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JULY 2016

Cover illustration Danny Allison

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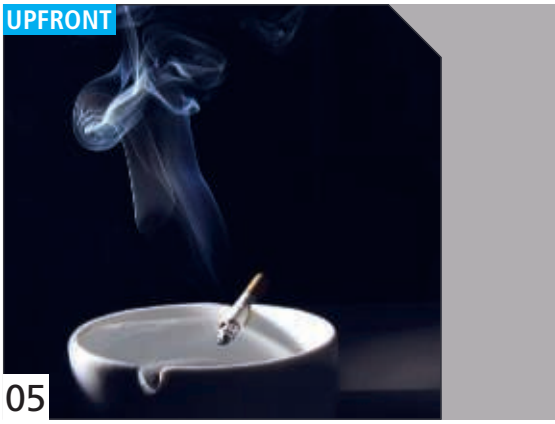
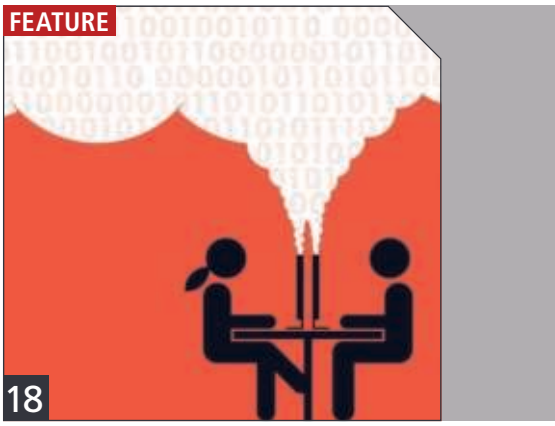
To contact the **Advertisement Office**: Tel: 020 7843 4729. To contact the **Editorial Office**: 64 Wimpole Street, London W1G 8YS. Tel: 020 7935 0875. Fax: 020 7487 5232. E-mail: bdjinpractice@bda.org. Web: www.bda.org/bdjinpracticeonline. Published for the **British Dental Association** by: Nature Publishing Group, The Macmillan Building, 4-6 Crinan Street, London N1 9XW.

 ISSN 2057-3308.





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COLUMN

The seven-year itch

Peter Baker,
Campaign Director,
HPV Action

In November 2015, the government's vaccination advisory committee (JCVI) recommended that HPV vaccinations should be offered to men who have sex with men (MSM) aged up to 45 via genitourinary medicine (GUM) and HIV clinics. This was, we thought, an important first step towards a decision to vaccinate all males against an infection that causes 5% of cancers, including oral cancers, as well as genital warts.

We were, however, disappointed by the government's announcement at the end of May that the MSM programme in England will be piloted rather than being rolled out nationally as soon as possible. This is an unnecessary delay which will inevitably leave many MSM at risk of infection. This delay is also characteristic of how the issue of vaccinating males has been approached in the UK.

The JCVI began its assessment of whether all adolescent boys should be included in the national vaccination programme in 2013 with the intention of making a recommendation in 2015. This was later pushed back to 2017 and, if a decision to vaccinate boys is finally made (which is currently far from certain), implementation is unlikely before 2020. This seven-year timescale leaves a cohort of 2.8 million boys at risk and is unacceptable.

HPV Action estimates that the cost of vaccinating boys would be £20-22 million a year at most. This is modest when compared to the costs of treating HPV-related diseases. The costs of treating oropharyngeal cancers alone have been rising sharply in recent years as the incidence has increased, mainly as a result of HPV. In England, between 2006/7 and 2010/11, the secondary care costs for this cancer increased from an estimated £17.21 million a year to £30.32 million, a rise of 76%. The annual cost of treating genital warts is an estimated £58.44 million.

On 7 June, a debate took place in Parliament about HPV vaccination. MPs from several parties, including Sir Pail Beresford (who is a dentist) and Shadow Health Minister Andrew Gwynne, urged Health Minister Jane Ellison to introduce vaccinations for all boys as soon as possible. There was also concern that waiting for an evaluation of the MSM pilot could further delay the decision on vaccinating all boys. The Minister said that the decision to vaccinate all boys and MSM adult men were independent of each other and that JCVI needed more time to complete its modelling work on vaccinating all boys.

It is unethical, discriminatory and poor public health policy to exclude boys from the HPV vaccination programme. These points have been made repeatedly by HPV Action and others and were also stated very clearly in letters sent recently to Jeremy Hunt, Secretary of State for Health, and The Times, both signed by a group of 13 leading HPV experts.

We must continue to push the government to make an early decision on vaccinating all boys. We also have to set out, at every opportunity, the scientific and policy case. An increasing number of countries now recommend HPV vaccination for both sexes, including Australia, Austria and Canada. The UK should join that community in order to protect men here and also to make a significant contribution to the global eradication of HPV-related diseases. ◆

BDA surveys of dentists' morale, motivation and job satisfaction

The British Dental Association is currently surveying associates, practice owners and all community dentists across the UK to find out more about their morale, motivation and job satisfaction. The surveys also seek to learn more about dentists' experiences and, in the case of practice owners, to learn more about practice investment and recruitment.

By taking part in these surveys you will help to support the policy activity the BDA undertakes on behalf of the profession and help us identify ways to improve dentists' working conditions. Your responses will also inform the evidence we supply to the Review Body on Doctors' and Dentists' Remuneration (DDRB).

All associates and practice owners who have received a paper copy of the survey through the post should aim to complete and return it using the prepaid envelope by Monday 1 August, 2016.

Community dentists should complete the online version of the survey by Friday 22 July, 2016; please check your email for a link to the survey.

