BDJ InPractice
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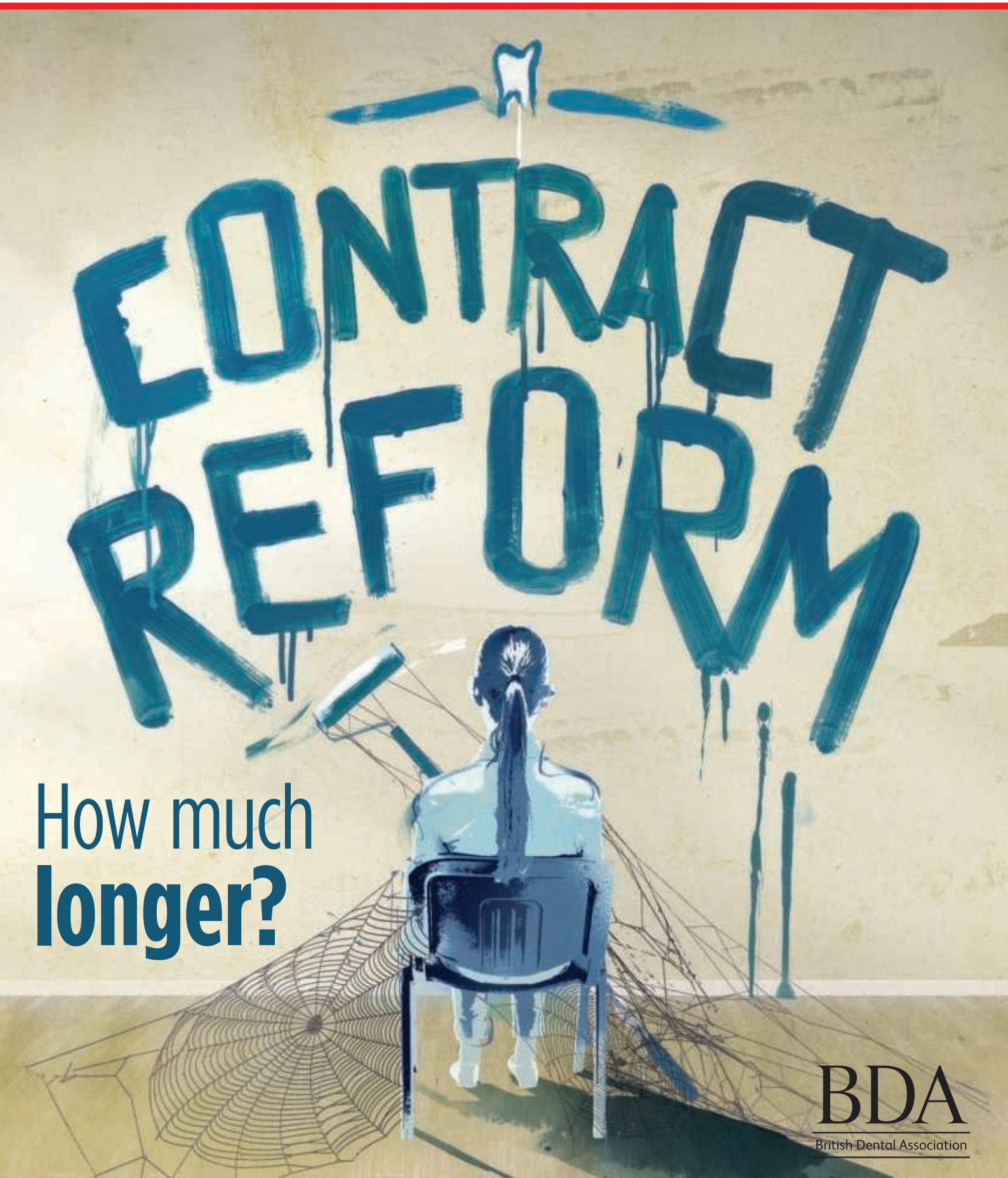

How much **longer?**

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Google AdWords ■ Digital Leadership ■ Leaving the NHS ■ Is dentistry making us sick?

IMMUTABLE LAW #6 OF PRACTICE PERFORMANCE

BRAND NEW WHITEPAPER

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We surveyed hundreds of dental practices to investigate the desire and current state of the industry in terms of running a paperless practice, and our latest Whitepaper documents the results.

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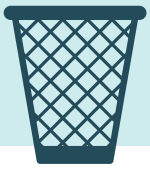
ONLY **5%** **OF PRACTICES** CONSIDER THEMSELVES AS **PAPERLESS**

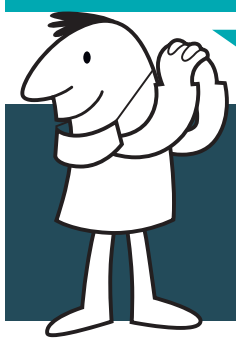


1/3 OF THOSE QUESTIONED ARE RUNNING OUT OF **PHYSICAL SPACE**

AND **20%** ARE STILL **SCANNING PAPER RECORDS** AS A FORM OF BACK UP

THE CAUSE

78% OF PRACTICES SAY THEY COLLECT PATIENT DATA **MANUALLY**



THE SOLUTION

Download our latest Whitepaper to read the **full report** including our **best practice checklist** to running a **paperless practice**.

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BDJ InPractice

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Changes to minimum pension contributions for practice staff from April

The statutory minimum pension contribution amount payable for both employees and employers for automatic enrolment is changing from 6 April 2018. If you have staff that are members of your workplace pension scheme you may be alerted to the change by your current pension provider but it would be wise to make a note of the details for future reference.

When automatic enrolment was first introduced in October 2012 the Government announced that the contributions payable for both employers and employees would be phased in over three stages. From April 2018 the second stage of contributions comes into effect and means that employees will be expected to pay 3% of specified earnings towards their pension with employers paying 2%. This is the minimum requirement for auto enrolment, however your chosen scheme may have already set the amount you must contribute as determined by the scheme rules. If you or your staff member already pay over the minimum level of contributions you may not need to alter the contribution rate. If a change is necessary you will need to ensure that your payroll system is updated with the new rate.

The third stage increase in contributions will take affect from 6 April 2019 and will mean that employers will need to contribute a minimum of 3% with the employee rate increasing to 5%.

Your staff will benefit from tax relief on the contributions paid as the Government will also pay into their pension pot by offering tax relief on their contributions – the employee rates quoted above are inclusive of this tax relief. Even if your staff do not pay Income tax they may still get tax relief if your chosen pension scheme uses relief at source to add tax relief to the pension pot.

As a reminder, employees are permitted to opt out of pension saving, but employers must not coerce anyone to do so.

If you fail to contribute to your staff pension scheme correctly or on time you risk being fined by The Pensions Regulator.

You should speak with your payroll provider to ensure that you are ready to comply with these changes in April 2018 and April 2019.

For further information on the changes please refer to www.thepensionsregulator.gov.uk/en/employers/phasing-increase-of-automatic-enrolment-contribution. ◆

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BOOK REVIEW

Leadership skills

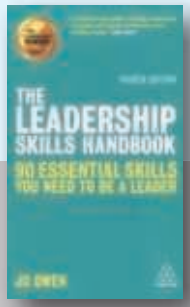
The leadership skills handbook – 90 essential skills you need to be a leader (4th edition)

Jo Owen

Kogan Page, 2017

ISBN: 978-0-7494-8033-2

£14.99



In a nutshell

Multi award-winning author, keynote speaker and social entrepreneur Jo Owen has written the fourth edition of his highly successful book on leadership and it's crammed full of helpful information. The 90 essential skills are translated as 90 chapters arranged equally over 10 parts, each covering ten related topics such as financial skills, political skills and the art of strategy. The chapters are very short, sometimes under two pages in length and this is deliberately designed to make the book easy to dip in and out of according to the needs of the reader. To assist in this process there's a handy and comprehensive subject index at the back.

Who is it ideal for?

As Owen says in his introduction, 'leaders learn not from courses but from experience, bosses, peers and role models'. This truism applies to all leaders and the author is under no illusion that this book will answer all the questions. However, it will provide some answers when required in a timely fashion. Everyone who has to take a leading role in any business or organisation, however small, will encounter problems of all types, whether they be related to employees (people skills) or various aspects of business (financial skills). As a new leader or even an established one, there will inevitably be issues that need addressing and this book can be an invaluable aid for those requiring some sage advice in a hurry.

Why you should read it?

The previous (3rd) edition of this book, published in 2014, was voted by the Chartered Management Institute as its book of the year for new managers. This is hardly surprising since the areas it covers are critical to any business. However, they are not discussed in such detail as to be opaque or incomprehensible. Indeed Owen uses everyday language to explain subjects which are not necessarily everyday matters. For example over the course of two chapters within the section covering strategy, he compares two main types which he identifies as 'classic' strategy, which is all about designing the solution, and 'post-modern' strategy, which is about discovering the solution and breaking all the rules as you go along. Owen is also mindful about self-awareness and career paths of leaders both of which are dealt with in the opening parts (mindset skills and career skills). Indeed there's little that isn't covered in this handy guide to becoming an effective leader. ◆

For more about these books: www.bda.org/booknews

COMMENT

‘Safety first’ for Chancellor Hammond

Charles Linaker, a tax partner with UNW, says that the Chancellor will still have to find ways of raising extra tax from somewhere and warns that dentists should be on their guard

Given the weakness of the Conservative Government as a result of the General Election and the tortuous negotiations with the EU over Brexit, it was perhaps no surprise that Chancellor Philip Hammond’s Autumn Budget should have avoided, if not evaded, making any major changes to the tax regime for the majority of businesses and individual taxpayers.

Those who are currently self-employed will recall that, in his Spring Budget earlier this year, Hammond announced increases to the rate of Class 4 NIC from 9% to 10% and then from 10% to 11%, which he then had to withdraw with indecent haste when it was pointed out that they breached a manifesto pledge made at the 2015 General Election. Had the Government been in a stronger position, those increases would surely have been reintroduced but the Chancellor confirmed that they will not now be implemented.

Similarly, dentists who operate via limited companies might have expected a possible reversal of the previously announced staged reduction in corporation tax rates, which many commentators thought could be implemented with relatively little controversy, not least because it would have been difficult for Labour to have opposed such a measure. But again, it was a case of no change as the Chancellor confirmed that 19% would remain as the rate for three years from 1 April 2017 and then fall to 17% from 1 April 2020.

On the personal tax side, Hammond could have decided to abandon, or at least delay, the previous proposals to increase the personal tax free allowance, but he confirmed that for 2018/19 this will increase from the current figure of £11,500 to £11,850 and that the basic rate band will increase for 2018/19 from the current figure of £33,500 to £34,500 (with the exception, it should be noted, of Scottish taxpayers).

Of course, it needs to be remembered that not everyone has the benefit of the full personal allowance. There is a reduction in the personal allowance for those with ‘adjusted net income’ over £100,000, which is £1 for every £2 of income above £100,000. So for 2017/18 there is no personal allowance where adjusted net income exceeds £123,000 and for 2018/19 there will be no personal allowance available where adjusted net income exceeds £123,700.

Capital Gains Tax was also left untouched in so far as the main rates of 10% and 20% remained unchanged and the annual exemption of £11,300 for 2017/18 was increased to £11,700 for 2018/19. Moreover, for any dentists contemplating retirement in the near future, not only did the 10% rate applicable for Entrepreneurs’ Relief remained unchanged, it was announced also that the Government will consult on how access to Entrepreneurs’ Relief might be given to those whose initial holding in their company is reduced below the normal 5% qualifying level of shareholding as a result of raising external investment for commercial purposes by means of issuing new shares.

An early major casualty post-Election and pre-Budget had been HMRC’s much vaunted Making Tax Digital (‘MTD’) programme whose implementation for income tax is now postponed until 2020 at the earliest – and later in the case of corporation tax. Only MTD for VAT will adhere to the original timetable from April 2019, which typically does not affect dental practices. Nevertheless, dentists would be well advised to plan on the basis that ultimately the proposed MTD requirement to file quarterly returns of income and expenditure to HMRC will be implemented.

A key argument from HMRC for the introduction of quarterly reporting under MTD is that it will help them close ‘the Tax Gap’. While HMRC estimates that it loses more than £1.5bn a year in tax through avoidance schemes (in which at least some dentists will have participated), the Department reckons that it loses in excess of £5bn a year through the hidden economy (i.e. payments made cash in hand) and that SMEs pay a total of £15bn less tax a year than it estimates they should.

The statistical probability is that there will be some dentists in both of those categories. Given the Treasury’s need for increased revenue, an increase in HMRC enquiries over the next few years is on the cards and the dental sector can expect to bear its fair – or possibly even unfair – share of attention. You have been warned.

BDA DFT Educational Supervisors study – share your experiences

The BDA is inviting all dentists with a DFT educational supervisor role in England to share their views on their role and responsibilities and how these may have changed over time.

