wanted to move because of poor future prospects and 17% said they are moving because they wanted more appreciation (**see below**).

Exodus drivers

- More progression – 26%
- More appreciation – 17%
- Career change – 17%
- Better salary – 15%
- More enjoyment – 12%

"Improved salaries over recent months mean that pay is less of a gripe for UK workers," head of IoP Paul Devoy said.

"But longstanding issues around poor management and how valued people feel in their work continue to make UK workers miserable.

"We know that bad leadership alone costs the UK £39 billion a year. If employers addressed these factors, they would have a more-committed workforce and far fewer resources tied up in constant recruitment drives.

"As the economy improves, many employers run the risk of losing their valuable, skilled staff."

> "Even simple actions can make all the difference, according to Paul Devoy. When asked what single thing their employer could do to increase their happiness in their current role, one in eight (13%) just wanted to be told 'thank you' more."

Head of research and policy ILM Kate Cooper agrees. "The beginning of a New Year is a natural point for people to start thinking about their future job prospects and there are many steps managers can take to respond to this.

"Our research indicates it is the opportunity to progress and not the desire for a bigger pay packet that is the main motivation in looking for a new job.

"Highlighting the progression opportunities that are available, such as project leading, secondments and job shadowing, will help demonstrate that there are development routes within the organisation.

"Ensuring staff feel part of the organisation and their achievements are recognised and appreciated will help to retain them and the talent the business needs."

Even simple actions can make all the difference, according to Paul Devoy. For example, when asked what single thing their employer could do to increase their happiness in their current role, one in eight (13%) just wanted to be told "thank you" more, he said.

"Feeling valued, understanding their role in the organisation and how they can grow with an organisation are all big concerns for UK workers.

"Saying thank you, involving employees in decisions and giving them responsibility over their work are basic ways to make staff happier and more likely to stay.

"Employers also win, with a more committed workforce, higher retention and a clearer view of the future," Paul Devoy concluded.

Although the Standard Life survey found that over one-half (54%) of UK workers said they wanted to change jobs, rising to 72% for those aged between 25 and 34 (**see below**), it also identified why some groups said they had no such plans. Worry about being too old to change direction (11%), valuing their current stability (11%), not knowing where to start (10%), and a lack of confidence (10%) were key reasons for not taking the plunge. And, crucially, it identified the job-happiness factors that would encourage 84% of staff to stay put: factors likely to be found in dental practices (**see above**).

"The fact that over half of us wish we could change careers is really interesting – the reasons why we want to move will depend a lot on the stage of our career, whether it's aiming for a higher salary or doing something we feel passionate about," author of *How to get a job you love* John Lees said.

"While it's not always easy, change is certainly possible. But before making the leap it's good to reflect on what it is that would make us satisfied in a new role, or what's making us unsatisfied right now, so that a change, whether it's job, company or career, does give us what we want.

"When it's time to make the change, there are lots of people and resources that can help with the process – and doing your homework is important." ◆

Entrepreneurial dreams

For many it would seem that the desire to strike out on their own is a reason for thinking about a career change. Almost six in 10 UK workers (57%) have considered starting their own business, with those between the ages of 25 and 34 most motivated to do so.

Wanting to be your own boss is the biggest driver for setting up or thinking about setting up a business and with 54% of workers saying they've had to miss a significant personal event owing to work commitments perhaps it is not surprising some people want to call the shots.

Happiness factors

- Having job security – 34%
- Making a difference to people's lives – 25%
- Feeling valued within their organisation – 25%
- Working with people they consider friends as well as colleagues – 25%

Recruiting costs

How much it costs a practice to recruit a member of staff is difficult to generalise. But if your practice records do not give an exact figure, according to the professional body for HR and people development, the CIPD, the average recruitment cost of filling a vacancy is £4000, increasing to £6125 when the associated labour-turnover costs are included.

Have an evidence-based website

by John Ling,
of the BDA's Marketing Team. John has the Professional Postgraduate Diploma in Marketing from The Chartered Institute of Marketing and is a Chartered Marketer

Although a practice website can be a great way to promote your practice, if you are not monitoring and analysing how it is being viewed, you are missing a trick. Analysed properly, data gives you an insight into how your website is performing and how you can improve it to make it work harder for your business.

Analytics tools

There are many tools that can be used to analyse your website – some free, some paid for. The most popular by far is Google Analytics (used by 83% of websites whose traffic-analysis tool is known). It is free

and provides a wealth of data to help you understand how people are using and interacting with your website so is particularly popular with small businesses.

Other popular tools for small businesses include Clicky (https://clicky.com/) which offers real-time data; and KISSmetrics (https://kissmetrics.com) which goes beyond analysing visitor statistics to look at behaviour and engagement, too. Beyond a certain level of use you have to pay for Clicky; KISSmetrics costs around £130 a month.

Assessing your website

There are a seven key elements of your website's performance you can assess. What you choose to analyse depends on what you want to achieve: do you want to raise awareness of your practice; share oral-health information with patients; or acquire new patients, for example?

1 If promoting the profile and raising awareness of your practice is what you primarily want to do, the number of "unique", that is individual, visitors each week or month will give you an indication of how successful you are being and can be tracked over time to identify any changes.

2 After running an advertising campaign that directs people to your website, you would want to measure the extra activity (above and beyond typical activity) it has generated. Look for spikes in visitor numbers after the appearance of each advertisement or other promotional activity. If you do not see any spikes, you need to look at your advertising. Think about the clarity of its message, its target audience and if the timing was poor.