Those members who complete the survey by the deadline will be entered into a prize draw to win a £100 Marks & Spencer voucher.

If you have any questions or would like more information about this research, please contact the BDA Research Team at research@bda.org or call 020 7535 5838. ◆

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Dentists reminded of potentially serious interaction between miconazole and warfarin

Dentists are being reminded of the potential drug interaction between the antifungal miconazole (Daktarin, Daktacort) and the blood thinning medication warfarin.

Miconazole, including the topical gel formulation, can enhance the anticoagulant effect of warfarin—if miconazole and warfarin are used concurrently, the anticoagulant effect should be carefully monitored and, if necessary, the dose of warfarin reduced.

Patients should be advised to tell their doctor or pharmacist if they are receiving warfarin before using products that contain miconazole (including those available without prescription), and to seek medical advice if they notice signs of over-anticoagulation during treatment, such as sudden unexplained bruising, nosebleeds or blood in the urine.

The Medicines and Healthcare Products Regulatory Agency (MHRA) have issued the reminder in their monthly drug safety update following a Patient Safety Notice issued in Wales last month which describes a fatality in a patient on warfarin who was prescribed miconazole oral gel by her dentist. This notice has been circulated to all dental practices in Wales. ◆

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NEWS FROM THE BDA

Stuart Johnston inaugurated as new BDA President

A Newbridge GDP for 41 years, and the voice for UK dentists on the world stage, Stuart Johnston was inaugurated as the British Dental Association's (BDA's) 130th President in a ceremony on the opening day of the Association's annual conference in Manchester.

Stuart has represented the BDA at the Council of European Dentists as Chair of the Working Group on Tooth Whitening, and was elected chair of the Dental Practice Committee for the FDI World Dental Federation. He has also led the World Dental Federation Dental Amalgam Task Team at the United Nations Environment Program mercury treaty negotiations.

He has previously served as Chair of the BDA's representative body and on its Principal Executive Committee. His work has been recognised with an Honorary Fellowship of the University of Wales School of Medicine. In his inauguration address the new President highlighted the challenge of stress and low morale across the profession.

Commenting on his inauguration, Stuart Johnston said: 'When I qualified I took the decision to get involved in dental politics. It gave me the chance to see the latest developments facing this profession, and to influence them before they became a reality. I have taken huge personal satisfaction from contributing to the well-being of my chosen profession, and it's my honour to continue in that role as President.

'Stress in dental surgeries is at record levels. For all those working under the cosh of the UDA, or at the mercy of overweening regulators that pressure is not letting up. Others see the rise of litigation forcing them to be ever more defensive at the chairside.

'These problems won't be solved by the armchair generals or the shoulder shruggers. BDA members will be at the forefront of needed change, and I am determined to be their best possible advocate, and for every dentist across the UK.' ◆

Mandatory training requirement for dentists applying to join the dental list

To join a Health Board's dental list in Scotland dentists now have to do a mandatory training programme. This involves attendance at a two part course, followed within six weeks by an online assessment, called the *Test of Knowledge*. Although the test will be online, to do it you will also have to attend an invigilated site visit. The mandatory training will cost £300 per day, with the *Test of Knowledge* at an additional £100. You will be responsible for meeting the costs of the training and assessment.

You will have to comply with this training requirement if you want to join Part 1 A of your Health Board's dental list for working in general dental practice under GDS regulations. There are some exemptions, such as those who have just completed Foundation Training or are returning to general practice within less than 12 months. It is anticipated that a similar requirement will be introduced for Part 2 of the list, those working as assistants under GDS rules.

For further information visit www.nes.scot.nhs.uk/ ◆

Smoking-related hospital admissions go up by 5 per cent in ten years

The number of hospital admissions estimated to be attributable to smoking was 475,000 in 2014-15 – a rise of 23,000 (5 per cent) in the last ten years.

However, the latest figures published by the Health and Social Care Information Centre also show that the number of deaths among adults aged 35 and over which were estimated to be attributable to smoking has declined – there were 78,000 deaths in 2014 compared to 89,000 in 2004. In 2014, this comprised 47,000 deaths of men (21 per cent of all deaths) and 31,000 women (13 per cent).

Conditions that could be caused by smoking resulted in 1.7 million admissions to hospital, for adults aged 35 and over, in 2014-15 – an average of 4,700 admissions per day. These figures refer to admissions with a primary diagnosis of a disease that can be caused by smoking, but for which smoking may or may not have actually been the cause. Since 2004-05, this figure has risen by 311,000 (22 per cent). This differs from the estimated smoking-attributable admissions because those headline figures are the result of more detailed analysis.

Statistics on Smoking, England 2016 presents a range of information on smoking among adults and children, including prevalence, behaviours and attitudes, smoking-related costs and the effect on health in terms of hospital admissions and deaths from smoking-related illnesses.

The report also includes regional data on hospital admissions and mortality rates estimated to be attributable to smoking for Local Authority areas. In 2014-15, Blackpool had the highest estimated hospital admission rate for smoking-related conditions, with 2,830 per 100,000 of population and City of London had the lowest rate with 880. Manchester had the highest estimated rate of smoking-related mortality with 458 per 100,000 of population and Harrow had the lowest rate with 185.

Responsible Statistician, Paul Niblett, said: 'Statistics on Smoking collates information from a wide range of sources so we can present a complete picture of smoking prevalence and its effect on health. By looking at survey, hospital and deaths data, it is possible to see how behaviours, attitudes and the consequences of smoking have changed over the past ten years.

The data are also analysed further to look at specific demographic groups and behaviours, such as young people, Local Authority areas and usage of e-cigarettes to inform public health initiatives.'