Our upcoming study aims to better understand DFT educational supervisors' workload, their level of engagement and satisfaction, what their future intentions might be and if applicable, suggestions they may have about the programme.

We are keen to hear from all dentists currently supervising a foundation dentist in England. So if you wish to be heard please get in touch with the BDA Research Team by emailing the information below to research@bda.org:

- Your name
- Your email address
- Your HEE area
- The practice name and mailing address.

As a thank you for your time, we are offering future participants the chance to enter into a prize draw to win a £100 Marks & Spencer voucher. ◆

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BDA board election results

The results for the BDA board (Principal Executive Committee) elections are now in and we are pleased to announce the results for the 2018-20 triennium. The successful candidates are:

- Eastern: **Jason Stokes**
- North West: **John Edwards**
- Wales: **Tim Harker**
- West Midlands: **Eddie Crouch**
- UK-wide: **Len D'Cruz**.

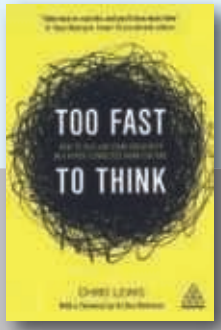
All of them will take up their mandate on 1 January 2018 alongside the other 10 sitting members.

View the full election results and scrutineers' reports at https://www.bda.org/dentists/policy-campaigns/campaigns/elections/pec-voting. ◆

BOOK REVIEW

Keeping pace

Too fast to think – how to reclaim creativity in a hyper-connected work culture
Chris Lewis
Kogan Page, 2016
ISBN: 978-0-7494-7886-5
£14.99



In a nutshell

When living in the 21st century continues at a seemingly ever-increasing pace, the danger inherent in this trend is that people are becoming too busy to pause and reflect, or in extremis actually too busy to think. This phenomenon, powered partially by the growth in technological advances, means that we are often subjected to an 'always on' work culture. In this two hundred page paperback, media trainer and founder and CEO of his own eponymously-named company, Chris Lewis exposes how current working practices are often, paradoxically, detrimental to productivity. As a counter to this he proposes an innovative and holistic approach to creativity.

Who is it ideal for?

This inspiring book is ideal for anyone who wishes to maximise their creative potential. It's aimed at such a wide audience that it could be said to apply to everyone who wishes to improve not just their working practices but indeed all aspects of their lives. Specifically, Lewis singles out millennial adults as a primary target group affected, as a generation, by the proliferating activity of constantly checking their emails wherever they are, be it in the bedroom, kitchen or even the bathroom. This doesn't even begin to address the Snapchat generations for whom paying attention to 'real life' is seemingly an action too far. Nevertheless this 'being too busy to think' business affects them just as much as anyone else.

Why you should read it?

Lewis advocates a novel system of creative thinking that he terms the 'eight creative traits' which comprise the following qualities: quiet, engage, dream, relax, release, repeat, play and teach. Each of these he deems a vital component in a new way of thinking that should be mastered in order to create a new thinking environment. To illustrate his thesis he populates the book with anecdotal evidence and case studies. Amongst chapters as varied as 'Sleep matters' and 'Generating better ideas' there's also one observing the differences between left and right brain processes (analytical and creative thinking, respectively), how these affect work and how they can be better understood in order to improve productive creativity. In the final chapter Lewis examines how leaders apply creativity, with some fascinating concrete examples from the great and the good in industry and politics. Whilst Lewis's book may not solve all his readers' problems, it does provoke questioning why we do things in the way we do them and whether there might be a better way. ◆

BDA insists on coherent strategy for amalgam phase down

The gradual reduction in the use of dental amalgam must be supported by investment in strategies to prevent tooth decay, particularly in England and Northern Ireland, where no national oral health improvement schemes for children currently exist. That's the verdict of the BDA in its response to the Department for Environment Food and Rural Affairs (DEFRA) consultation on the UK's implementation of the EU Regulation on Mercury, which comes into force next January.

The BDA believes this is necessary to support the requirement for countries to have a national plan in place by July 2019 on the measures they will employ to phase down the use of amalgam in restorations. The BDA believes that the scale of the phase down is such that it also needs to be supported by investment in research and development into alternative materials to amalgam.

By July 2018, the EU Regulation stipulates that placing amalgam restorations in under-15s and pregnant/breastfeeding women should be restricted to instances when it is 'deemed strictly necessary by the dental practitioner based on the specific medical needs of the patient'.

The BDA has strongly argued against plans proposed for Wales to define a restricted list of clinical scenarios in which the placement of an amalgam filling would be acceptable. The best interests of each individual patient are paramount and such a list could not possibly cover all situations in which a clinician might find it necessary to recommend the use of dental amalgam.

While prohibitions on specific drugs or medical procedures in pregnancy are often based on the precautionary principle, the BDA is concerned that the proposed restrictions are not based on any evidence of health risks. The BDA draws DEFRA's attention to the comprehensive review of the safety and efficacy of amalgam by the European Commission's Scientific Committee on Emerging and Newly Identified Health Risks (SCENIHR), which concluded that the current evidence does not preclude the use of either amalgam or alternative materials in dental restorative treatment to children or pregnant/breastfeeding women.

By 1 January 2019, dental amalgam will only be permitted in pre-dosed encapsulated form and dental facilities will have to be equipped with an amalgam separator.

Commenting, BDA Chair Mick Armstrong said: 'We support an environmentally-responsible phase down of amalgam in dental restorations, but are concerned that government is setting a tone that is more reflective of unfounded health scares rather than any genuine evidence-based health risks.

'Individual dentists are best placed to make clinical decisions on the most appropriate materials to use to restore damaged or decayed teeth in the best interests of each patient, and that includes amalgam. There are well recognised situations where amalgam restorations may be preferable, if not the only realistic solution to ensure long lasting and durable solutions for our patients.

'The phasing down of amalgam is substantial and needs to be thought through carefully and mustn't be done on a whim or prayer. UK governments need to develop proper, funded strategies for prevention, especially in England and Northern Ireland, to deliver the scale of phase down required.'

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CONTRAC
REFORM

Paint drying or contract reform: which comes first?

By Martin Woodrow,
Director of Member Services, BDA

Since 2015, the Department of Health has been prototype testing two remuneration models for a reformed NHS dental contract in England. The prototype process is expected to continue now until March 2020 probably with a small number of practices joining the programme in 2018/19. This article describes where we are in the process, the issues we have with the prototypes and some changes we would like to be made.

Government objectives

The Department of Health's stated aim for contract reform is 'to improve access, quality and appropriateness of care and improve oral health, within the current cost envelope, in a way that is financially sustainable for dentists'. The BDA's objectives are to develop a more appropriate payment system (including the removal of Units of Dental Activity (UDAs)), improve oral health and improve dentists' working lives.

Prototypes – current issues

There are now just under 80 prototype practices that have been testing two remuneration models:

- Blend A pays for Band 1 level care via capitation payments and more complex Bands 2 and 3 treatment via UDAs
- Blend B pays for Bands 1 and 2 under capitation and Band 3 via UDAs.

Both use the preventive clinical care pathway that has been tested since 2011.

The Department's interim evaluation report showed that practices that were not former pilots have been doing generally better than former pilots (who had to catch up on patient numbers lost during the piloting process).

The evaluation reinforces the fact that any rollout will be undertaken by practices new to the process so these non-pilot 'wave 3' practices arguably give a better feel for what a rollout would look like.

We want to see contract reform succeed but have the following issues with the prototypes:

- Patient numbers can be very difficult to maintain
- UDA targets can be difficult to meet at the same time as maintaining patient numbers
- Retaining associates can be difficult
- To maintain patient numbers, new patients often have to be taken on who can require a lot of treatment
- There may be a shortage of available new patients in some areas
- Having to extend working hours or recruit new staff increases practice costs.

The present context

The BDA has evidence of widespread shortages of associates prepared to work in NHS general

dental practice, stressed and over-burdened NHS practitioners and a service that is in crisis. The BDA remains supportive of contract reform as the current system is not fit for purpose. But that change cannot be at any cost, and change must not make the situation worse. The Department of Health and NHS England must be more flexible and creative to ensure that a reformed contract helps to solve current difficulties and doesn't make things worse.

Access

It would be beneficial if the Department could rethink what they mean by access to care. In September there was a Parliamentary Adjournment Debate on access to NHS dentistry and Opposition MPs had been extensively briefed by the BDA. During the debate, the Minister with responsibility for dentistry, Steve Brine, said: 'The prototypes are being evaluated against a number of success criteria, but let me be clear that they will have to prove that they can increase dental access before we consider rolling them out as a new dental contract.'

Evidence suggests that it will be difficult to increase dental access using the current prototype model and current definition of access, unless practices themselves pay for increases in staff time and facilities. Such an approach will not be sustainable for dentists. There are two main ways of addressing NHS access:

- → Increase Government investment in NHS dentistry
- → Develop an alternative measure for access for use in the prototypes.

We would welcome a more imaginative approach to access. For example, the number of patients registered for and receiving NHS care seems an accepted approach to access. Lifelong NHS registration seems to be working in Scotland. Using an approach along these lines would mean that patients wouldn't fall off a practice's capitation list unless they died or attended another practice. A system like this would give practices more time to serve the needs of their population without losing financially.

Remuneration

The BDA position is that capitation payments should be weighted to reflect treatment need. We believe that the remuneration system needs to recognise the amount of time spent delivering care for particular patients. A Dental Reference Officer system should be reinstated to demonstrate that appropriate care is being provided. This could be paid for out of the money previously used for seniority payments.

We believe that Blend B prototypes seem to be working better than Blend A, so current Blend A prototypes should have the option to change to Blend B if they wish. We would like to see more practices taken on as Blend B prototypes in 2018/19 to enable further testing in a wider variety of practices.

> 'Evidence suggests that it will be difficult to increase dental access using the current prototype model and current definition of access.'

Long overdue

Although wider roll-out seems far away the Department and NHS England need to start negotiating with the BDA soon. The profession can't wait around forever for change to come – it's already long overdue.

Although Len D'Cruz, Practice owner of Woodford Dental Care, a six surgery practice in North east London, has managed to maintain a solid patient base throughout the pilots and the prototypes, he believes both are fraught with problems.

'We have actively zoned our appointment books from the outset. We calculated how many oral health assessments we needed to do per dentist per day and put this into the book. For us it was 7-8 OHAs per dentists per day. We then built out the appointment book to accommodate urgent treatment slots and treatment time. We since have altered the zones now to prioritise Band 3 treatments since as a Blend B prototype we get measured on our Band 3 activity. This has the effect of reducing Band 2 time and therefore increases the waiting time for patients to have just B2 treatments. This is not really fair for patients, causes some grumbling at reception but is a pragmatic solution to how we are measured

'Running two treadmills of UDAs and capitation numbers is very time consuming exercise particularly since we have 7 dentists. This is more challenging since the system allows for taking on more patients and offsetting this using an exchange calculation to reduce the number of annual UDAs you have to achieve. This means constant monitoring to make in-month adjustments throughout the financial year. In our case we achieved 107% of our capitation target and consequently only had to meet about 85% of the UDAs we were contracted to do at the start of the year.

'We over performed last financial year and we did not get paid so we will be ensuring we don't do that again! This has meant however that as of December, we have run out of Band 3 UDAs till April 2018. This adds to the general chaos of the system and patient's treatment having to be delayed. This creates a feeling of mistrust amongst our patients who think either we lack the organisational skill to run the practice or we are trying to push them into having private treatment. Neither is true.'

Az Hyder Clinical Director, Burgess Hyder Dental Group, believes there is no end in sight to the issues relating to the prototypes.

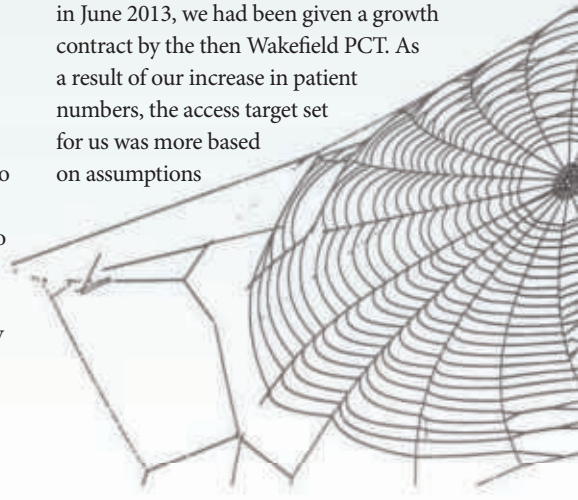
'There is a huge issue relating to the fine balancing act of capturing new patients and activity based measures to treat these patients', Az said. 'The current system does not reward a practitioner for working in a high needs area. The patients in these areas do not regularly attend and do not lend themselves to capitation, but at the same time are costly to treat due to multiple restorations.'