3 Web analytics can tell you how long people spend looking at a particular web page – "dwell time". This tells you if visitors are engaging with your content or not. If you have given detailed advice on oral health but visitors are leaving in under 10 seconds, it suggests that the information is not compelling or is presented poorly. This can also tell you if important pages that you want people to visit are being overlooked. By making adjustments to your website so a particular page appears more prominently you can drive people to the web pages you most want them to see.

4 If you are promoting a special offer, create a landing page specifically for the offer so you can see how many times the page is visited. Most web-analytics tools can track online "purchases" – online bookings for appointments in a dental context – that result. People may be going only so far along the process of making an appointment or consultation and then drop out. Web analytics enables you to identify this problem so you can rectify it.

5 Another useful dataset that web analytics can record is on which devices your website is being viewed. If 70% of your visitors are using mobile phones, but your website does not present pages in a way that makes them is easy to view and read on a mobile (mobile-friendly), you have a problem that needs to be urgently addressed.

6 You can see the route viewers have taken to access your website: what percentage are typing your web address into their browser; what percentage are finding you through a search engine; or how many are using the specific links that you created for your advertising campaigns. If few are finding you through a search engine, you need to improve your ranking in the search results (see www.bda.org/bdjinpracticeonline *5 steps to rank top on Google* **bda**news January 2014 page 16) or consider paying for Google AdWords or similar.

7 Check if viewers are becoming frustrated by broken web links on your website: these can ruin even the most carefully crafted user experience. It can be hard to keep on top of all your web pages but web-analytics tools can set up an alert for when a *404 Error* occurs on your website.

For beginners

Web-analytics tools can be intimidating to use at first because there is so much data available. But with practice and repeated use it soon becomes familiar. Any data is better than having no data and continuing to stumble around in the dark. Begin with a few basic and simple figures and build up your knowledge from there. Benchmark your data over time so that you can see trends. For this you will need to set the right parameters from the outset, otherwise they can become disjointed or cannot be properly compared.

Building up a picture

Web-analytical tools are not always intuitive so provide staff training and set aside time for self-learning. Make sure that everyone using them understands the key metrics for the practice: for example, unique visitors, page views or online bookings. Establishing a culture of using web analytics regularly and often sends out a message that your professionalism extends to everything you do and that you take the development of the practice seriously.

Proper use of web analytics can be incredibly powerful and deliver impressive results. Its power lies in providing evidence about which pages of your website are working well and which are not; where problems are arising; and where you can make improvements. It brings greater scrutiny and accountability to your marketing activities, enabling you to see which methods are most effective for your audience and which are largely a waste of time and effort. Without web analytics you would be oblivious to it all. Evidence really is everything with web analytics. ◆

To find out more about getting more from your website, our event, *Marketing for the modern dental practice*, on 18 March, London, will help with attracting new patients. Visit www.bda.org/digimktgevent for more details.

Fact-find first when handling grievan

by Neeta Udhian,
a practice management consultant in the BDA's Practice Support Team. Neeta advises general dental practitioners on associate contracts and all aspects of employment law

Practices should have a grievance procedure to address any concerns or complaints raised by members of staff. It will not often be needed because most problems can be resolved informally with just a chat. But if matters progress to a formal grievance, the practice needs to investigate, have a formal meeting with the employee and provide a full response.

But before the investigation and formal grievance hearing it often helps to arrange a fact-finding meeting with the complainant. To deal with a grievance effectively the practice needs to know what the employee's concerns really are before it can investigate the matter and respond to it.

Guidance by the Citizens Advice Bureau to employees advises them to make sure their grievance letter is to the point and keeps to the facts. But with the emotions involved when someone is unhappy at work, this letter may not explain clearly what the problem is or what they want the practice to do about it.

Fact-find agenda

The first step is to tell the employee at this meeting that their grievance has been received but it has to be looked into fully before a formal response can be given. Ask the employee to attend a meeting to begin the investigation. This fact-finding meeting is also to give the employee the chance to express their feelings in full. Let them know they have the right to be accompanied at the meeting by a trade-union representative or work colleague if they wish.

Explain you need further details to do this: the date, time and location of any specific incident; who was involved; and who else saw the incident. When questioning the aggrieved employee try to use open questions so they can give as much detail as possible in their own words: basically, the what, when, how and why of the matter. This is to get the employee to paint a detailed picture of why they are upset or aggrieved. This process will also enable you to clarify the allegations so you know on what to focus your investigation. The more detailed the picture the employee paints, the more information you will have and the easier it will be for you to investigate the employee's concerns.

Give reassurance

Reassure the employee that the matter will be carefully considered. Use the fact-find meeting to show that, as an employer, you deal with concerns thoroughly. If the employee becomes visibly upset, allow them time to compose themselves. If the employee stops talking mid-way through a sentence (most likely because they are unsure about saying more) encourage them to finish what they were saying. Often an aggrieved employee primarily wants to feel they have been listened to.

No answer yet

The fact-find meeting will leave things unresolved. It is not the place to say if you believe the allegations. Investigations will be needed before a firm written response can be given to the employee (see www.bda.org/bdjinpracticeonline *Follow Acas guide to show fairness* January 2016, page 10).

So, do not be tempted to respond or speculate on the outcome. You are only finding out the full background to your employee's grievance: you are not answering it. Be careful because it may be hard not to reply, especially if you think they are mistaken or are raising an unjustified complaint. You need all the facts first.