The full report is available at: http://www.hscic.gov.uk/pubs/smoking16 ◆

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BOOK REVIEW

Prioritise. Efficient. Control. Getting things done

Getting work done
Harvard Business Review Press, 2014
ISBN: 978-1-62527-543-1
£7.99

The best thing about this little paperback is its brevity. At less than 100 pages and not much bigger than a CD in dimension, it can be read cover-to-cover in a couple of hours and this succinctness reinforces the central point that the anonymous author is making. Do things quickly but efficiently, therefore save time and do more. Divided into six sections the book begins suggesting that it's sensible to invest time in improving productivity, with the caveat that 'busy doesn't mean productive'.

By way of becoming more productive it might be a good start to analyse one's working day, tracking all the components such as core responsibilities, personal growth, managing people, crisis management, administrative tasks and free time. This could be done over a two week period, tracking the time taken by each element. Although this exercise may seem time-consuming it allows a clear view of where too much time is being spent on certain tasks.

This naturally leads on to scheduling one's workload by prioritising what is important and what isn't. Some things being perpetually put-off may not need to be done at all. The next stage of the efficiency process is to organise the work environment. De-clutter the desk, keep a physical in tray and ensure the working area is comfortable. Then start to organise email. Maybe check it once an hour rather than every minute (maybe even turn it off) and perhaps not always 'close the loop' of every email with 'will do' or 'okay', despite the temptation.

A final section deals with working with others and this can mean effective delegation of tasks without micromanaging. Also, meetings that continue for more than 90 minutes are unproductive; 'stick to the 90-minute rule' so if it's not possible to cover everything in that time, schedule a follow-up. ◆

For more about this book and others please visit www.bda.org/booknews

Dental care professionals reminded to check their indemnity by DDU

The Dental Defence Union (DDU) is reminding dental care professionals that it their responsibility to ensure they have access to indemnity in their own right or that appropriate arrangements are in place via their employer, as they renew their GDC registration.

Following a legal change, the GDC changed its rules in November 2015, meaning all dental professionals applying to register or renew their registration will need to tell the GDC they have indemnity arrangements in place for their scope of practise, or will have by the time they start practising.

This has led to a number of queries from dental care professionals (DCPs), who should check with their employer in the first instance if they are not sure about their indemnity arrangements. Registrants will not routinely have to provide an indemnity certificate when they renew their GDC annual retention fee, only if they are specifically asked to do so.

DCPs must pay their annual retention fee by the end of July or risk having their name removed from the Register.

John Makin, Head of the DDU, explained: 'The GDC says all members of the dental team, 'must have appropriate arrangements in place for patients to seek compensation if they suffer harm' (paragraph 1.8, Standards for the Dental Team).

'DCPs are responsible for ensuring they have access to indemnity in their own right or that appropriate arrangements are in place through their employer.

'We have received a number of queries, particularly from dental nurses, about whether the indemnity they have in place meets the GDC's new requirements. Our advice is to check with your employer if you are not sure about what indemnity arrangements you have in place in the first instance.

'The GDC recognises dental defence organisation membership, either in the DCPs' own right or provided through an employer's membership, professional indemnity held by the DCP's employer and NHS indemnity.

'However, our message to dental nurses relying on their employer's professional indemnity arrangements for claims, is it is worth considering whether it is better to be a member of a dental defence organisation in your own right for access to dento-legal advice and support.'

Research gives insight into dentists' attitude to marketing

A recent study into the attitudes and actions of dentists in regard to marketing their practices reveals results that support the theory that dental professionals have neither the knowledge nor the tools to support a co-ordinated marketing effort.

These factors have created a 'perfect storm' which has fuelled the desire of dentists and managers to understand and improve their systems for communication and tracking marketing performance, and recent research conducted by Software of Excellence confirms that 93.6% of those surveyed want acquire new patients and 89.4% want to improve their marketing.

However, figures from the same survey have discovered a disconnect between the wish to attract more patients and market services more effectively on the one hand, and the knowledge and resources to do so on the other. In fact statistics show that 77% of those questioned have no plan of how they will achieve either goal. With a third of UK practices spending less than £1000 per annum on marketing and almost half not knowing what their marketing spend is, there is a clear shortfall between the desire to improve marketing and the practical application of effective tools.

Patient recommendation remains the most popular method of gaining new patients for 75% of dentists, but the research data shows less than a third routinely ask for specific reviews.

The full results from Software of Excellence's survey will be published in a White Paper this summer.