Joe Hendron, Principal at St Michaels Dental Practice, also has a number of issues with contract reform as it stands.

'Practices who have had a stable patient base and a low turnover of Performers will have an access target which is more easily achieved. A practice which is more volatile where patients often attend for urgent and single courses of treatment and do not return for regular recalls and/or where there is a high turnover of Associates will find maintaining access targets more challenging.

'The access target is set unilaterally by the contract reform team, apparently using historical records provided by NHS Business Service Authority and it can be very difficult for a practice to understand the justification of the numbers set. When we moved from pilot to prototype in 2015, there was a reconfiguration of the access targets and every practice I have spoken to have had their targets increased further as a result.

'In our case, prior to embarking on the Pilot in June 2013, we had been given a growth contract by the then Wakefield PCT. As a result of our increase in patient numbers, the access target set for us was more based on assumptions



than fact and we frankly did not know any better at the time. We assumed a certain trust that the contract reform team and NHS BSA knew what they were doing and the figures must have been appropriate. However, when we set about the access targets we found that they were impossible to achieve with the current workforce.

'However, as some patients signed up for continuing care and returned for regular recalls, others only wanted urgent or single short course of treatment often ending with FTAs. When it came to the pilot, patients are registered on the dental list for three years and if they had not been seen again in that time, drop off that list. We started to suffer as the new irregular patients were dropping off, we had to replace them with often, more irregular new patients and the idea of trying to achieve the plateau level whereby we could tread water was becoming less attainable.'

The same old brand new

One underlying issue everyone has with the contract is the promise of a new dawn tainted by the paint of the past.

Units of dental activity have underpinned the demise of the ill-fated contract that will soon be 12 years old. So why do they appear in the proposed contract reform?

Len said: 'The return of the UDAs has been the most depressing and disappointing aspect of the whole process. Whilst I accept in principle that activity needs to be measured, the UDA is not the way to do it. It bears no relation to the complexity of the treatment provided, the individual needs of the patient or the time taken to provide the care as well as preventive advice that is needed to ensure that the intervention provided is looked after. The unit value of the UDA varies so much across the country that after 11 years they have no relationship with the demographics of a practice population.

> 'Frankly I am puzzled that we are still seeing UDAs as part of the prototypes. Az said. 'It seems that the Department of Health are refusing to remove UDAs as a currency.'

'A pure capitation scheme is something we worked with in our practice in the pilots and I believe we delivered good care, in a timely manner with all the prevention it needed to put patients' on the right path to looking after themselves. Capitation leaves the dentist with the decisions on how care for their patients should be achieved without the artificial targets of UDAs hanging over their heads. Patients are not a means to an end to achieve UDA targets. They are human beings with oral health issues that need to be cared for with an entitlement to have those needs ethically managed in their best interests.'

'Frankly I am puzzled that we are still seeing UDAs as part of the prototypes', Az said. 'It seems that the Department of Health are refusing to remove UDAs as a currency. As long as this continues any type of commissioning will be flawed and inequalities will not be addressed because dentists will not want to work in high needs area.'

Joe agrees that their appearance in any conversation surrounding contract reform is puzzling.

'Everyone is asking it but no-one can answer it', he said. 'When the Department of Health decided to re-introduce activity, they did not have the imagination to call it by any other name.

'The initial aim of the reforms was to produce a dental contract with prevention at its core. How can you care for people giving the prevention message alongside the current thinking of minimal intervention when you have an activity target hanging over your head? The concept is a complete contradiction. Of course, treatment intervention is necessary but the CRT seem to think that this is the only way of measuring activity. They refuse to recognise that the time and effort taken to provide the message of prevention is in itself activity.

'Simply put, the CRT and NHS England do not trust dentists. If they cannot see widgets for fillings, extractions and dentures, they think we are sitting looking out the window drinking coffee like in the advert a few years ago or God forbid, on the golf course.

'DH and NHS England will remain in the dark ages of drill and fill dentistry and are unwilling and refuse to take the leap of faith required to produce a dental contract which is of its time, which will improve our patients' oral health and which is fulfilling for the clinicians who deliver that care.'

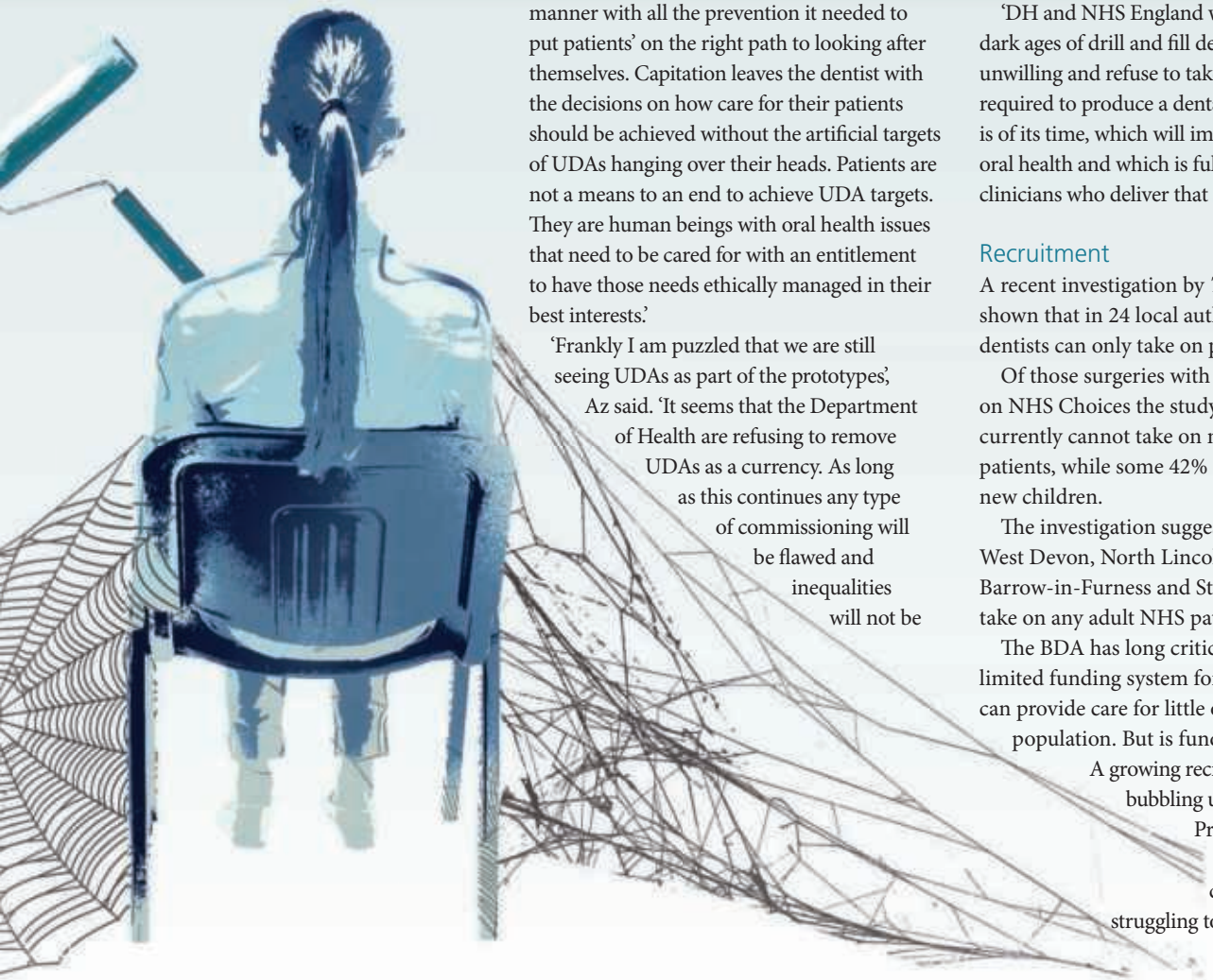
Recruitment

A recent investigation by *The Times*[1] has shown that in 24 local authorities in England dentists can only take on private patients.

Of those surgeries with information on NHS Choices the study found 49% currently cannot take on new adult NHS patients, while some 42% are unable to see new children.

The investigation suggests areas including West Devon, North Lincolnshire, Gosport, Barrow-in-Furness and Stafford are unable to take on any adult NHS patients at all.

The BDA has long criticised the cost-limited funding system for dentistry that can provide care for little over half the population. But is funding the only issue? A growing recruitment crisis is bubbling under the surface. Practices across the country – including corporates – are struggling to recruit dentists.



However the CDO for England, Dr Sara Hurley, has long insisted the future of the workforce lies with dental care professionals. So the question is, how does the prototype reflect their skillset?

'There is no doubt that DCPs have a vital role to play in the future delivery of dental care', Joe said. 'They can provide the time and the skills in specific areas of periodontal health and children's dentistry amongst other disciplines allowing general dental practitioners to spend time on the advanced needs of our patients.

'But there are things that have to change first and it must be a gradual process – what may be good in Rugby or Leatherhead may not be appropriate for Wakefield or Keighley. Not every practice has the physical space to accommodate DCPs or the resources to support them either and it is a fine balance knowing how many dentists or DCPs you need and when you need them.

> 'The numbers and statistics suggest progress, but the reality of the situation is very different. Those running and making the change aren't moving at all.'

'The patient has to accept the change and this cannot be forced on them. Patients are still used to attending their dentist for all their treatment needs and they have built up a level of trust over the years. They don't necessarily want to be farmed out to what they might consider, a less experienced clinician, with whom they have to build up that rapport again.

'The regulations must change to allow DCPs to open a course of treatment on the NHS.'

While Joe thinks it's about a fine balance, Az believes a change would be beneficial.

'A move to utilising dental care professionals is a huge move forwards. Currently, no treatment credit can be allocated to a therapist without prior endorsement by a dentist. Is that the most efficient service for patients?

'Therapists and their services do not lend themselves to commissioning under the NHS. True oral health and disease prevention pathways, together with ICM courses, get no credit under the present system. I am very keen for this to happen.'

According to Len, cost prohibits their value being fully utilised.

'Yes, dental care professionals are valuable members of the team, but their support is limited in a reformed contract even if their scope of practice with the GDC is extended. This is primarily because of cost.

'Therapists cost more than hygienists but only slightly less than associate dentists on an hourly basis. They have a narrower scope of practice than associates, cannot perform examinations on the NHS and are often not as quick and efficient as dentists.

'On the other hand, dental nurses do have a significant part to play in contract reform as they are well placed to provide and deliver prevention in accordance with Delivering Better Oral Health to a wide range of the practice population. Encouraging dental nurses to pursue further training such as Prevention in Practice and other certificated post-qualification courses is certainly the way forward to developing the wider team. Hygienists are an essential part of the prevention agenda but again on the basis of cost, certainly in the south of England, their services are often only provided to patients under private contract. This is because the hourly rate demanded by hygienists makes offering their services on the NHS uneconomical.'

An honest mistake

It's not inconceivable that the use of dental care professionals will continue to evolve over time. The current system may allow for that. What it also allows for is 50 shades of grey.

For example, ethical considerations around the desire to take on high-needs patients versus the cost to do so is a dilemma opened up by contract reform. As it stands, the system does not provide what Az described as 'an honest day's pay for an honest day's work' with its continued insistence on UDAs.

So will patient numbers create ethical and moral dilemmas for practitioners moving forwards?

Joe said: 'I feel that the number of patients we have to see is too high and this is why we struggle with the access targets, providing timely treatment and struggling to get any prevention message out.

The Oral Health Assessment has been the victim of its own success. For years prior to pilot we were putting appropriate patients on 12-month recall as recommended. These were patients who had excellent oral health or who simply were not engaging and anything more regular was a waste of resources.

The Assessment resulted in setting recall periods of 3, 6, 9, 12 or 24 month recalls for ICM or Oral Health Review. Long-term patients with periodontal problems and who smoked started to engage with the process who were otherwise on 12-month recall. They did not like the idea of being classed in the 'red category', undertook their intensive periodontal treatment and are now being maintained every 3 months.

'Children previously on 6-month recall with caries risk are to be seen every 3 months for fluoride varnish and very soon our books became clogged. Currently, routine treatment for a restoration will usually be seen in 4 months – a simple DO may well then require endodontic treatment – how is this reform?

'Therefore, to free up the books, prevention messages are abrupt if at all. Three month ICMs are now 6 months; 6 month recall are now 12 months. I no longer have the space for our nurses to provide fluoride varnish applications. It's just not working.'

According to Len, the most significant issue facing practitioners operating in a system weighted heavily towards capitation is the lack of financial incentive to provide extensive or expensive treatment.

'For those within the prototypes this is a well-recognised issue, and whilst it would be easy to say dentists should not succumb to the perverse incentives of such a system, it is human nature.