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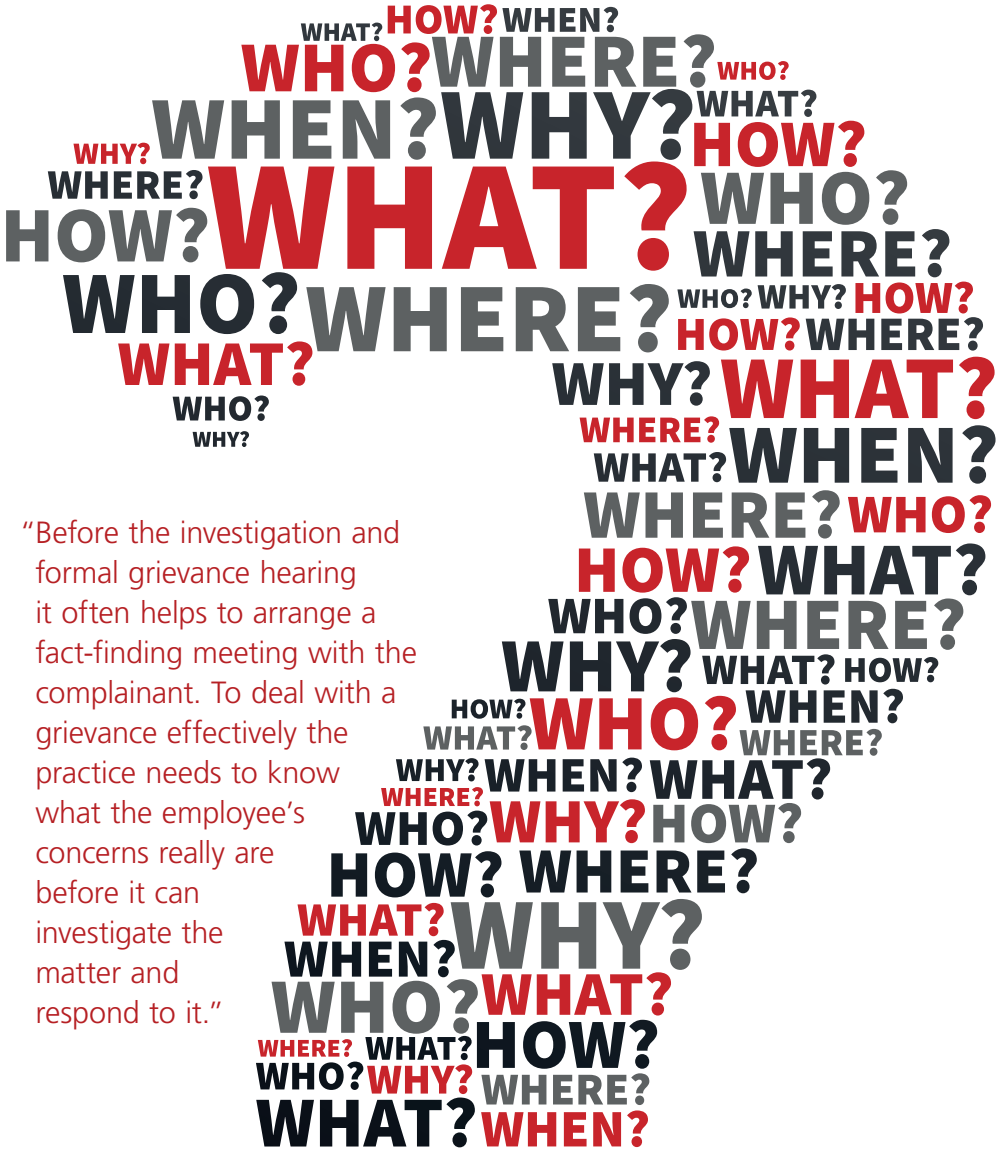
Remember, the more detailed the picture the employee gives you the easier it will be for you to prove or disprove their allegations.

But do ask the employee if they can suggest a solution to their complaint.

For example, they may want training; to be moved to a different dentist or to working with another colleague; or for adjustments to be made to accommodate a disability.

Perhaps the most important question you can ask at a fact-finding meeting is: "If this could all be resolved today what would be your ideal outcome?"

Every fact-finding meeting should end with this question so you know the employee's expectations and their answer will provide some guidance to what they expect the practice to do. Sometimes, the solution they are seeking can be as simple as an apology. And the employee will probably leave the meeting feeling that they have been heard.