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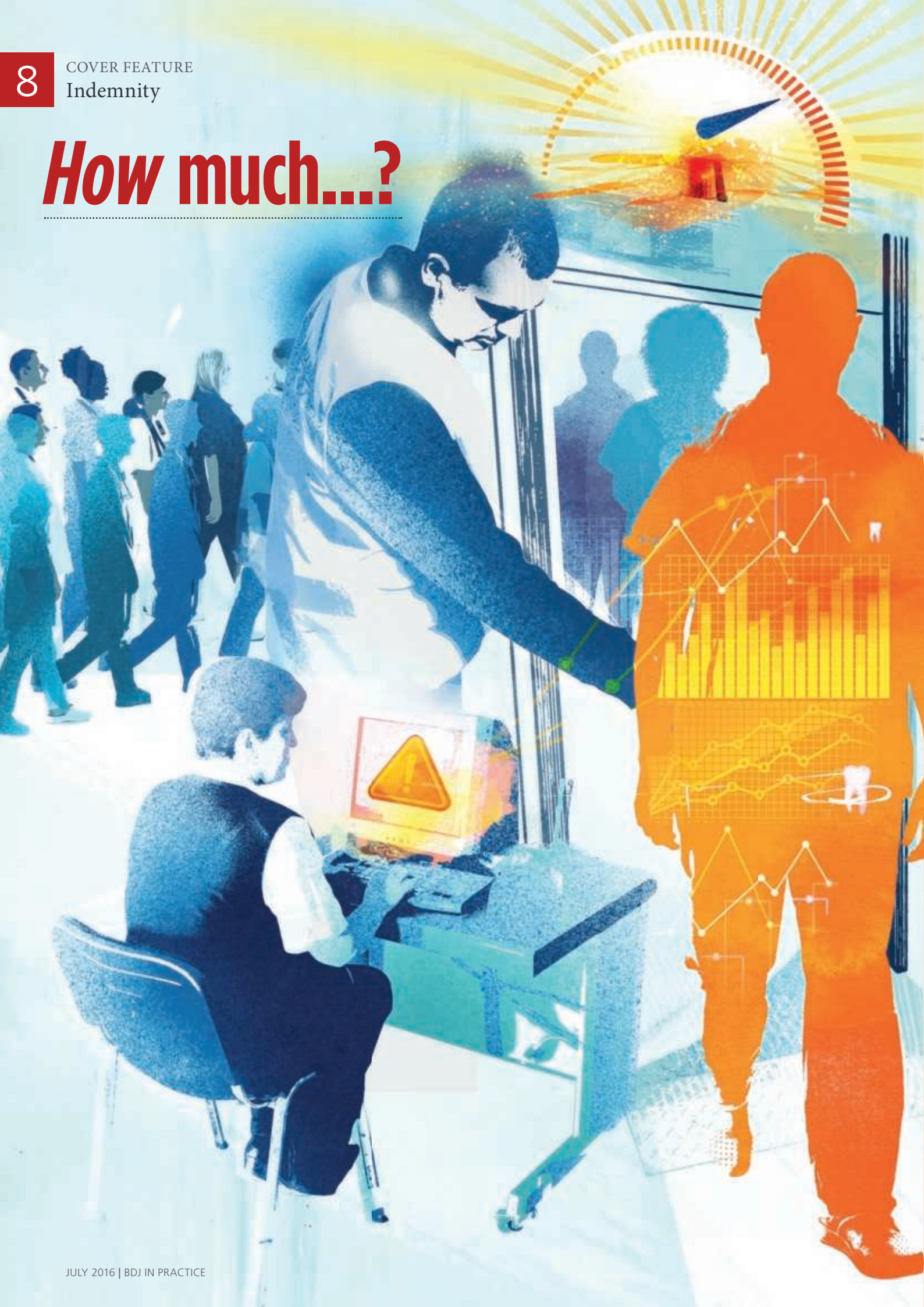


Peter Ward,
Chief Executive, BDA

At the LDC Conference in 2015, Trafford LDC put forward the following motion.

'…This conference urges Indemnity organisations to take a more sympathetic view in dealing with dentists who have made mistakes. Such dentists should not be thrown to the wolves i.e refused further cover other than in the most extreme cases…'

The motion was resolutely supported and since then we have seen a fair bit of debate about indemnity cover. Indeed the concerns raised have been elaborated upon. The first concern has been about how much the price of cover has gone up, but then there has been growing concern about 'loaded' fees and in some cases dentists being declined cover altogether.

In light of the debate, we thought it best to get the story direct from the horses' mouths – well three of them at least. So we asked the three largest providers of indemnity cover for dentists in the UK to give their take on these phenomena.

All three players commenting here are free standing companies which are accountable to their own members. So, in making decisions they have duties to manage their companies competently and to make sure that they balance the needs of the whole member base with the needs of those who appear to have higher risk profiles.

The historic model has been that by having a large body of mainly 'low needs' members these organisations have been able to generate a pool of money to provide for when individual members occasionally get into trouble. A combination of a more litigious society, voracious litigators and the presence of some 'frequent flyer' members has made all the big players revisit some of their original presumptions.

The question is about the balance of priorities. The body of 'low maintenance' members are likely to grumble if their annual fees go up. But the level of those fees is directly influenced by the amount of claims on the pool. And if a small number of individuals are making a disproportionate number of claims on the pool, is it reasonable to ask them to pay more than the others, or indeed to say that their presence is no longer conducive to the good of the collective?

But how bad does it have to be? How many mishaps do you have to have before you become *persona non grata*? If you've paid your subs for thirty years and then you are suddenly cast out on your own – you may feel let down. But did you contribute to it? Should you have spotted the signs? Or, what if your subs have gone up by factors of ten or more? Is that fair? Who decided – and why?

And then there's the matter of process. Even if you can be persuaded that perhaps your profile has changed to the extent that you may no longer be welcome, isn't it fair that you should be afforded sufficient time to make alternative arrangements? In light of the fact that dentists can't legally practise without indemnity in place, abrupt expulsion from cover can create total calamity for the individual. So what duties are owed by the indemnifiers to give the dentist long enough to sort out their affairs?

In the discussions that I have heard amongst concerned members, the recurring themes have been; Why have they done that? What rights have they to do it? and, If they must do it don't they have a duty to give plenty of notice?

I am not in a position to speak for each of the individual providers; hence why we have asked for them to speak for themselves, but as you will read, they point to their articles of association and their membership rules. The purpose of this discussion is to try to put some flesh on the bones and to ask the organisations to give their side of the story in plain English.

Overwhelmingly, the challenge from worried practitioners has been one about fairness and equity. Explaining why these things happen is one thing, but beyond this there is a need to reassure subscribing members that when decisions of this moment are made this is done in an even-handed way and in a way that is fully informed by facts.