'One can only imagine how HR departments the world over, in every sector of business and industry, think of more and more innovative ways to increase production in their workforce. The other problem that is created by the dependence of your NHS income on patient numbers is that it creates direct competition with other local practices for those patients. This would make sense if the money followed the patients so that the more popular a practice the more patients they get and the more contract value they attract. It is the natural way of high street competition. It appears however this is not the commissioning model NHS England are planning on following.'

Perhaps the situation surrounding contract reform can be likened to running a marathon on a treadmill. The numbers and statistics suggest progress, but the reality of the situation is very different. Those running and making the change aren't moving at all. Time is ticking to deliver effective change. Practitioners are tired of waiting for change, and with no end in sight, for many time will expire. ◆

References

1. The Times. News article: Millions denied an NHS dentist. 30 November 2017. Available online at: www.thetimes.co.uk/article/millions-denied-an-nhs-dentist-xfhbgzlz0 (Accessed December 2017).

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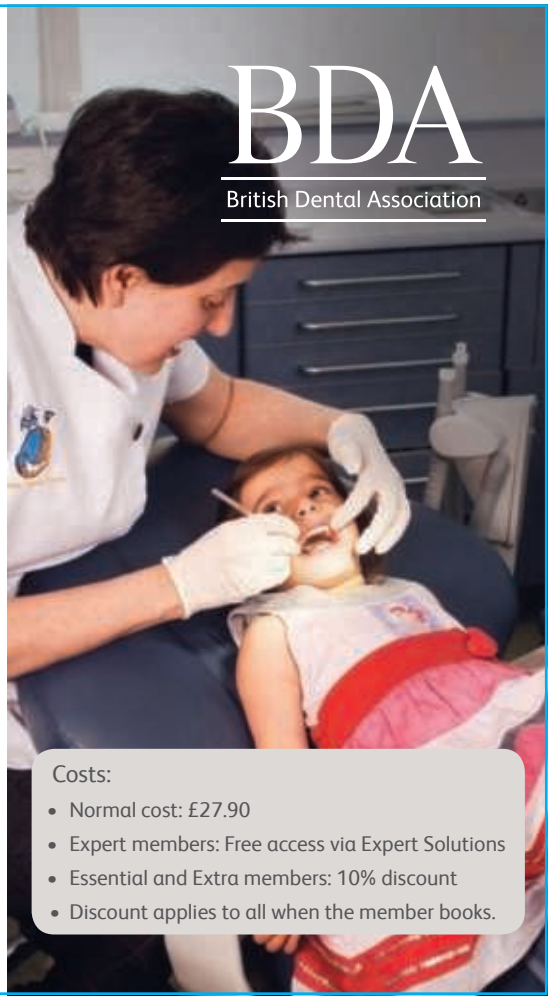

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How Google can help your practice grow

Laura Assassa, BDA Marketing Manager, gives an insight into paid search and how you can use this to help your practice grow.

When you search for something on the internet, you will often see adverts at the top of the search list highlighted with a small green 'ad' button. Making sure your practice is at the top of this list can be very lucrative. The higher you are up the search list, the more people click on your advert and be directed to your website instead of your competitors.

Getting to the top of the search list is very competitive, but can be achieved by paying for advertising space. This is known as 'pay-per-click' (PPC) advertising and means you only pay when people click on your advert. Google AdWords is the single most popular PPC advertising system in the world, having captured over 80% of the market[1]. Other search engines such as Yahoo and Bing also offer a similar service, however using Google AdWords is particularly valuable due to the huge number of users.

An example PPC campaign

PPC has the potential to have a big impact on your business in a short space of time. For example, an individual who wants a brighter smile may type 'tooth whitening' into Google. PPC adverts can be tailored to target different geographic areas and demographics. For example a dental practice that is bidding on these words will have their tooth whitening promotional advert shown in the search results for people in their local area. This means the practice has the potential to win a new patient if the reader clicks on the advert and is directed to the practice website.

How to set up a PPC campaign

In recent years PPC has transformed the way that companies spend their advertising budgets. One advantage is that you can spend as much as you're willing to, so you can start small and grow your campaigns based on the feedback you get.

It typically takes a PPC agency around ten working days to create a campaign for a new customer. This should include the creation of an account plan, plus getting tracking set up so it's easy to monitor performance of the campaigns. Following this, an initial three month trial is then recommended.

A great deal goes into building an effective PPC campaign – from researching and selecting the right 'keywords', for example 'tooth whitening' or 'smile make-over', to organising those keywords into well-organised campaigns. To get the best results, we also recommend setting up a specific landing page on your website that relates to your campaign.

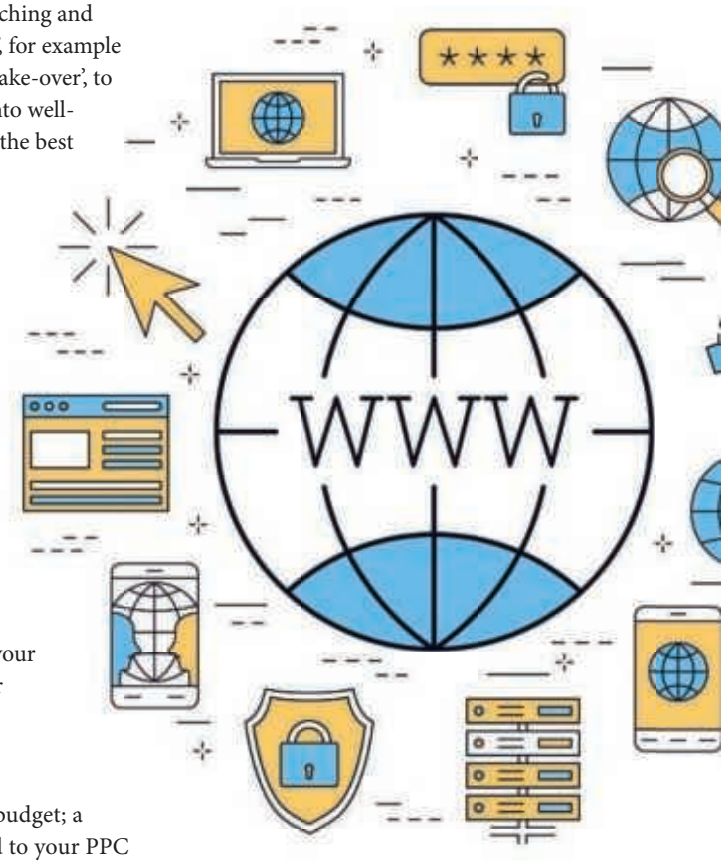
Search engines reward advertisers who create relevant, intelligently targeted campaigns, by charging them less for advert 'clicks'. If your adverts and website landing pages are useful and satisfying to users, Google charges you less per 'click', which means that more people are directed to your website and higher profits for your practice.

Setting your budget

There are two parts to your budget; a monthly retainer that is paid to your PPC agency, plus Adwords payments which goes to Google.

Many businesses that are new to PPC make the mistake of setting initial budgets too low. This means there aren't enough data to accurately refine campaigns and can result in poor response rates. If you want to see strong results quickly you need to invest and then carefully monitor performance.

You will set your maximum monthly budget with your PPC supplier, then they will tell you



if you have hit this spend each month. How much you spend in total depends on how many people click on your adverts.

Monitoring success

The first thing to really take home about AdWords is that you get rewarded for the time and effort you put into your campaigns. Google are changing and adding tools at a fast pace and many advertisers are just not keeping up. This is where having an expert supplier to advise you about this can really help.

Once you've created your new campaigns, you and your PPC supplier need to manage them regularly to make sure they continue to be effective. We would typically recommend a three month minimum commitment as PPC campaign improvements take time.

Choosing a PPC supplier

You can set up a PPC campaign yourself, however there is a fine art to getting everything right. It is easy to waste money if you don't know what you are doing, so we advise getting expert advice from a PPC specialist.

When choosing a supplier you should look for:

- A Premier Google Partner
- Specialist in PPC. AdWords is a complex product where it is easy to waste money if you don't know what you are doing. Be wary, there are lots of companies that offer this service, but don't get results.
- Proven track record and experience in the industry
- Account managers that are Google certified
- Commitment from a supplier reference to communication and regular reports that monitor performance as well as calls to review your account. For example a monthly telephone meeting, plus monthly report.

When mastered, online advertising can transform your business as you out manoeuvre your competition and drive high numbers of relevant leads into your company at ever decreasing costs. However, if managed poorly, online advertising can also see businesses spend a great deal for very little return. ◆

[1]Net Market Share. Desktop Search Engine Market Share. Available at: www.netmarketshare.com/search-engine-market-share.aspx?qprid=4&qpcustomd=0 (accessed 29 November 2017).

Expert View

Tariq Elmenstirly, Digital Account Manager at PUSH, gives his top tips for getting great results from your PPC campaigns.

While a number of factors determine how successful your PPC advertising campaign will be, you can achieve a lot by focusing on the following areas.

- **Put yourself in the shoes of your target audience.** Think about things from your potential patients' point of view. When searching the internet for your type of product or service, what will they search for?
- **Make sure your keywords are relevant.** 'Keywords' are what patients search for on the internet, for example 'emergency dentist' or 'tooth whitening'. Keyword research for PPC can be incredibly time-consuming, but it is also very important. It is vital that you put together a relevant PPC keyword list and have appealing advert text that relates to this.

  Your entire PPC campaign is built around keywords, and the most successful Google AdWords advertisers continuously grow and refine their PPC keyword list. If you only do keyword research once, when you create your first campaign, you are probably missing out on lots of valuable, low-cost and highly relevant keywords that could be driving people to your website. It is also important to review expensive, under-performing keywords and shut them off to avoid wasted spend.
- **Make sure your website landing page is tailored to your campaign.** In order to get the best results, create landing pages on your practice website with persuasive, relevant content and a clear call-to-action, tailored specifically to what patients are searching for on the internet. For example, if you have set up a campaign promoting Invisalign, when people click on your PPC advert they are sent to a tailored Invisalign webpage on your practice website rather than your home page.
- **Make sure you landing page is mobile optimised** as over half your traffic will come from mobile phone users. This means that your practice website needs to be 'mobile friendly', so it is easy to view from a smartphone.
- **Ensure your website loads quickly.** According to Google's latest research, the average time it takes to fully load a mobile landing page is 22 seconds, however, it also indicates that 53% of people will leave a mobile page if it takes longer than 3 seconds to load.
- **Aim for a high Google Quality Score.** This is a metric Google uses to determine your ranking in the internet search list, plus how much you pay per click for your campaigns. Advertisers with higher Quality Scores pay less for each advert, plus are more likely to appear higher in the Google search listings. Your score is determined by the quality and relevance of your keywords, website landing pages and PPC adverts. It is ranked from 1 – 10, with 10 being the best. A quality score of 7 is average.
- **Add negative keywords.** In the same way as you add the keywords you want to bid on, you can also tell Google the 'negative keywords' for which you do not want your advert to be shown. When used correctly, negative keywords can help you save unnecessary budget expenditure.

  Negative keywords are ambiguous words that mean more than one thing. For example if you are promoting orthodontic work, you may wish to advertise your practice to people that search for 'braces' on the internet. However, you may find that other types of braces may also be shown alongside your advert in the Google search results, for example menswear braces to hold up trousers. If a person searching for menswear braces accidentally clicks on your advert, this drives up your bill for no reason. So it important to add 'braces' to your negative keywords list to minimise unnecessary spend.

PUSH are offering BDA members the following:

- Free Google AdWords audit if you are already running Google AdWords campaigns. This a comprehensive review of your current campaigns, highlighting areas for improvement
- A free Google AdWords campaign plan if you are not currently running AdWords campaigns. This is a full proposal on how your business can grow through a controllable campaign to deliver more sales and enquiries at a cost that meets your budget.

These audits and proposals are entirely free and without obligation on your part. You will also be given a copy of the presentation that PUSH take you through. For further information visit https://pushgroup.co.uk

Is dentistry making us sick?

Dr Alun Rees

on whether our day-to-day affairs are bringing us down

Dentistry is tough, with unique pressures. Of that there is no doubt. All professions expect knowledge and skills, but dentists do intricate, exacting work in one of the most sensitive areas of the body with conscious patients. Add to the mix the increasing burden of compliance and legislation, then throw in the pressure of running or being part of a small business where time is money. The resulting stress and its consequences are widespread and can affect all team members.

In many dental businesses there still exists a macho culture where speed of work and high 'grossers' are lauded. Those with interests in the less 'sexy' subjects such as periodontology, paediatric dentistry and prevention are often viewed as being less important.

It is little surprise that with an NHS system that is built around delivering UDAs like so many widgets on a production line, often in practices that are owned by faceless venture capitalists, the 'performers' can feel unappreciated.