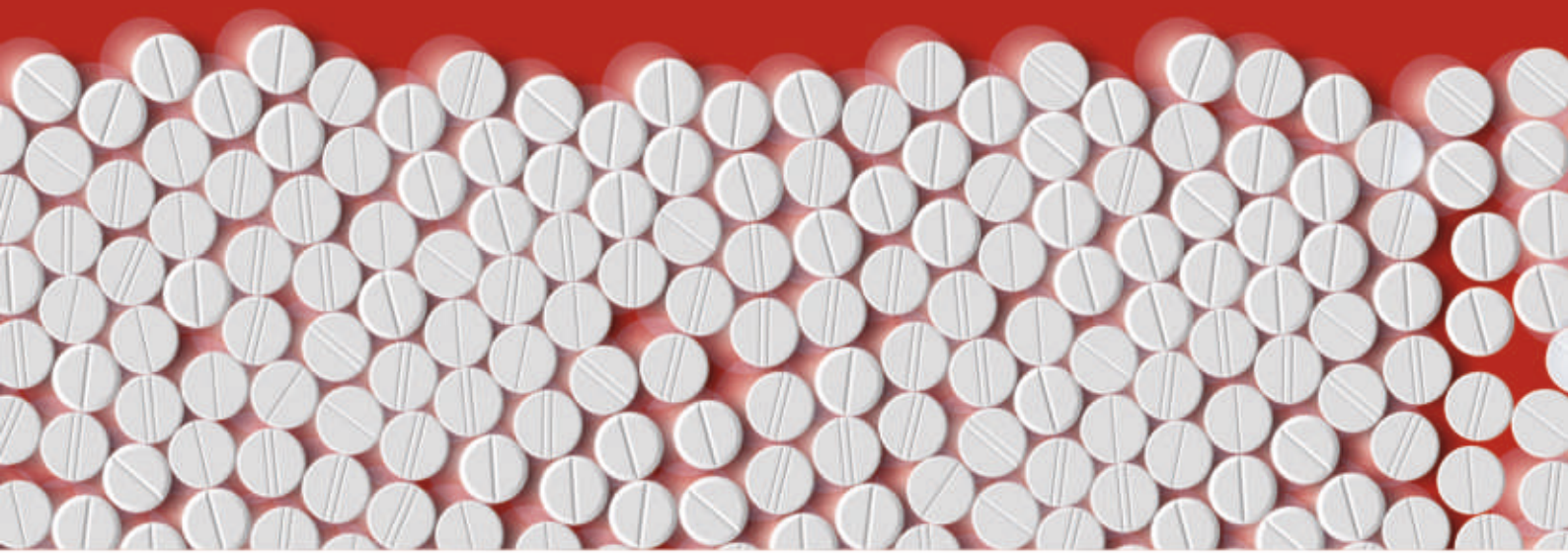
"Before the investigation and formal grievance hearing it often helps to arrange a fact-finding meeting with the complainant. To deal with a grievance effectively the practice needs to know what the employee's concerns really are before it can investigate the matter and respond to it."

It's a question of two questions

A grievance is essentially a question. The employee is asking the practice how it is going to deal with a worry or concern. To give a proper answer, the practice needs to ask a question, too: what exactly is the employee's question.

A fact-finding meeting allows a practice to find out more so both practice and employee can work together to answer the two questions and resolve the issue. Once you have established exactly what the employee's grievance is and investigated their concerns, you will be able to formulate a response addressing each concern: either accepting the concerns and making necessary changes; or rejecting the grievance with a thorough explanation. ◆

Rules for Patient Group Directions



by Edward Sinclair,
a member of the BDA's Compliance Team. He helps members on all aspects of health & safety law, infection-control requirements, practice inspections and compliance with professional regulations

Within dentistry, only dentists are currently allowed *to prescribe* prescription-only medicines (PoMs) to patients. So, because many dental-treatment plans involve their use – especially local anaesthesia and fluoride applications – Patient Group Directions (PGDs) allow registered hygienists and therapists to use a PoM within their scope of practice. But, hygienists and therapists can only *administer* the PoM: they never become the prescriber themselves. The introduction of direct access in May 2013 did not introduce prescribing rights for hygienists or therapists.

PGDs are valid UK-wide in NHS primary-care dental practices. In England, Wales and Northern Ireland they can also be used in private care. But in Scotland they cannot currently be used on private patients. This may soon change when Health Improvement Scotland begins regulating private dental settings as independent clinics.

Medicines covered by PGDs

Any PoM can be included on a PGD. And, legally, a PGD can be used for more than one medicine. But it is good practice to limit each PGD to one medicine.

But before setting up a PGD the responsible dentist should decide if the hygienist or therapist is competent in the use of the PoM. Relying on the fact that they are on the GDC register and that their scope of practice includes the use of the particular medicine – for example, a local anaesthetic or fluoride – may be enough. But the dentist should always discuss this with them.

Particular caution should be exercised if drawing up a PGD for antibiotics. Microbial resistance is a major public-health concern so should be done only if absolutely necessary and a local microbiologist should

PGD required details

- Name of the business to which the Patient Group Direction (PGD) applies
- Date the PGD comes into force and the date it expires
- Name and description of the medicine(s) to which the PGD applies
- Class of health professional, which will be hygienist or therapist, who may supply or administer the medicine
- Clinical condition or situation to which the PGD applies
- Description of patients excluded from treatment under the PGD
- Description of when further advice should be sought from a dentist and arrangements for referral
- Details of appropriate dose and maximum total dose; quantity; pharmaceutical form and strength; route and frequency of administration; and minimum or maximum period over which the medicine should be administered
- Relevant warnings, including potential adverse reactions
- Details of any necessary follow-up action and the circumstances
- *A copy of this record should be kept for audit*

Mandatory PGD signatories

- Dentist who was involved in developing the direction
- A community pharmacist
- A representative of a local NHS body if it is to be used on NHS patients
- Or a representative of the CQC/RQIA/HIW registered dental practice if it is to be used for private patients only
- The manager of the dental practice
- *Although not legally required, it is recommended that the senior dental therapist or hygienist involved countersigns the PGD*

be involved. A PGD is also needed for the administration of midazolam. Although it is a required medical-emergency drug it can otherwise only be administered by a dentist or on the prescription of a dentist.