Ultimately, it appears that the litigation landscape around us has changed. In responding to that change, the indemnifiers have chosen their own courses of action. We ask Raj Rattan, Dental Director at Dental Protection John Makin, Head of the DDU, and Aubrey Craig, Head of Dental Division at MDDUS to explain here what that looks like for them…

Raj Rattan,
Dental Director,
Dental Protection

John Makin,
Head of the DDU

Aubrey Craig,
MDDUS Head of
Dental Division

Why have some members/dentists seen significant hikes in their indemnity cover?

RR The past few years have been a particularly challenging period for dental professionals in the UK. Sadly, dentists are more likely to be sued now than ever before; with a 35% increase in the number of claims from 2010 to 2015.

Dental Protection is alive to the impact that the increase in the cost of subscriptions has had, and we are keen to be part of the solution by campaigning for legal reform to tackle the rising cost of clinical negligence. We are also constantly reviewing and investing in our operations, on behalf of our members.

JM As a mutual (member owned), not-for-profit organisation, our subscriptions are set at the level needed to fund members' claims and the other services we provide, both now and in the future. Over the past few years we have seen a significant year on year increase in the number of claims brought against our members and this has to be reflected in the cost of membership.

The vast majority of DDU members pay our standard subscription rates, reflecting that their risk is in line with the majority of their colleagues.

There is a common myth that if a dental professional contacts the DDU for advice, they will in some way be penalised by way of a subscription increase. For the avoidance of doubt, providing dento-legal advice to members is one of our core services and we positively encourage them to contact us for help at any time whether pre-emptively when they need guidance on

how to approach a potential matter or when something has gone wrong.

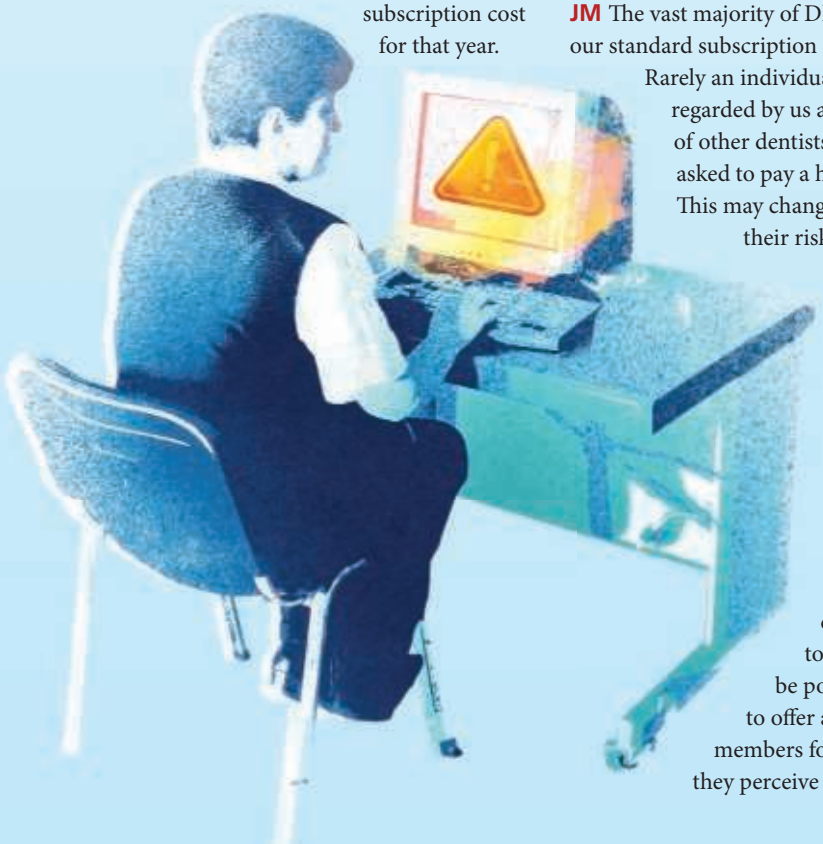
Indeed, last year we (and our medical colleagues) answered over 30,000 calls from members calling our 24-hour advice line. We can assure members that calling us to seek advice or writing to us with general dento-legal or risk management queries will not affect their subscription. It would make no sense for there to be any disincentive to members contacting us in this way and we encourage members to contact us whenever they need our input.

AC MDDUS provides discretionary indemnity and offers dentists access to an occurrence-based product incorporating unlimited settlement of damages, uncapped legal costs, professional assistance and dento-legal advice.

MDDUS charges subscriptions that are based on a detailed consideration of likely future costs – including the costs of claims which have not yet been reported – based on our previous claims and experience and incorporating expert actuarial analysis and guidance from auditors.

What is the procedure for notifying dentists of an increase in their indemnity?

RR Each year we contact our members to offer them the opportunity to renew their membership with us, and this letter includes the membership subscription cost for that year.



We also ask members to update us if there is any new information about their area of practice.

JM Members are notified of their subscription for each membership year in writing, well in advance of the date of their annual renewal.

AC On an annual basis, prior to a member's renewal, a notification of the subscription for the forthcoming year will be sent out, together with a qualifying letter from MDDUS chief executive Chris Kenny which will highlight the rationale behind any movement in rates.

If there is a period of no litigation/ complaints, would indemnity/ subscription be decreased?

RR The nature of clinical negligence means that claims can be brought years after an adverse incident occurs. For example, a fractured endodontic file may go unnoticed for several years until the tooth suddenly abscesses. A dentist who fails to record and monitor a patient's periodontal condition despite the fact that he or she sees them every 6 months for 20 years, may not come to the patient's attention until they move to a new dentist or an acute periodontal incident occurs.