Increasing stress and subsequent burnout are on the rise. Dissatisfaction and unhappiness, not only with the NHS system and the drop in income, but also with the threat of the possibility of a career ending complaint, have made many look beyond their chosen calling.

What do we mean by sick? 'Suffering from ill health; mental, spiritual or psychological disturbance; disgusted or weary and not in working order.' Feelings that are familiar to many in dentistry.

Some people can deal with this; they are able to roll with the punches, adapt to the changes and live their lives. However it is clear that more and more dentists, young and old, are being negatively affected by internal and external pressures.

It was always believed that practice owners were more susceptible to stress because of the pressure that came from running a business. However it is clear that associates have problems for different reasons. Not only the old 'favourites'; pressure of time and patient expectations — now we must include the conflicts of having little or no say in decision making, materials, laboratories or policies. This lack of autonomy and participation can weigh heavily on associates.

For many there is no release from the day-to-day stresses and the demands outstrip the resources they have to deal with them. Stress becomes distress and leads to burnout with a decrease in performance leading to physical and mental problems.

Burnout brings emotional exhaustion, depersonalisation and reduced personal accomplishment. Symptoms include a feeling of being used up emotionally, physically and cognitively; there are problems concentrating, the individual can be easily upset or angered and have problems sleeping. They get sick more often with muscoskeletal, head, skin and autoimmune problems.

Often their performance will suffer clinically and output falls. They seem to be working harder but accomplish little. Sometimes problems manifest themselves in unhealthy displacement activities including the use of alcohol, drugs, gambling and overspending on credit cards.

Is it a real problem? Repeated research by the BDA and others leave us in no doubt that stress and burnout are major problems in UK dentistry amongst all team members.

How to deal with the problem? Firstly, you have to come to accept that, 'It's OK to say that you're not OK'. The role of a successful clinician means that you tend to take in a lot of other people's emotions, fears and problems. Once upon a time the 'stiff upper lip' was not only encouraged, but anyone who dared to admit they were feeling the strain was looked upon as admitting a sign of weakness. In some practices and institutions the word 'snowflake' is unfairly used to describe anyone who has had the courage to admit that things are not 'OK'.

Dealing with the problem can be difficult; if you feel that someone on the team is not OK then ask them, listen to them, do not judge but encourage them to get professional help. They are sick and they need the help.

A practice owner has many pressures and acknowledging that they are sick in any way is hard; sometimes it is their colleagues who have to broach the subject. They must be supportive, non-confrontational and sympathetic. It could be that they will need help from outside the practice.

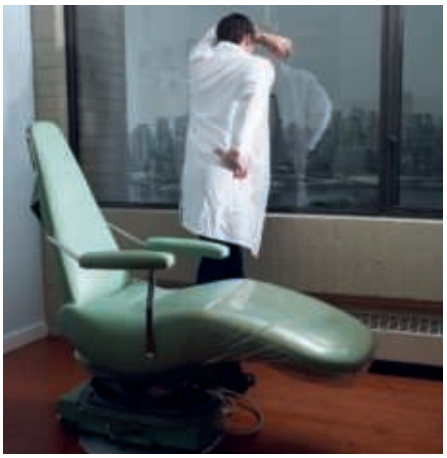
Prevention is key. Dentistry can be a very lonely existence; make sure you have a good circuit of supportive friends, both within and beyond the profession, who you can trust, who will not judge you and who will support you through the difficult times - and we all have difficult times.

Take time away from dentistry, indulge in your hobbies and turn off. Have regard for your nutrition, take regular exercise and get sufficient rest. Learn to know yourself and where your limits lie. We are all different; we each have a varied response to individual stressors with unique levels of resilience.

If you are able to, then aim to treat people you like and who place a value on what you do. Mentally wipe your feet on leaving the surgery, avoid taking work home — you'll be too tired to do it effectively and this will lead to more frustration. Regularly make a list of your tolerations and remove them.

If you have had a crisis take stock and reassess your life. Ask yourself what you can change and what you cannot and then make the changes. Unfortunately most people only make change when the pain of doing nothing exceeds the pain of doing something.

You only have one life, enjoy it, all of it, don't suffer in solitary silence, there is help. ◆



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Defining digital leadership

Nicola Hawkey searches for the meaning of digital leadership

The cyber-attack on the NHS last year caused a whole host of issues, primarily those associated with recovering the data. Now the dust has settled, it's only right to ask how it was able to happen in the first place. Pointing the finger of blame does no favours, but highlighting responsibility and areas the NHS – and other organisations – has to improve on cannot be swept under the carpet. And that brings me onto a phrase I have heard since then; digital leadership.

What is digital leadership?

At a recent healthcare conference there were a number of talks on the Wannacry attack of 2017 which involved a ransomware affecting large parts of the NHS. One of the trusts affected gave their experience to a roomful of delegates and it was not the expected outcome. The Deputy Chief Executive of the Trust said in a video that she learned more about cyber security that weekend than she had ever expected to, and that crucially her and colleagues realised that this was a leadership issue rather than a technical IT issue. This was enormously eye-opening and a number of sage nods across the room showed that this was news to most of us but that actually sounded, in this new cyber world, the right answer. On whatever scale of digital engagement, from large NHS Trust to small independent dental practice, this suggests that digital leadership comes from the top. Digital leadership does not simply come by having a dedicated and highly expert digital and IT technical team, it is the management and oversight (and financial decision making) whilst listening to those experts when they caution or escalate issues of security risk or outdated methods.

Another leadership challenge facing the NHS is how to quality assure and evaluate apps for the new NHS app library whilst upholding the integrity of the NHS. The NHS is a trusted brand worldwide, and with only around 30 apps currently approved - Brush DJ[1] being the only dental one at this point – the challenge is making sure that those live up to the high standards that patients in the UK and across the world expect from the NHS.

What happens though when the digital landscape overtakes what is traditionally taken as acceptable behaviour? Smartphones provide lightning speed access to the latest news, trends, updates or whatever else takes your fancy day or night and society abides by laws and regulations governing what is appropriate. It is possible to search and view that which you should not, but most of us use it appropriately. The world is digitising at pace and people are using that digital wave to make their lives easier. This then raises moral questions about when technology overtakes commonly accepted legal practices.

In a recent speech at a conference, the former Chief Medical Officer in Scotland, Sir Harry Burns spoke about public health interventions and to 'proceed until apprehended' rather than ask for what could be done if the sole intent is to improve lives.

These all beg the question whether we

needed a crisis like WannaCry or challenges to the accepted norms of using different platforms like Whatsapp to communicate. How can we rise above and manage to become digital leaders? The difficulty is making those moral decisions and enabling the digital world to complement not conflict.

There are already a number of high profile organisations in healthcare that have some role in the promotion of digital leadership. The most notable is the National Data Guardian for Health and Social Care[2] who reported in 2016 about the dangers of old and unsupported IT infrastructure and software platforms which were the reason that the Wannacry virus was so effective in the end. For dentistry the Office of the Chief Dental Officer (OCDO) is advancing the digital agenda and driving forward developments to digitise dentistry alongside the wider NHS. NHS Digital in England is driving forward the Personalised health and Care 2020 agenda[3], it keeps patient data safe and broadcasts cyber alerts to NHS organisations and generates and manages the NHS statistical data. In growing as a digital leader, there are lots of sources to draw on and learn from.

Transitioning from simple IT to a leader in digital health

For the small general dental practice or community dental setting that is responsible for their own IT infrastructure and digital presence, digital leadership is vital to make sure things run seamlessly and manage glitches when they happen. You don't need to have swathes of IT technicians running your IT solutions or a dedicated social media/ digital team to become a digital leader. As the owner or director, you are responsible for all elements of leadership and management decisions of what you do have, and that includes the digital and IT presence. Your staff will look to you to set the tone, so listen to their concerns, act accordingly and understand that your leadership and decision making is key.

There are exciting and early new developments in Natural Language Processing (NLP) in the US using Twitter to look at 'Measuring patient-perceived quality of care in US hospitals'. The website crowdclinical.com builds on that *BMJ* article[4] and there is further work being done in this field. Essentially, patients are sharing experiences of care on Twitter and this is being measured against patient reported data held by the hospital. NLP (similarly Artificial Intelligence (AI) or machine learning) is a digital way of transferring the written word made by human text and transferring this into something a computer can understand and process (automatically removing profane language for example).

The natural question that I imagine that you are asking is what can I do? I am a dentist first and foremost not an IT whizz or digital native. You don't personally have to be, what you do have to be is a leader and understand that you don't need to know how the software charts tooth surface loss at a click of the mouse on a picture of the mouth, just that it does. You do need to know why you need that particular software in the first place and that you and practice staff do need to know how to use it properly to get the most out of it. If you do have someone in the practice that does your IT technical work or runs your social media, they are experts in their fields. You simply need to enable them to do the best they can for you.

Data protection concerns and implications

As highlighted in the debate over the use of Whatsapp, a digital leader needs to understand the wider concerns and developments around data protection. An understanding of the ever changing digital world and how you can use software, technology and apps within the confines of what is legal and appropriate. Whatsapp was useful however in the aftermath of the Wannacry attack as one of the means of communication not affected.

The General Data Protection Regulations are enforceable from May 2018. This brings data protection across Europe standards in line with developing digital platforms and aligns the requirements for the digital age. How different EU member states implement that, will vary but the UK Parliament are currently reviewing the new Data Protection Bill which incorporates the GDPR requirements in to UK law.

Future considerations and developments

Across Government, the digital change is happening, all departments are working towards a highly digitised service. HMRC for example is currently working on a project called Making Tax Digital. From 2020, legislation is being scrutinised that sets out how organisations will have to submit their tax returns, quarterly and annually and in the same way, digitally record, store and transmit all relevant data. This will be another element of the digital leadership that will be required in practices and those who are self-employed may have to grapple with, once the detail has been decided.

All the central systems being worked on at pace NHS Mail, Electronic Prescription Service, e-referrals are on the dental horizon with some geographic areas already adopting these practices. According to NHS Digital[5], 96% of community pharmacies have access to the Summary Care Record enabling (with permission) access to an updated medical history for the patients they come into contact with. Getting this available for dental services is on the agenda and being pushed for by both the BDA and the Office of the CDO.

Getting dentists access to all the digital tools, available to other NHS clinicians, to help them in their working lives is a work in progress. Once dentists and their teams have these tools to hand they will be incredibly important in improving ever further the care given to patients.

This means that the digital landscape is a vast and ever growing portfolio for businesses and organisations to manage. Digital leadership is a vitally important skill that is parallel with financial, staff and premises management. It is potentially a significant area of vulnerability to get wrong, with patient data breaches, or failure to keep up with patient feedback just two of the reasons to become a digital leader. ◆

1. Brush DJ Available online at https://apps.beta.nhs.uk/brush-dj/
2. National Data Guardian for Health and Social Care. Review of Data Security, Consent and opt-outs. 2016. Available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/535024/data-security-review.PDF
3. HM Government/NHS/National Information Board. Personalised Health and Care 2020, Using Data and Technology to Transform Outcomes for Patients and Citizens. A Framework for Action. 2014. Available online at www.gov.uk/government/uploads/system/uploads/attachment_data/file/384650/NIB_Report.pdf
4. Hawkins J B, Brownstein J S, Tuli G, et al. Measuring patient-perceived quality of care in US hospitals using Twitter. *BMJ Qual Saf* 2016 **25**: 404-413.
5. Henry C. Technology is the easy bit: Achieving a paperless NHS. Oral presentation. 2017 UK healthshow.

Nicola Hawkey
Senior Policy Advisor
Nicola has been a policy adviser for general dental practice at the BDA for over 10 years. She graduated in 2010 with an MSc in Public Policy and Management and has a wide portfolio of policy areas mainly for England spanning digital developments, and drafting evidence to the Review Body on Doctors' and Dentists' Remuneration.

Leaving the NHS

Last year the BDA discovered that a significant number of people under the age of 35 signalled their intent to leave the profession early. Stress is often cited as the main reason, and it is certainly with good reason. At the heart of that lies the constraints of working within the NHS. There are well-documented shortcomings, many of which the BDA has pointed out since 2006. It's never an easy decision to leave the profession you love, so many seek alternate ways to practise.

Claire Morley spoke to *BDJ In Practice* about her decision to leave the NHS for a private practice, and why the decision was one of the most difficult she had to make.

Claire Morley

Claire Morley is a dental surgeon at Ravat & Ray Dental Care in Chorley, having qualified in 2012 and gained BDS at UCLan through Liverpool University

When I started out at dental school I was 21 years old, and although not a teenager I had no idea what it was I wanted from life. I was coming up to the end of my Medical Biology studies at UCLan and I had no idea what was next. UCLan had just opened their Dental School and began providing the BDS qualification through Liverpool University. Somewhere in my mind I thought that could be interesting. I did enjoy education so another four years at university seemed like a good idea. Off I went to apply, interview and subsequently get accepted.