Setting up a PGD

Setting up a PGD is quite complex. The form requires considerable detail: about the medication; when it would be used; who will be providing it; and how often it would be used (**above left**). And several people must sign it for it to be legally valid (**above right**).

But a community pharmacist is not obliged to sign a PGD and many, because they do not know dentistry can use them, will refuse to countersign them for dentists. So, before completing a PGD form, it would be wise to seek the support in principle of a local pharmacist and your local NHS body (health board or area team). Some local NHS bodies, too, are unfamiliar with PGDs in dentistry and may not support their use. Here, seek advice from the BDA and raise this issue with your local dental committee.

And if only a few patients are to be treated under a PGD, it may not be practical to set one up: just using patient-specific directions might be more efficient.

The PGD form is generic and no single format is more acceptable than another. BDA Expert Solutions includes a version available to BDA Expert members. Other examples are available through the National Institute for Health and Care Excellence (NICE) website at www.nice.org.uk

Buying PGDs online

Commercial websites have recently begun selling PGDs directly to hygienists and therapists with pre-populated information and *some* signatures. Such PGDs will only be legally valid if *all* the required signatures (**above right**) are provided. ◆

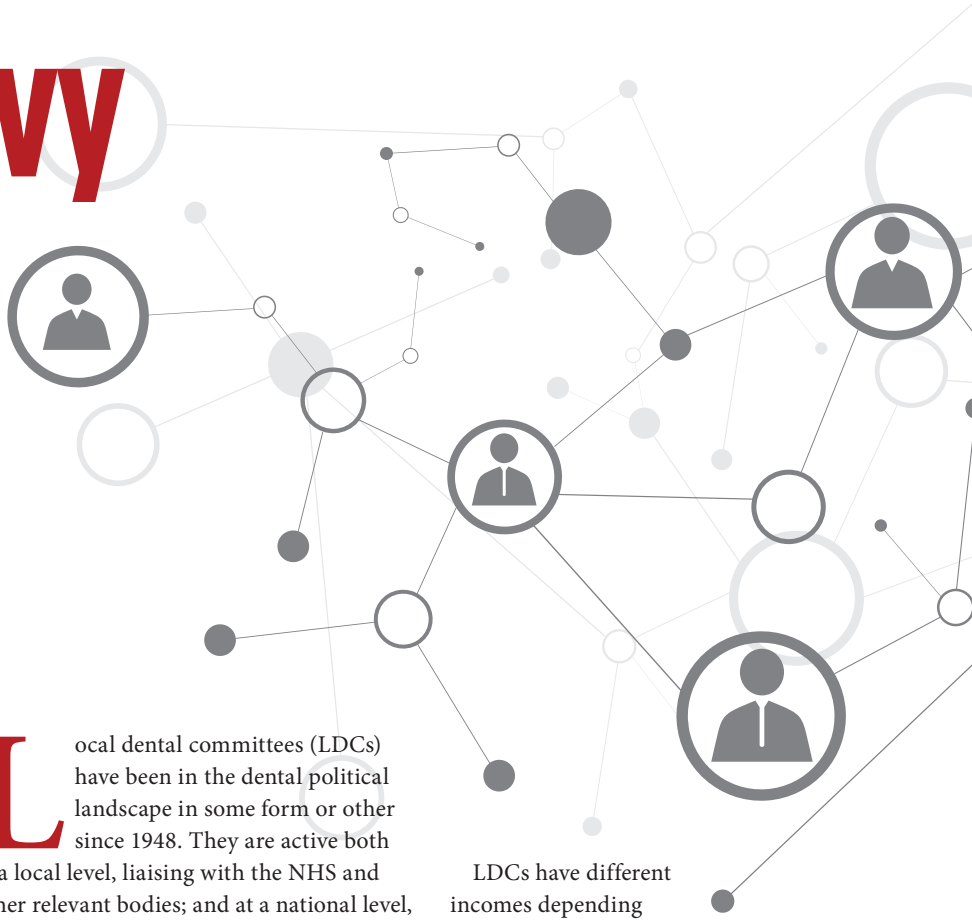
Duraphat anomaly

An anomaly of Patient Group Directions (PGD) legislation is that dental hygienists and therapists are the only members of the dental team who can give Duraphat toothpaste directly to NHS patients to take home without it having to be dispensed from a community pharmacy. An NHS dentist, who has full prescribing rights, has to issue an NHS prescription for the patient to take to a pharmacy.

So, an unintended consequence of the regulations is that, under the conditions established in a PGD, hygienists and therapists can supply these drugs directly to the NHS patient.

A dentist in private practice can dispense and supply medications, including Duraphat, from their own practice (subject to normal labelling requirements).

What you get for your LDC levy



by Victoria Michell,

a practice management consultant in the Business and NHS Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and other general-practice matters

Local dental committees (LDCs) have been in the dental political landscape in some form or other since 1948. They are active both at a local level, liaising with the NHS and other relevant bodies; and at a national level, feeding into national policy.

They are funded by a combination of mandatory and voluntary levies from primary-care dentists. General Dental Services (GDS) contractors are, by statute, required to make contributions to their local LDC. Personal Dental Services (PDS) agreement providers and private practitioners (where agreed locally) can voluntarily make contributions if they want to be represented by their local LDC.