Therefore, a short term period of no litigation or complaints would not necessarily mean that the long term level of risk has subsided.

JM The vast majority of DDU members pay our standard subscription as explained above. Rarely an individual's risk may be regarded by us as higher than that of other dentists and they can be asked to pay a higher subscription. This may change over time if their risk later reduces to a similar level to that of their colleagues.

AC Due to the fact that there can be several years between the events that give rise to a claim/complaint and the claim/complaint coming to light it would not be possible for MDDUS to offer any refund to members for a period that they perceive to be complaint free. It is important to remember that a claim/complaint can even be lodged against the estate of a member once they are dead.

In what circumstances would indemnity be refused or an increase backdated?

RR Dental Protection helps thousands of members every year with the problems that arise from their professional practice and all requests for assistance are dealt with on a case by case basis.

> 'A dentist who fails to record and monitor a patient's periodontal condition despite the fact that he or she sees them every 6 months for 20 years, may not come to the patient's attention until they move to a new dentist'

It is rare for us to decline to assist a member, and would normally include matters where they were not in membership when the event occurred, or were not in the correct category of membership. Similarly, a request for assistance may be declined if members have not paid the correct subscription rate or not informed us if the scope of their practice has changed.

Any decision to retrospectively alter a membership subscription category would depend on the facts of the case.

JM We would never backdate a subscription increase.

The DDU is part of a mutual not for profit organisation and as such, we must act in the interests of all our members. This includes monitoring for and managing risks to which the organisation may be exposed.

When considering new applications for membership from dentists who want to join the DDU, we take in to consideration the interests of our existing members and the risk any new applicant may pose to the mutual fund.

AC All individuals who are interested in joining MDDUS must complete an online application form. These forms then undergo a careful risk assessment process that is implemented fairly and consistently. Such a process is necessary as due to the fact that we are a mutual indemnity organisation and have a responsibility to protect our members' interests by ensuring the decisions we make do not incur any inappropriate risk – this can

sometimes mean refusing applications for membership.

It is important that MDDUS members carefully review the information that we send at the time of renewal to ensure that their subscription grade reflects their current practice. Similarly, our members should tell us before they make any significant changes to their practice, to ensure that their subscription remains appropriate.

However, the discretionary nature of MDDUS cover means that if it was identified that an individual member did not have the appropriate level of cover then they could back-date this to their second-last renewal, with payment of the right subscriptions, to ensure adequate and appropriate indemnity was in place.

If we looked at indemnifiers from a 'competition' point of view, do you think there is enough competition out there to offer dentists a competitive price?

RR We believe that there is a healthy choice of professional protection options for dentists and we believe that Dental Protection offers the best choice to all members of the dental practice.

We exist purely for the benefit of our members, with no shareholders to answer to. All our funds are used to provide member services; not just for this year, but for their whole career and for whatever challenges lie ahead.

JM Yes but this is not just about a competitive price. It's about having a high quality service and adequate and appropriate indemnity so that patients will be compensated if they are negligently harmed and a dentist's personal assets are not put at risk.

Our subscriptions are set as low as prudently possible in order to meet the cost of providing the benefits of membership to members in respect of any problems likely to arise from the year in question. They include no profit element, no insurance premium tax and no broker or agent fees. Our members' subscriptions go straight into the mutual fund.

Beyond the not-for-profit defence organisations, there are a number of commercial insurance options available. There are, however, significant differences in the indemnity offered.

The benefits of DDU membership are provided on an occurrence basis which means that if an incident occurred while a member is in active membership, they can seek assistance whenever in the future they are notified of a problem. This could be 10 days, 10 months or even 10 years after the incident took place – as long as they were a member of the DDU at the time they saw the patient they can call on us for help.

By contrast, commercial insurers normally offer indemnity on a claims-made basis. With dental claims often notified several years after the date of treatment, dentists who opt for a claims-made indemnity option will need to source run-off cover indefinitely or risk future claim notifications not being covered. Hence such policies can, on the face of it, look like a cheap option in the early years only to become a more expensive option over time. They are also usually subject to financial limits and exclusions and could leave the dentist's personal assets exposed.

The benefits of DDU membership are much wider than simply access to indemnity for claims. For example, our dento-legal advisers, all of whom are fully qualified dentists, are also here to advise and support members facing GDC Fitness to Practise investigations, disciplinary or performers' list investigations, patient complaints and even criminal investigations arising out of their clinical practice.

> 'Such a process is necessary as due to the fact that we are a mutual indemnity organisation and have a responsibility to protect our members' interests by ensuring the decisions we make do not incur any inappropriate risk'

AC Within the UK, there are three dental defence organisations as well as a range of alternative insurance providers. It is therefore the view of MDDUS that there is sufficient competition to offer dentists a competitive price.

Can you clarify what you mean by discretionary cover?

RR Every year Dental Protection helps thousands of members with issues arising from their professional practice and our discretionary nature is positive for members as it means we may be able to assist them even in unusual circumstances. It allows us to respond to changes in the dentolegal environment and assist members with emerging problems that may not have been foreseen.

We are not an insurance company. We are a mutual, not for profit organisation offering a range of discretionary membership benefits. As a benefit of membership, dentists and practice staff have the right to request assistance from Dental Protection if they need help or support.

It is rare for us to decline to assist a member, and would normally include matters where they were not in membership when the event occurred, or were not in the correct category of membership. Similarly, a request for assistance may be declined if members have not paid the correct subscription rate or not informed us if the scope of their practice has changed.