I will admit the next four years of my life were hard. No longer in an undergraduate degree I quickly realised life just got real. It was difficult amongst my wealthier friends. Affording the rent and travel costs was a challenge and I found myself as a health care assistant in various care homes and hospitals. I thought I hated doing that job. I could not wait to finish school and be a dentist, earn money and be a professional. Looking back I realise those were some of my best moments. The only politics I had to deal with came from the ward staff who were rarely welcoming to the bank staff. What made this time amazing was the care I could provide for people, as *ad-hoc* staff you'd get the 'rubbish' jobs so to speak, but for me it is one of the occasions of my life I could truly provide the patient care I wanted to.

One to one care would mean I had to sit with the same patient for 14 hours. The lady who, forgetting where she is, keeps wandering off and trying to leave the ward. The 87-year-old who one minute thinks you are her best friend from when she was nine and the next moment thinks you're her neighbour who is having an affair with her husband. That I know now, is one of those life experiences I was lucky to be a part of. To be able to offer that lady some company during what I can only imagine to be a living nightmare is an honour.

> 'The NHS puts its healthcare workers under so much pressure. There are so many boxes to tick, and so much stress from the prospect that one day someone could sue you and then the NHS wouldn't want you anymore.'

One of the other duties I had was personal care. I would be responsible, along with another healthcare assistant (HCA) to bed bath, clean bums and freshen up the patients. Can you imagine being 76 years old, having raised three children, cared for a husband and maintained the most perfect garden, now unable to move and wipe your own bum? To be able to treat someone in that way with the dignity and respect that they deserve does not come naturally to some. I am fortunate enough to be able to say that I was excellent at that job. I could ignore the politics, take my time, brush their teeth or dentures and hear a little about their life.

I remember one day arriving at 6:30am for a handover meeting and being told Mr X in room 12 had died. That I was to go and freshen him up and make him presentable for his family. I walked into that room hands shaking, to find a gentleman, a double leg amputee with no teeth, heavy and cold and peaceful in himself. I will never forget how rigid he was. How I put his belongings together so his family did not have too. How I found his dentures and thought it would be a good idea if he had them. I will tell you now, false teeth will not stay in without saliva and muscle tone, in another context it would have been comical.

I realised that I had to give these people my time and respect. Because the ward staff unfortunately did not have the time to. It is not that they didn't want to spend the time, more that they couldn't. I do not believe for one second a nurse goes through university looking forward to the day they have all that paperwork to do. There are just too many constraints and demands in the NHS that prevent the nurses from having the time to provide that one-on-one care, as well as complete their paperwork, checklists and meet their targets.

The NHS puts its healthcare workers under so much pressure. There are so many boxes to tick, and so much stress from the prospect that one day someone could sue you and then the NHS wouldn't want you anymore.

In retrospect, at the time I hated it and could not wait to be a dentist. Surely all that would be in the past right?

Wrong.

Five years in NHS dentistry has shown me that it is no different. The pressures, the stress, the targets. I struggled on a daily basis to be able to provide my patients with the care and attention, the dignity and respect that they deserve. If I was to spend 45 minutes with a nervous lady, holding her hand through the tears because I have just told her she needs a tooth out, (that usually she has sedation and I can refer her for that but it will take four months and in the meantime she will be in pain); if I was to sit and coach her through the appointment and the extraction, to tell her she can do it; if i was to congratulate her and tell her how proud of her I am after I removed the tooth. I would and do get behind on targets, potentially lose my NHS contract and be out of a job. I have so much working against me being able to do what I was trained: what the government spent hundreds of thousands of pounds for me to learn seems to be irrelevant.

The future of NHS dentistry is in doubt. We have been told for a few years now that they are going to change the way it works. They told us that it will soon change and we may lose our contracts if we do not adapt overnight and start doing it the new way. Some dentists left the NHS, the uncertainty of their future not enough to get them to stay.

Other dentists left the country and the NHS not willing to wait and see what would happen with their lives. Many, like myself decided to stick with it and ride the tide. The problem is we are yet to see any changes, we just hear talk of it. I wonder if the government are hoping if provided with enough restrictions their NHS dentists will leave of their own volition. Then they can hold their hands up in defence and say 'well it wasn't our fault'.

Now I am a mother I cannot just ride the tide. I need security. I need job satisfaction and I need to be able to provide the care that my nature desires. This is why I am now considering alternatives to the NHS. I cannot quite bring myself to do it just yet. Leaving the NHS does mean I will be happier and I will have more time with my patients. I will be a better parent not being as stressed at home after a long day at work and I will be a better practitioner as a result.

Unfortunately, it also means that I will inevitably lose some of my patients. The people who I care for and about, who I have helped and genuinely want to continue to help. I will worry about Mrs Y and her mental health problems, not knowing how she is doing as I do not get to see her anymore. I will jump into bed and wonder about Mr X's front tooth which I had to root treat and if it is still OK.

Most of all I am worried that my patients will think I have left the NHS to focus on private for money. That is the image that is portrayed in the news and it is what I hear on a daily basis when patients tell me they used to see another dentist down the road for 25 years but then he went private.

I do not want them to think I have left them because I do not care. The reality of the situation couldn't be further from the truth; it's quite the opposite. ◆

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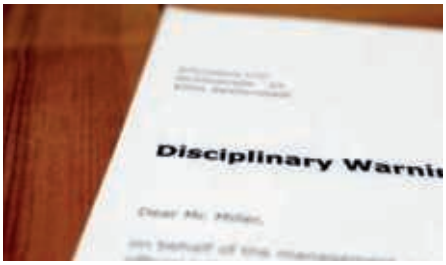
Conducting a disciplinary meeting



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By James Goldman
James is the Associate Director of Advisory Services. James trained as a barrister and has advised dental practitioners on a wide range of matters. He has represented practitioners in many Employment Tribunal disputes and has mediated in numerous partnership disputes.

It is usually unfair to punish people before they have had an opportunity to defend themselves against an allegation. That is the case whether it is a criminal matter where the accused is entitled to a trial, a professional conduct matter where a dentist is entitled to a hearing before the GDC or a disciplinary matter where a member of staff is entitled to disciplinary meeting. A disciplinary hearing may well give the employer useful information to help decide on the guilt of the member of staff, and on whether the employee has understood the situation.

It is best if the person conducting the disciplinary hearing is independent from the incident concerned, though this is not always possible in a small practice.

Once the introduction is over, most of what you say should be questions rather than statements. Give the employee time to answer. Silence can be a very powerful inducement for the other person to talk. When you get the response, think about it carefully. Consider whether you understand the response sufficiently or whether you need to ask follow-up questions. Take your time.

Introductions

Start by introducing everyone and their role. Explain that the purpose of the hearing is to help the employer decide whether the allegations are true and, if they are, what action should be taken. If the employee has brought someone to accompany them, make sure they know that the employee must answer the questions, but they can take a break to meet the employee in private at any time.

What are the rules?

Ask the employee for their understanding of what is expected of them. It is difficult to punish someone if they were unaware that what they were doing was wrong. If, for example, they frequently come in late, ask them what time they are supposed to be at work. If they have been caught using their mobile phone during surgery, ask them about the practice rules on mobile phone use.

What happened?

Ask questions to establish what actually happened in relation to the allegation. If the allegation is that the employee has frequently come in late, ask the employee if they agree with the times that they came in late. If the allegation is more serious, such as theft, ask the employee about the movement of money.

If the employee denies the allegation, test their response. Ask them how they explain the evidence that suggests the allegation is true.

Why it happened

If they accept that the allegation is true, then ask why it happened. If they were late, why were they late or what was their route? If they were using the mobile phone, what was so important that it could not wait? If they took money, the reason might be less important, but it is worth asking. There could be some very significant reason that might change your view.

The effect of the conduct

Ask the employee what they think is the effect of their conduct or performance on the practice, on patients and on their colleagues. If they are late, you might expect them to say that it is unfair on their colleagues who had to work harder to cover for them, and unfair on patients with early appointments. If the allegation is that a nurse failed to clean instruments properly, you might expect them to talk about infection-control risk.

In many cases, this part of the discussion can be a sobering and useful opportunity to get the employee to think carefully about their conduct. If they demonstrate insight, if they show they understand how their conduct affects other people, you may take a more lenient stance than if they simply do not care. They may not have given thought to how their conduct affects their colleagues or how their colleagues feel about them. You may be able to use this part of the meeting to help the employee understand that, by changing their conduct or the way they work, they have the power to improve relationships with their colleagues, patients and with the practice.

Preventing recurrence

Ask the employee what they think they could do to prevent recurrence of the problem. If it is a timekeeping issue, it could be as simple as setting the alarm clock a little earlier. Each case will be different. If you know why the problem occurred, it will be easier to discuss ways to prevent recurrence.

Setting targets

If you are going to give a disciplinary warning, the warning has to be that if an event happens in the future, or if a target is not met, then the employee will face further disciplinary action. So it is important to discuss what those events or targets are. In relation to timekeeping, it may be that further disciplinary action will be triggered if they are more than five minutes late again in the next six months. It may help to agree the targets with the employee.

Conclusion

Explain that you are going to think about what the employee has said and that you will get back to them soon. In some cases, you will be able to make a decision quickly and you might simply suggest that the employee gets a cup or tea. For other matters, you may want to say you will let them know in a day or so. ◆

The BDA's employment and general practice team is happy to advise members on disciplinary and other issues, contact advice.enquiries@bda.org or 020 7935 0875.

Juggling holiday requests

By Sunit Joshi
Sunit is a Practice Management Consultant at the BDA specialising in employment and general practice.

It is not unusual for practices to be inundated with multiple requests for holiday leave during the same dates. It could create a problem, but a sound, well-structured annual leave system implemented in the spirit of collaboration will be effective.

Effective management in this situation involves:

- Employees giving adequate notice of holiday requests
- Anticipating oversubscribed holiday times in the holiday year; and
- Good communication.

These three beacons of effective management should help navigate you through the holiday leave year. Crucially, you do not want to deter staff from taking their annual leave but staff must be acutely aware of complying with the practice's written holiday leave policy.

Written rules/policy

You should have an annual leave policy that sets out the rules for taking holidays. Its purpose should be to enable staff to take their holidays in a manner that is compatible with the operational requirements of the practice.

It should cover:

- Annual leave entitlement
- Whether leave can be carried forward into the next holiday year
- When the holiday year starts
- How staff should request annual leave; and
- How leave is approved.

It is a good idea to get staff to acknowledge receipt of any staff handbook incorporating the holiday policy through a simple signature.

Usually, a staff member's holiday entitlements will be first determined by reference to their written employment contract and legislation requires an employee's annual leave entitlement to be set out in their written particulars of employment.

First-come first-served

This is invariably the fairest way to resolve multiple requests for annual leave covering the same period. An audit trail will help to prioritise competing requests and so you should require staff to give notice of any holiday requests in writing. Under current regulations, notice of a holiday request must be twice in length of the holiday requested. So, a person requesting 3 days' annual leave must give 6 days' notice. You may wish to impose longer notice periods to accommodate certain leave requests that may require some nimble logistical planning and this should be reflected in your policy on annual leave.

Accessible holiday planner

You should have a readily accessible holiday leave year planner showing booked holiday related absences. There is a myriad of software packages available that enable the managing and co-ordinating of holiday leave requests to be carried out relatively simply. It typically allows employees to ascertain their remaining annual leave entitlement, to book a period of leave and to see in advance the dates of holiday related absences of other staff.

Processing annual leave requests

A well-managed practice should be able to either approve or refuse requests speedily. The approval or refusal can be processed through the computer system and any decision will generate an automated email to the employee confirming approval or refusal. If you are operating a manual system, then it becomes imperative that all holiday requests are made in writing (typically email) and approved in writing to enable a verifiable audit trail.

School and religious holidays

You are likely to have to deal with oversubscribed periods of the year and approving multiple holiday leave requests can prove operationally debilitating for small practices. Insufficient cover can be a nightmare to a practice.

It may be that other staff are willing to work overtime to cover holiday related absences and this can be achieved. If this is not feasible, then it might be worth forging an agreement with staff to compromise the timing of their holidays, for example alternating their holiday plans between school holiday periods.

Of course, you are not beholden to the whim of your employees and you can lawfully refuse a holiday leave request if by the end of the annual leave year, your refusal has not prevented the employee from taking his full quota of annual leave. Any formal refusal will require you to furnish notice equivalent in length to the period of annual leave sought.

An employee may argue that a refusal to approve an annual leave request is indirectly discriminatory on the grounds of maternity, sex, religion or other protected characteristics. Your refusal was likely to be a religiously neutral decision but the refusal may adversely affect members of a given religion who are required to observe religiously auspicious dates.