Statutory levies are collected on behalf of each LDC by the NHS: in England and Wales, by the Business Services Authority; in Scotland, by Practitioner Services; and in Northern Ireland, by the Business Services Organisation. These levies are passed onto each LDC, which can use them for their administration and to pay their members' expenses for attending meetings or when working for the LDC.

Voluntary levies, however, are agreed locally and can be used for a wider set of purposes, including charitable donations.

LDCs have different incomes depending largely on the amount of NHS funding in their area and their activity levels. And each LDC's members may want an area-specific emphasis on services and issues. So, individual local committees will have evolved to reflect their members' demands, the behaviour of their local NHS staff (particularly the decisions made by commissioners in England and Wales) and the circumstances of their geographical area. But all should be performing three key functions.

1 Peer support

LDCs often help local general dental practitioners (GDPs) with their communications with the local NHS office: helping individual contractors or performers with specific contractual issues and negotiations. Because LDC officials deal regularly with the local NHS staff, their knowledge of the personalities involved and their experience of resolving previous matters and disputes can be invaluable.

They can advise practitioners on how best to approach the local staff and can act as intermediaries where appropriate.

LDC officials can also support local practitioners with contractual-management and performers-list issues, by advising them how best to present their position and to prepare their arguments appropriately.

> "LDCs often help local general dental practitioners (GDPs) with their communications with the local NHS office: helping individual contractors or performers with specific contractual issues and negotiations."

2 Political dimensions

LDCs will regularly be involved in the development and execution of local initiatives. Here they present the views of the local dental community to the local NHS office to influence local policy: the implementation of local-contract or performance management; the operation of referral systems; ensuring national policies are applied correctly and fairly; and the enactment of oral-healthcare initiatives, for example. The impact local representatives can have here is considerable and should not be underestimated: so the LDC and its officials need to be well informed and supported by the local dental community.

Within England, LDCs often participate in NHS England's Performance Advisory Groups (PAGs) and Performers Lists Decision-making Panels, including contributing to determinations about performance management of performers. So, officials often have first-hand knowledge of this process and can help practitioners prepare for these hearings and explain what they should expect.

Many LDCs are also involved in Managed Clinical Networks. These oversee specialist dental services and the Local Dental Networks that are increasingly providing clinical leadership to the NHS to improve oral health and to commission effective services. These bodies will become increasingly important in keeping resources within NHS dentistry and meeting the challenges of local populations with complex and diverse dental needs. LDCs are, and should be, heavily involved in shaping these networks and holding them to account.

Each area also has a representative who feeds into the GDPC-LDC Liaison Group, which is a subcommittee of the BDA's General Dental Practice Committee (GDPC), the body elected by general dental practitioners that collates the views of dentists and formulates policy for UK general dental practice. Local GDPC representatives act as conduits, presenting local views at a national level and reporting national policy initiatives back to the grass roots.

Feeding into the local LDC, voting in LDC elections, and attending meetings and events give dentists the chance to stay up to date with both local issues and national dental policy and have their voices heard, allowing an LDC to perform its mandate more effectively and engaging the profession.

But the Group has another vital role. It allows regions to meet one another to discuss developments and specific local issues at a pan-national level. Here they can share knowledge and experiences to address common problems and issues collectively.

3 Learning opportunities

Those LDCs whose funding allows, provide local educational courses, offering dentists free or reasonably priced continuing professional development (CPD) that is easily accessible and of particular relevance to current or local issues. Because of how they are funded, LDCs listen to the views of their members when choosing topics or arranging speakers. Talk to your LDC if there is a specific topic that you would like covered or if there is a topic you would like to present.

These are just three common roles many LDCs perform: but all LDCs are different. To get in touch with your local LDC to find out what is going on in your local area and to get involved, go to www.bda.org/ldcs or email Victoria.Michell@bda.org or telephone 020 7563 6886. ◆

What could herald a new era in regulatio

by Ulrike Matthesius,
the 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

In January 2015, BDA chief executive Peter Ward wrote in *BDJ In Practice* about where regulation might turn next. This followed the hike in the annual retention fee (ARF) and the BDA's court case over the General Dental Council's (GDC's) consultation about this fee. So a year on, what has happened?

Since then, the BDA has continued its efforts to hold the leadership of the GDC to account. We briefed the Parliamentary Health Committee in March 2015, which held an accountability review for the regulator, and we have made sure that the regulators' regulator, the Professional Standards Authority (PSA) knows what we think of the GDC. We again submitted detailed and challenging evidence to the 2015 GDC fees consultation, have written directly to Council members asking them to justify their approach, and repeatedly approached government ministers asking them to intervene. We have engaged in other consultation exercises and stakeholder meetings around the regulation agenda.

But as BDA members will be aware, the work to call for proper accountability of the GDC and its leadership continues, as our various articles, blogs and Press releases confirm. We have seen significant changes in the executive team at the GDC, including the resignation of the chief executive, but have an unmoved chair and Council.