JM The MDU, of which the DDU is the dental division, is a discretionary mutual organisation. This means that rather than being bound by a finite, limited and rigid policy with terms, conditions and exclusions, DDU members have the right to request discretionary assistance in accordance with the MDU's Memorandum and Articles of Association. Details are clearly set out in our Member Guide and on our website.

This discretion has enabled us, to assist not only individual members but also to support issues in the interests of the wider membership.

AC Discretionary means that the settling of claims and providing of assistance is at the discretion of the Board. The ability to operate discretion, as opposed to compliance with inflexible terms and conditions such as those found in insurance policies, is a positive benefit. In many cases we have offered levels of support to our members that would not have been possible with a conventional insurance policy.

What would you say to allay the apparent growing concerns amongst the profession about indemnity cover?

RR We know that the past few years have been a particularly challenging period for dental professionals in the UK, and the sad reality is that they are more likely to be sued now than ever before.

We are aware of the impact that this is having on our members and we are keen to be part of the solution by campaigning for legal reform to tackle the rising cost of clinical negligence.

From our experience of managing claims, it is not unusual for claimants' lawyers' costs to exceed the damages awarded to claimants in lower value clinical negligence claims. To ensure that legal costs do not dwarf compensation payments, we believe a fixed costs regime for small value claims should be introduced.

A recent example of a dental case with a wide disparity between damages and costs include a claim alleging failure to diagnose and treat periodontal disease. This settled for £5,000 but the bill of costs submitted by the claimant's solicitors totalled just over £47,000. Costs were finally agreed at just over £20,000 which is still over four times the level of damages that the patient received.

JM There are a number of myths, misunderstandings and some ill-informed comment out there at present, particularly on social media. The MDU, the parent organisation of the DDU, was the world's first medical defence organisation, and is still a mutual organisation owned by its members. Our success for over 130 years is based on the profession contributing to a mutual fund in the professions' mutual interest with no food chain of brokers and shareholders taking a slice of the fund for themselves.

We are proud of our rich history of guiding, supporting and defending our members. My colleagues and I are out and about meeting members and the wider profession at a variety of events and are always happy to address any concerns raised by dental colleagues.

AC Members of MDDUS should be reassured both in terms of the analysis undertaken in determining appropriate subscription levels as well as ensuring the delivery of a high quality service to members who request it. Unfortunately, we all live and work in an ever-increasing litigious society with increasing complaints, claims and regulatory investigation; all with an associated cost.

All members should ensure that they have adequate and appropriate indemnity in place to ensure that appropriate support is provided when requested.

Do you offer corporate indemnity cover which covers the individual dentists employed by the policy holder?

RR Our corporate membership can give organisations and its officers the right to request assistance and indemnity in respect of the defence and/or settlement of civil law claims of clinical negligence made against the business. Such claims might arise from the act or omission of the organisation or the employees or individual contractors for whom the organisation is responsible.

Corporate membership of Dental Protection is tailored to their needs and we can provide assistance to entities of all shapes and sizes, in many different parts of the world.

Subscription rates are competitive, and priced on a bespoke basis. While it is often a condition of membership that all registered dental practitioners and dental hygienists employed or engaged by the business maintain their own individual professional indemnity arrangements, such as a personal Dental Protection membership, it is also possible to include clinical staff in a corporate membership if required. Corporate membership is usually offered on a claims-made basis, and subject to financial and territorial limits, in line with an organisation's own requirements.

JM We offer a wide variety of indemnity solutions including products for corporate membership. The detail of the arrangements will vary according to the particular circumstances of the organisation. However, where a company is a member of the DDU, the dentists working for that company would usually maintain their own individual membership and, hence, receive all the benefits of membership in their own right.

AC Yes, MDDUS can provide corporate indemnity arrangements for corporate bodies offering complete peace of mind.

If another organisation was providing corporate cover and did NOT support the employed dentists against employer-led disciplinary/capability action, would you allow the dentists to buy cover from your organisation? What cover could you offer? Would there be any restrictions?

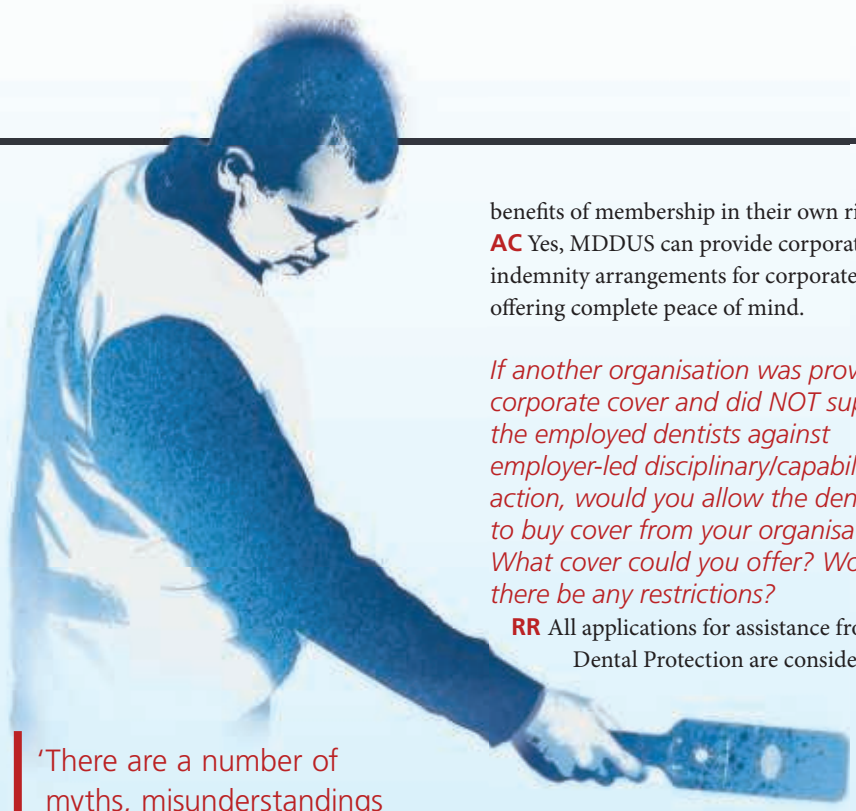
RR All applications for assistance from Dental Protection are considered on a case by case basis; however it would be extremely rare to offer membership retrospectively.