Ask staff to advise you of any 'special' leave requests and ensure that any refusal can be appealed so that a decision can be reviewed.

Any formal refusal will require you to furnish notice equivalent in length to the period of annual leave sought.

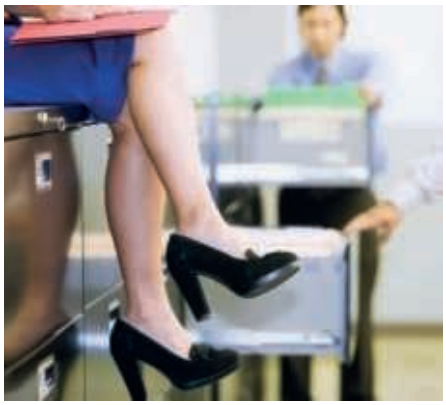
The regulations do not require you to reason your refusal to the employee but good industrial practice would recommend that you meet with the employee and explain the difficulties you will have in approving the request; typically, refusal will be because of inadequate staffing cover.

Nurses and dentists

It is common for nurses to be paired with dentists, so synchronising respective annual leave absences is often recommended. It is best to discuss it with everyone early in the year, to find out their preferences and possibly mix-and-match staff to ensure each gets their preferred time. Foresight, communication and planning should ensure that your practice is adequately serviced.

Circumstances may compel you to require staff take holidays at certain times of the year. You can do this but any such notice will have to be twice the length of the holidays required to be taken. Also it's best to discuss these needs with the team beforehand to get their views.

Weinstein to Westminster and everything in between



By Samantha Harris
Samantha is a contracts advisor at the BDA. Samantha advises members of their commercial liabilities when entering into associate positions.

At the end of last year we saw one of the most influential sexual harassment cases of modern civilisation. The case involving Harvey Weinstein highlighted the power disparity in one of the most influential industries. The crisis hit both the media and entertainment world, laying the culture of sexual harassment bare.

Weinstein was a turning point in the fight against sexual harassment. Shortly after the Weinstein scandal hit the mass media, accusations of sexual harassment were raised in Westminster. Defence Secretary Michael Fallon resigned in November 2017 as a result of being accused of inappropriate behaviour.

How does this affect you? There is now a burgeoning awareness in organisations about culture and power and there is a real risk that any accusation (especially one that is left undealt with) will become public knowledge. Sexual harassment in the workplace is a form of discrimination and includes both direct and indirect comments and conduct which relates to sex, gender or sexual orientation. There is no cap on the amount of compensation that can be awarded in sexual discrimination cases – the amount will be left to the discretion of the employment tribunal assessing the case, such as they consider to be just and reasonable in the circumstances.

Indirect conduct causing discrimination

Provisions concerning physical attributes have to be justified by a legitimate aim.

In 2017, the European Court of Justice held that the Greek Police Force's minimum height requirement constituted indirect sexual discrimination[1]. While there is a clear case of sexual discrimination by stating a height provision which directly disadvantages women, there is also an argument for same sex discrimination where the height requirement puts men of a certain physical attribute behind others – one male might be taller where as another might be physically fitter.

The person's feelings are important

Behaviour of colleagues in the workplace will amount to discrimination from the moment they are asked to stop behaving in a certain way by the victim.

In a 2004 case, an openly gay man was working in an organisation and his manager regularly mimicked the way he spoke. He even asked his manager to refrain from mimicking him on the basis that it felt like harassment on the grounds of his sexual orientation, yet the manager did not refrain. The courts held that from the time the employee voiced his concerns to his manager the mimicry was considered to violate his dignity and amounted to discrimination on the grounds of sexual orientation[2].

Failure to complain is not significant

While someone generally needs to complain or voice their disregard for certain treatment, in cases of inherently unwanted conduct, whether the victim complains or not, it will still be considered discrimination.

In a 2000 case it was held by the EAT that despite the employee not complaining about being told by her manager to attend an interview in a short skirt and see-through blouse it still constituted sexual discrimination[3].

It is often in workplaces that people will not complain of conduct amounting to sexual discrimination. A lot of people would rather remain quiet and accept the unwanted behaviour then make a noise in their workplace about it. From the recent media frenzy surrounding sexual discrimination in the workplace it is likely that there will be a growing trend in organisations to toughen up their sexual harassment policies. This is something that you as a practice owner might want to think about and also encourages your organisation to be more considerate of other people's feelings.

What your organisation should do

If an accusation arises it is important to work out if it is direct or indirect sexual discrimination. This is the starting point to make sure incidents are handled properly and fairly. A lot of grievances can be dealt with informally, especially if the conduct is indirect (the person might not realise they are offending another). In a circumstance as such perhaps a quiet word can resolve the issue.

You need to make sure that all issues and complaints are investigated properly and that you have the correct internal complaints procedures to deal with this sort of complaint. You should also ensure that you keep a record of all issues. ◆

1. Ypourgos Esoterikon v Kalliri (C-409/16) EC:U:2017U767 (ECJ).
2. Mann v BH Publishing Ltd and anor ET Case No.2203272/04.
3. Driskel v Peninsula Business Services Ltd and ors 2000 IRLR 151, EAT.

Key points to take away – grievance procedure

It is important that your grievance procedure involves fairness and transparency, which means you should:

- → Deal with issues promptly
- → Deal with all issues consistently (even if you think one is less serious than another)
- → Investigate the scenario fully and establish all of the facts.

Why you must give staff a written contract

By Neeta Udhian

Neeta is 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.

Understandably, employers do not want to enter into a legal relationship with a member of staff unless they are sure the employee is a good fit for the practice. However, a contract exists from day one so it is better to set the terms out clearly as early as possible.

Section 1 and section 3 of the Employment Rights Act 1996 legally requires employers to provide employees with a written statement of employment particulars within 2 months of employment.

A written statement can be made up of more than one document such as an employment contract and a staff handbook containing practice policies If this does happen, one of the documents (called the 'principal statement') must include at least:

- The business name
- The employee's name
- Their job title
- Job description of work
- Start date (if they have worked with you before, say in another role or in a partnership that has been dissolved this period of employment should also be mentioned)
- How much and how often an employee will get paid (weekly, monthly)
- Hours of work
- Holiday entitlement (and if that includes public holidays)
- Job location and whether the employee might have to relocate
- If an employee works in different places, where these will be and what the employer's address is.

As well as the principal statement, a written statement must also contain information about:

- How long a temporary job is expected to last
- The end date of a fixed-term contract
- Notice periods
- Collective agreements
- Pensions
- Who to go to with a grievance
- How to complain about how a grievance is handled
- Disciplinary rules and procedures.

You don't need to cover the full details in the statement, you might simply refer to where the employee can find this information, perhaps in a staff handbook

All the information you need to provide in the written statement is more-or-less what you need to put in their employment contract. It's not exactly the same, the contract may contain other clauses (see below) and some of this information may, as just noted, be in a staff handbook

The BDA model contract is of course more comprehensive than a written statement but as well as including all the information you are legally required to provide an employee with, the contract also provides specifics in relation to:

- References and checks
- Registration with the GDC and the requirements in relation to this
- Course fees and what happens if you pay for staff training
- Jury service
- Maternity/paternity pay and leave
- Immunisations
- Deductions from pay
- Confidentiality
- Changes in terms and conditions.

These additional terms provide further clarification and boundaries and often protect the employer if there is any dispute over the employee's terms and conditions.

Regardless of how comprehensively drafted a contract is, it will likely also have some implied terms. That is a term that is not set out expressly in the contract, but which arises because of the circumstances in which the contract is entered into. This could be things such as custom and practice (maybe leaving early on a Friday) or following proper professional standards. Nevertheless, it is clearer to anticipate these things and put them in writing.

When employing a new member of staff, a contract/written statement should be posted or emailed to them, ideally before their first day of work. They will then have an opportunity to fully review all of your terms and conditions and any relevant policies. A covering letter sent with the contract should ask the employee to review the agreement and to bring a signed copy with them on their first day of work.

During the induction process, you should ask the new member of staff for their signed contract, photocopy it and give them a copy to keep. The original agreement should be scanned and saved in a restricted folder and/or filed away in a lockable filing cabinet. If the employee has forgotten their contract on their first day, you could print off a copy ask them to sign it.

If the employee appears reluctant to sign the contract or keeps putting it off, you need to find out why. Ask them if they have any comments or queries about the contract. They would have had sufficient time to review the terms. This is a good opportunity for them to raise any concerns with you and for you to address them.

A written statement of particulars does not need to be signed and as a very minimum, this must be issued to all members of staff within the first 2 months of employment. However, there is good reason to cover these terms in their employment contract and to make sure they get is as soon as possible and give you a signed copy to acknowledge that they got it.

Failure issue a statement within 2 months could leave you liable to pay between 2-4 week's pay should the employee decide to take this matter to an employment tribunal. ◆

Please send product and services news through to David Westgarth, *BDJ In Practice* via: David.Westgarth@bda.org

Stays looking good

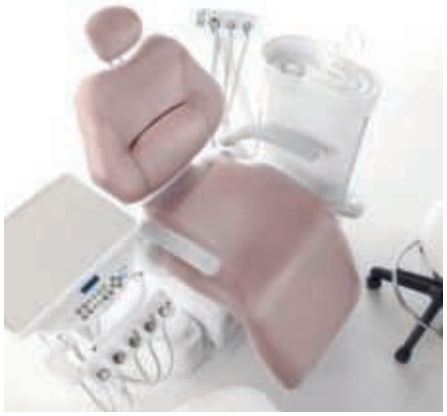
A treatment centre is likely to be what patients first notice when they enter your surgery, so whilst functionality may be paramount in your mind, it's also got to look good. Belmont chairs do both. Moreover, the newly launched Ultrasoft Pro upholstery ensures your treatment centre stays looking as good as it did the day it was installed.

The Ultrasoft Pro upholstery is both ink and stain resistant, particularly important with the growing trend for lighter hues. It also offers greater microbial protection and is much more environmentally friendly as the material does not emit any toxic by-products as 99% of solvents are recaptured and recycled. The upholstery is available in a diverse colour range to ensure you get just the right shade to complement your practice's decor. In total, there are 33 shades from which you can choose.

Comfort is obviously just as important. Good looks can sometimes belie the comfort of a dental chair, which is why Belmont's upholstery exudes luxury and comfort. Arguably, a comfortable chair is a prerequisite for a relaxed working environment, especially when patients are undergoing lengthy treatments.

This New Year is it time that your surgery underwent a bit of a revamp?

For more information call 020 7515 0333.



The human hand is remarkable

The human hands are amazing instruments of touch, expression and ability. They are probably the most valuable tools in your armamentarium and they should be looked after properly with high quality gloves from the Unigloves Vitality range.

Unigloves understands that you need premium quality and strength for effective protection but as experts in the field, Unigloves also know how to care for your hands properly.

Vitality gloves are available in a variety of sizes for the most suitable and comfortable fit. They feature double-chlorinated beaded cuffs making them easy to put on and remove as well as a micro-roughened texture to ensure optimal grip.

For an added bonus, Unigloves also coat the internal surface of each glove with a soothing Vitamin E (Lano-E) moisturiser to keep your hands flexible and hydrated.

The Vitality range includes:

- Vitality Nitrile – white, powder-free with Lano-E coating
- Vitality Latex – white, powder-free with Lano-E coating
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For further information about Unigloves products, please visit www.unigloves.co.uk.

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Straumann CARES Digital Solutions has the complete digital workflow covered. Achieve precision, efficiency, and predictability by introducing digital dentistry into your practice:

- Intraoral scanners which can take accurate, fast, powderless scans of your patient's dentition and render them in glorious full colour 3D imagery
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The full digital workflow is seamlessly connected and fully validated for speed and precision. The open format allows files to be shared with any other software, including that of your lab.

With such unprecedented quality and integration at your fingertips, make 2018 the year you embark on your digital journey with Straumann CARES Digital Solutions. Straumann aim to be more than a dental implant company – we want to be your total solutions partner.

For more information on the range of Straumann CARES digital dentistry equipment, please contact Straumann on 01293 651230 or visit straumann.co.uk.

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For an instant feel good factor and long lasting confidence all day, encourage your patients to make a habit of using CB12 mouthwash as part of their oral health routine.

CB12 has been developed by dentists and has a clinically proven formula to power through unpleasant smelling breath. Unlike some mouthwashes, it does not just mask smells – it contains low concentrations of zinc acetate and chlorhexidine diacetate to target and neutralise the Volatile Sulphur Compounds (VSCs) that actually cause oral malodour.

As well as this, CB12 chemically binds to tissues in the oral cavity to prevent unpleasant smelling breath reoccurring, so your patients can enjoy confident breath for up to 12 hours.

CB12 contains fluoride to strengthen the teeth and prevent cavities, it's easy to use and, by using it regularly after brushing, patients can make positive steps to improve their oral health.