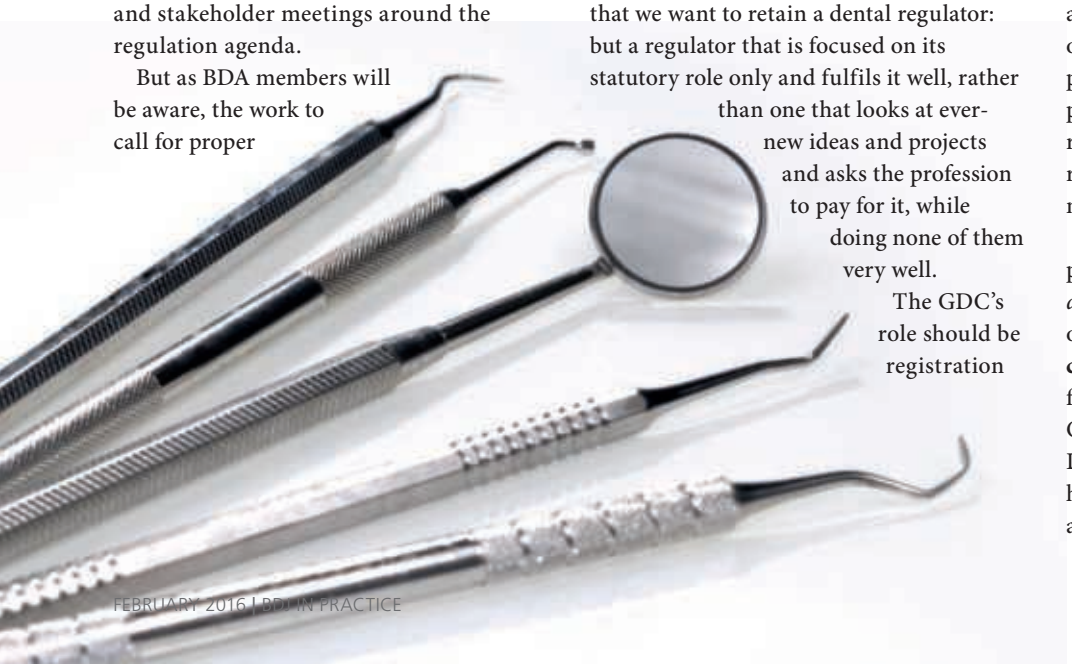
There have been other, more positive steps. Enshrined in the BDA's strategy for the next three years is a key objective: the development of a new approach to professional regulation. We are working to describe the key components of a system we think would work in the interests of patients and in a way that does not cause harm and distress within the profession. We plan to reach out to members when developing that framework and, once we have a consensus of workable ideas for change, we will approach Parliament with these proposals to improve the current fragmented and unfair system.

This work has begun in earnest. And one of the fundamental planks of our work is that we want to retain a dental regulator: but a regulator that is focused on its statutory role only and fulfils it well, rather than one that looks at ever-new ideas and projects and asks the profession to pay for it, while doing none of them very well. The GDC's role should be registration of professionals, prosecution of illegal practice, the setting of reasonable standards of behaviour, and the undertaking of fitness-to-practise investigations and sanctions where there is a case to answer.

Questions remain over whether or not initial complaints should be assessed by an alternative organisation, with only those issues that are likely also to have a fitness-to–practise-impairment component being sent to the GDC.

Similar ideas have been raised in the broader debate about regulation. The discussion paper, *Rethinking Regulation*, published in August 2015 by the PSA, highlights the need to reform regulation so that it supports professionals providing health and care, and recommends shared objectives for system and professional regulators, benchmarking to set standards, a reduced scope of regulation, a proper risk-assessment model, and to place responsibility with those who manage and deliver care. The paper makes a lot of points that resound strongly with the plight of the dental profession over the past few years, and includes a call for regulators to return to the principles of right-touch regulation, one the BDA has made repeatedly.

Another major development was the publication of the report *The future of dental service regulation* by the Regulation of Dental Services Programme Board (**see commentary, right**). This report, resulting from a collaboration among the Care Quality Commission (CQC), the GDC, the Department of Health and NHS England, highlights important issues that the public and the profession are facing; the unclear



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roles of the main players; the lack of a clear regulatory model; the lack of support and communication; and, above all, the issue of double or even triple jeopardy when a complaint is investigated by the GDC, the CQC and the NHS. The BDA, alongside other stakeholders, contributed to the development of this work through a series of stakeholder meetings.

The GDC will also now finally receive long-awaited powers to introduce case examiners into its fitness-to-practise processes. These examiners were approved by Parliament in January, with the GDC again subject to intense criticism, not least by Labour health minister Lord Hunt. The change should speed things up and, in the medium to long term, provide a reduction of cost in this area, which we hope and expect will be passed on to registrants through a reduction in the ARF (see also http://j.mp/gdc-s60).

The BDA has supported the introduction of these examiners, although that support has certainly cooled given the GDC's performance in managing its other functions. We hope the GDC recruits the right individuals with the right knowledge and provides the right training – if so, this could still be a positive step forward.

Finally, the Department of Health indicated a few weeks ago that it believed that a review of regulation undertaken by the Law Commissions in 2013/14 should be taken forward, although it has not yet indicated a timescale for this work.

Taken together, all of these issues combined *could* hail a new era in dental regulation – if all those involved stick to their promises and timescales and listen to the profession. ◆

COMMENTARY

Working groups to take forward work to improve dental regulatory model

by Dr Janet Williamson,
Deputy Chief Inspector – Central Region Primary Medical Services and Integrated Care, Care Quality Commission

Following the publication of *The future of dental service regulation* last year, the Regulation of Dental Services Programme Board (RDSPB) has established seven working groups to take the areas of improvement it identified forward.

The future of dental service regulation report was the culmination of a one-year programme carried out by the RDSPB, which identified seven key areas of improvement and agreed actions that will make dental regulation more coherent, streamlined and effective.

The Board is made up of representatives from the General Dental Council, NHS England, The Department of Health, the Care Quality Commission, NHS Business Services Authority and Healthwatch England.

The seven working groups will focus on the following areas of improvement:

- defining respective roles and responsibilities in the dental system;
- defining a clear model for the regulatory system;
- improving data, information and intelligence sharing;
- defining a system with a recognised role for complaints handling;
- developing a proactive approach to keeping patients informed and involved;
- defining the role of quality improvement; and
- implementing a communications programme to providers.

Earlier this month the Board met to discuss the scope of each working group, other partners across the system it should involve, programmes of work already being carried out that could support this work, and to agree timelines and next steps.

Several short-term outputs have already been identified, including mapping out and communicating the roles and responsibilities of organisations across the system and identifying gaps in data-sharing among organisations. The Board also discussed the need for complaints to be dealt with at a local level where possible and how it could help to support that.

> "The Board is made up of representatives from the General Dental Council, NHS England, The Department of Health, the Care Quality Commission, NHS Business Services Authority and Healthwatch England."

The Board will continue to have oversight of the working groups, and has committed to updating stakeholders on progress regularly. CQC has also committed to continue working with other regulators and commissioners to ensure it develops its approach and work on a system-wide basis.

You can share any thoughts and feedback relating to this work by taking part in our online discussion at https://communities.cqc.org.uk/provider If you are not already a member of the CQC online community you will need to join to take part – you can join at https://communities.cqc.org.uk/provider/user/register

You can also email the Board and working groups directly futuredentalregulation@cqc.org.uk ◆

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Sensodyne® demonstrates impact of dentine hypersensitivity at FDI 2015

GSK Consumer Healthcare, manufacturers of Sensodyne®, hosted a special symposium at the FDI conference, Bangkok, to share results of research into the impact of dentine hypersensitivity (DH).

The research used the Dentine Hypersensitivity Evaluation Questionnaire (DHEQ), a validated tool, to demonstrate the impact of DH.[1,2] Through a new pooled analysis of DHEQ data, Sensodyne® revealed some surprising findings about how people who experience the condition will compensate, cope, and alter their social activities when living with dentine hypersensitivity:[3,4]

- → 9 out of 10 sufferers had been experiencing the condition for longer than one year;
- → 70.4% of DH sufferers considered their sensitivity takes a lot of pleasure out of eating and drinking; and
- → 59.4% of DH sufferers try to avoid the sensations by biting food into small pieces.

Research also confirmed the clinical benefits of continuous twice-daily use of sensitivity toothpaste.[3,4]

1. Boiko OV *et al. J Clin Periodontol.* 2010; **37**(11)**:** 973-980
2. Baker SR *et al. Ibid.* 2014; **41**(1)**:** 52-59
3. GSK Data on File RH02026
4. Sufi F and Baker S. *The subjective experience of dentine hypersensitivity – a pooled analysis.* Presented at the 93rd General Session & Exhibition of the IADR. 2015.

Powder-free gloves

Unigloves has launched a range of three powder-free gloves, called Vitality.

Vitality Nitrile are white, powder-free with Lano-E coating; Vitality Latex are white, powder-free with Lano-E coating; and Vitality Latex are green, powder-free with Lano-E coating and scented with a citrus and peppermint flavour for patients' comfort.

The lanolin and vitamin E (Lano-E) coating is designed to reduce skin irritation and dehydration. This is supported by the multiple wash cycle, which makes the gloves cleaner and safer by reducing residual water-soluble proteins and other harmful chemicals to reduce allergy risks.

They have double-chlorinated beaded cuffs to make it easy to put them on and take off. The micro-roughened texture is to ensure optimal grip. This combination of features makes the Vitality range of gloves ideal for use within the dental industry.

For further information about Unigloves products, visit www.unigloves.co.uk or call 01634 726516.

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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

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On Specialist List: Yes, Orthodontics

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Interests: Fixed and Removable Prosthodontics, Dental Implants, Periodontics **On Specialist List:** Yes, Prosthodontics and Periodontics
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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
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Interests: Endodontics **On Specialist List:** Yes, Endodontics
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On Specialist List: Yes, Endodontics
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Interests: Oral Surgery, Implant Surgery, Sedation
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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
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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
Mrs Julie Kilgariff BDS MFDS RCS MRD RCS (Endodontics)
Interests: Endodontics
On Specialist List: Yes, Endodontics
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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.

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Dr Asim Ayub BDS MFDSRCS MClinDent MRDRCS
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Interests: Endodontics
On Specialist List: Yes

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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

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Nick Williams
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B Public liability insurance

C Building and contents insurance

D Business interruption insurance

Q2: Which of the following would seem to be the most popular website traffic-analysis tool?

A Clicky

B KISSmetrics

C Google AdWords

D Google Analytics

Q3: Which of the following is probably the most important question to ask at a fact-finding meeting?

A What was the date time and location of the incident?

B Who was involved in the incident?

C Who else saw the incident?

D What would be your ideal outcome?

Q4: Which of the following are required details on a Patient Group Direction (PGD): a – date the PGD expires; b – clinical condition or situation to which it applies; c – name and description of the medicine to which the PGD applies?

A a and b only

B a and c only

C b and c only

D a, b and c

Q5: Which of the following must sign a PGD: a – the dentist involved in developing the PGD: b – the manager of the dental practice: c – the senior dental hygienist or therapist involved?

A a and b only

B a and c only

C b and c only

D a, b and c

Need help?

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