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It also stands for innovation; carefully attending to the many complex requirements that modern dentistry demands to bring technical excellence, reliability and solid design and to all its dental units.

Combining traditional values and innovation together the Skema 8 from Castellini is the 'all inclusive' dental treatment unit. It offers freedom and flexibility with advanced performance from sophisticated electronic controls, cutting-edge technology and integrated systems making it a thoroughbred of quality and design.

Castellini understands how important practitioner comfort is and with careful attention to detail, the Skema 8 has been developed with sublime ergonomics and unique synchronised movements to maintain a relaxed working position.

It really is the 'all inclusive' dental unit, suitable for any clinical situation. To deliver excellent patient care in comfort and style, contact Castellini on 08000 933975 and speak to Castellini UK directly for assistance.

Dentist to Dentist

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

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 RCSEd, FDS RCPS (Glasg)
Interests: Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts.
On Specialist List: Yes, Oral surgery (60534)
Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants
On Specialist List: Yes, Prosthodontics (66211)
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 (84070)
Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA
Interests: Fixed and removable prosthodontics, endodontics and dental implants
On Specialist List: Yes, Restorative Dentistry and Endodontics (77605)
Mr Graeme Lillywhite BDS Edin, MFDS, MSc, MRD, FDS RCSEd
Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics (68916)
Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd
Interests: Endodontics
On Specialist List: Yes, Endodontics (79246)
Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR
Interests: Cone beam CT imaging
On Specialist List: Yes, Dental and Maxillofacial Radiology (70079)

266979

East Anglia

J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

J Smallridge Dentalcare
Childrens Dentistry
82 Berners Street, Ipswich, Suffolk, IP1 3LU
Tel: 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Consultant Orthodontist
Clinical Psychologist
Specialist Prosthodontist for adults
Endodontist

289511

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 Periodontists:
Trisha Whitehead and **Puneet Patel**

Specialist Orthodontist:
Dirk Bister

296176

North

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

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
Tel: 01908 630169 **Email:** admin@dentalspecialistmk.com
Interests: Orthodontics, Periodontics, Implants, Peri-implantitis, Full Mouth Rehabilitation, Prosthodontics, Endodontics, Oral Surgery including TMJ , Restorative Surgery, Sedation and Snoring.
CT scanner and Zeiss microscope on site
On Specialist List: Yes, Orthodontics Dr Ayodele Soyombo, Dr Patel
Special Interest in Orthodontics: Dr Juanita Levenstein
Specialists in Periodontics: Dr Adetoun Soyombo, Dr Carol Subadan and Dr Olanrewaju Onabolu
Specialist in Prosthodontics: Dr Peter Yerbury and Dr Ulpee Darbar,
Specialist in Restorative Dentistry: Dr Ulpee Darbar
Specialist in Endodontics: Dr Neil Kramer
Specialist in Oral Surgery: Dr Tamer Theodossey, Dr Wale Towolawi and Dr Yinka Lesi

209440

MOOR PARK SPECIALIST DENTAL CENTRE

www.moorparkdental.com

10 Main Avenue, Moor Park,
Northwood, Middlesex, HA6 2HJ
Tel: 01923 823 504
Email: info@moorparkdental.com

Dr Joe Bhat BDS FDS RCS MClinDent MRD RCSEd
Specialist in Oral Surgery and Prosthodontics

Dr Lydia Hopkins BDS MSc Ahea
Specialist in Periodontics

Dr Nick Vyas BDS MSc FDSRCS Cert. Implantology
Specialist in Periodontics

Dr Norman Gluckman BDS Rand
Specialist in Endodontics

Dr Neeta Patel BDS FDS RCS
Specialist in Oral Surgery

Dr Sheetal Patel BDS MFDS RCS MSC Morth
Specialist in Orthodontics

Professsor Raman Bedi BDS MSc DDS honDSc DHL FDSRCS(Edin) FDRCS(Eng) honFDSRCS(Glas) FGDP FFPH
Specialist in Paediatric Dentistry

Dr Amanda Reynolds DDS LDS DDPH(Eng) MSc DPH Dip Endo, Cert Sed & Pain Management, CILT
Specialist in Special Care Dentistry

294230

BOSTON HOUSE DENTAL CLINIC

www.bhddc.com

82 London Wall, City of London EC2M 5ND
(few minute walk from Liverpool Street, Moorgate & Bank / Monument Stations)
Tel: 0207 6284869 **Email:** info@bhddc.com
Practice Manager: Marcela Pallova

SPECIALIST REFERRAL CENTRE IN THE CITY OF LONDON

Specialities and Interests: Prosthodontics, Restorative Dentistry, Endodontics. Periodontics, Orthodontics, Oral Surgery & Oral Medicine, Implant Dentistry, Implant Rescue Clinic, Aesthetic Dentistry, Sleep Medicine and Sleep Apnoea.

Specialist Referrals:
Robert Crawford Consultant in Restorative Dentistry, Specialist in Prosthodontics, Endodontics & Periodontics
Hatem Algraffee Specialist in Periodontics (Co-founder of PerioAcademy)
Natasha Wright Consultant and Specialist in Orthodontics
Anish Shah Consultant and Specialist in Oral Surgery with Special interest in Oral Medicine
Farid Fahid Specialist in Prosthodontics
Farid Monibi Specialist in Prosthodontics

Dentists with Special Interests:
Aditi Desai Sleep Medicine and Sleep Apnoea (President of British Society of Dental Sleep)
Kostas Papadopoulos Aesthetic Dentistry and Dental Implants

Our aim is to facilitate patient-focused management of complex dental problems in partnership with referring colleagues.

295045

DENTAL SPECIALISTS ST ALBANS

www.thedentalspecialists.co.uk

96 Victoria Street, St Albans, Herts AL1 3TG
Tel: 0172 7845706
Email: admin@thedentalspecialists.co.uk

Interests: Periodontics with a special interest in Peri-Implantitis and hard and soft tissue Regeneration, Orthodontics, Implants, Full Mouth Rehabilitation, Anti-Snoring Devices, Non-Surgical Management of TMJ problems

Specialists in Periodontics: **Dr Adetoun Soyombo, Dr Olanrewaju Onabolu and Dr Carol Subadan**
Specialist in Orthodontics: **Dr Ayodele Soyombo**
Special Interest in Orthodontics: **Dr Juanita Levenstein**
Special Interest in Prosthodontics: **Dr Richard Craxford**

239826

PERIO & IMPLANT DENTAL REFERRAL CENTRE

www.perionimplant.com

351 Richmond Road, Upper Ground Floor, East Twickenham, TW1 2ER
Tel: 020 8912 1346 **Email:** info@perionimplant.com
DR CHONG LIM - GDC No. 70007
BDS (National University of Singapore)
MSc in Periodontics (Eastman Dental Institute, UCL)
MSc (Distinction) in Dental Implantology (University of Bristol)
Specialist in Periodontics
Interests: Periodontics and Dental Implants
On Specialist List: Yes - Periodontics

293125

ROOT CANAL DENTAL REFERRAL CENTRE

www.rootcanalcentre.co.uk

351 Richmond Road, Upper Ground Floor, East Twickenham TW1 2ER
Tel: 020 8050 0351 **Email:** info@rootcanalcentre.co.uk
Dr Nicolai Orsteen
DDS Oslo 2002
Specialist in Endodontics
GDC No. 175404
Interests: Endodontics
On Specialist List: Yes

293124

Midlands

DENTAL SPECIALISTS MM
www.dentalspecialistsmm.co.uk

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

Interests: Periodontics, Orthodontics, Peri-implantitis

Dr Ayodele Soyombo On Specialist List: Yes, Orthodontics
Dr Bola Soyombo On Specialist List: Yes, Periodontics
Dr Richard Craxford On Specialist List: No

209439

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, 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

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

CT Scanner and dedicated implant suite on-site.

236739

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, Orthodontic Specialist, Endodontic Specialist, Paediatric Dentistry, Sedation, Restorative and Cosmetic Dentistry.
On Specialist List: Yes, Endodontics and Orthodontics

261006

If you wish to be included in these pages please contact Jamie Feek on 020 7843 4712 or Email jamie.feek@nature.com for a quote.

In Practice CPD

Employment

Q1: Which of these is not considered a stage in a disciplinary process?

A Investigating
B Holding a meeting
C Notification of outcome
D Briefing staff on the details

Q2: Under current regulations, how long should notice of a holiday request be?

A One working week
B One calendar month
C Twice the length of the holiday requested
D No limit

Q3: When does behaviour begin to amount to discrimination?

A When it is reported
B When the investigation starts
C When the victim asks the perpetrator to stop
D When the first meeting is held

Q4: When should an employer provide a written statement of employment by?

A Two weeks
B Two months
C Three weeks
D Three months

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To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists keep up with the latest developments in the profession.

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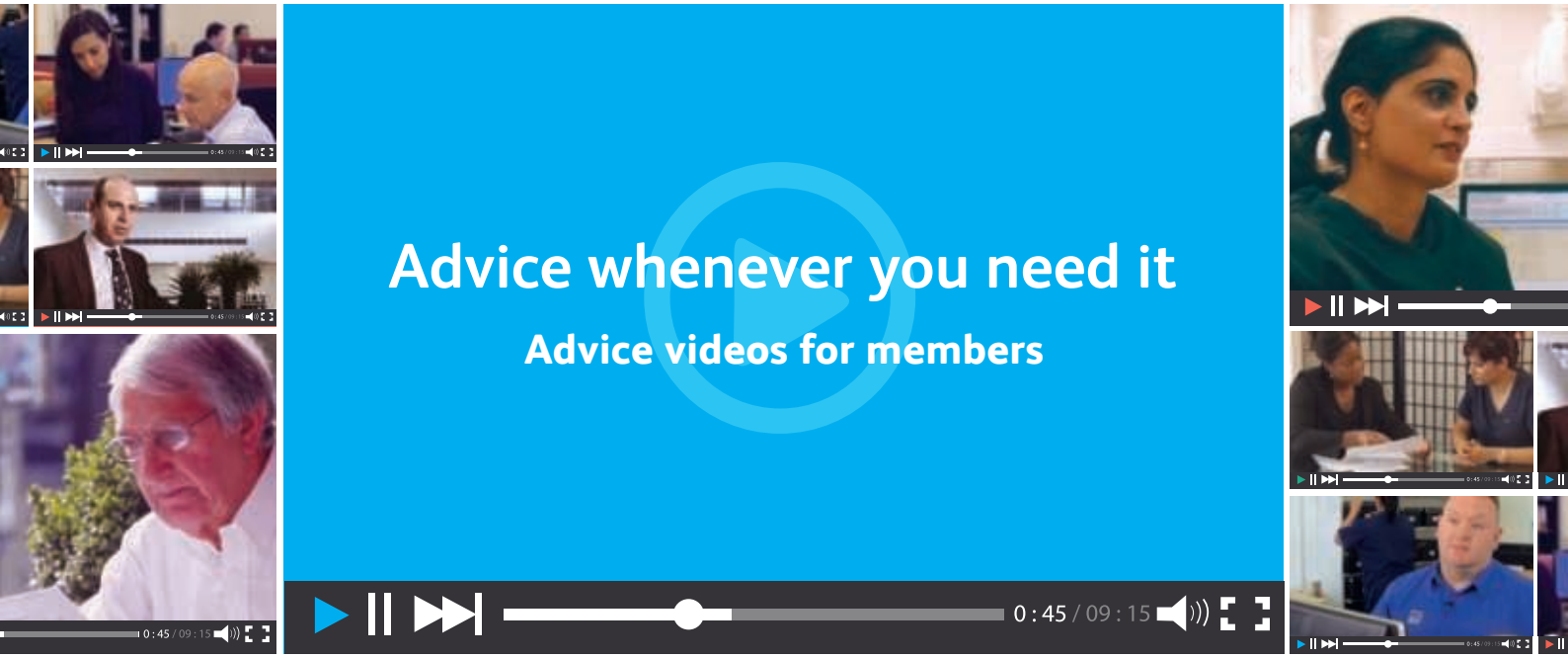
For support use: cpd.hub@bda.org

BDA

British Dental Association



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- Making an associateship work for you
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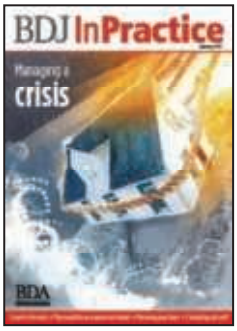

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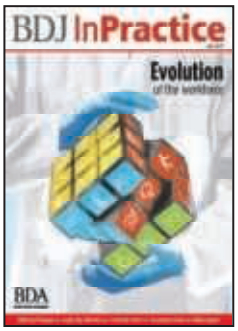
MAY 2017

JUNE 2017



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