JM Any application for membership would be considered individually on its merits. However we would normally only assist with matters which arose after a dental professional's membership commenced, in accordance with our benefits of membership.

AC MDDUS is very concerned about the increase in 'claims-made' indemnity products being touted as equivalent to NHS indemnity or MDO membership. We urge any dentist to check carefully, the terms and conditions of an employer's indemnity arrangements, to ensure that they are not personally liable in the event of the employer or insurer ending the arrangement for any reason.

We recognise that there will be some occasions where a dentist chooses to work for an organisation that provides indemnity on a claims-made basis as a non-optional contractual condition and we do generally allow those dentists to hold MDDUS membership that protects them against disciplinary matters, regulatory investigations and provides access to our expert dento-legal advice.

Any restrictions would be explicitly set out in the Membership Agreement. Retrospective cover could not be provided as the current MDDUS product is occurrence based. ◆



'There are a number of myths, misunderstandings and some ill-informed comment out there at present, particularly on social media'

If you have any questions or need advice on indemnity contact the BDA on 020 7935 0875.

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Excellent clinical work can mean different things to different patients. It can mean understanding their deep anxiety, or it can mean treating them in one visit if their lifestyle means getting to the dentist isn't the easiest thing – and that includes financially. It can mean a whole host of things, but for **Mohsen Tehranian**, it meant opening up a door to a new world. David Westgarth caught up with the Invisalign practitioner to discuss career paths, philosophies and straightening.

Public interest in improving dental aesthetics and function with removable orthodontic appliances has been growing significantly over the years. What once was considered a purely aesthetic treatment now sits within a grey area of aesthetic wishes and necessary requirement. And it is this very grey area that means clinical excellence can lead to Invisalign, as Mohsen explained.

'As a practitioner you know the patients that have high levels of compliance and keep their oral health to a high standard. We all know that patients look to avoid the dentist for whatever reason, be it financial, lack of time or lack of appetite, so for me talking to patients about Invisalign wasn't a one size fits all. I knew some patients wouldn't last the course, so it's pretty pointless talking to them.'

Mohsen first qualified in 1998 From Carol Davila Bucharest, before moving to London and completing his exams. When he qualified in 2002 his first job was in private practice in Boots, and it was here he picked up some very valuable but intangible skills.

'Patients come in and don't want to be judged or told off. They don't want to hear what they have done wrong, they only want to know what we can do to put it right. Yes you need to educate the patient so they do not make the same mistakes again, but I learned very quickly that a calm, relaxed, friendly persona would help me deliver the type of care I wanted to. Of course if I see something that isn't quite right then I will let them know for them to pass onto their dentist, but I have always found this approach can help to drop the fear factor. If you went to your GP with a problem and the first thing he did was to tell you what you did wrong, are you going to listen as much if he explained what he can do to put it right followed by preventive messages? I don't think I would.

'In my opinion the setup at Boots was absolutely crucial to how I have developed. I learned from so many practitioners right at the top of their game. The working environment and the standard of equipment they used really set a barometer I did not want to fall below.'

Mohsen's journey from private to NHS to private to Invisalign practitioner isn't a path many would probably forge during their career. So where did the love of aesthetic work come from?

'It has always been there. Always. I was adamant that my patients had non-invasive work, and would always suggest it as an alternative. I referred many, many patients onto orthodontic specialists, and one of

them offered Invisalign. My curiosity grew from there. I learned a bit about the treatment, the procedure, the clinical benefits. To be able to straighten teeth without the need for fixed orthodontics was something of great interest to me.

'Things went from there. I realised there was a huge benefit to patients if they wanted Invisalign. After completing the courses in 2005 I started asking patients I believed were good candidates if they were interested. At first it was those with minor crowding before gradually doing more complex work. When patients started to understand fixed braces weren't the only option, it was probably at this point I knew Invisalign was my future.'

Recent studies have shown patients treated with removable aligners had a better periodontal health status compared to patients treated with fixed appliances' and that 'removable aligners seem to facilitate oral hygiene procedures'. Mohsen agrees, citing clinical work as the reason he can offer Invisalign. 'I love dentistry. My motto is to do it as good as it can be because patients feel that. Don't get me wrong, I have nothing against NHS dentistry, but it dawned on me pretty quickly that the only way to treat patients in the manner I wanted was to go private. I did nine months of NHS work and found it extremely restrictive. I also found I wasn't making enough money due to the length of time I was taking on procedures. My argument is patients appreciate the time you spend with them, be it treating them or understanding their lifestyle habits. It enables you to offer a better service, rather than treating them like they have to be in and out in a matter of minutes.

> 'Recent studies have shown patients treated with removable aligners had a better periodontal health status compared to patients treated with fixed appliances'

'Every clinician has the technique to do dentistry very well, but we're all so used to being rushed. It's become the norm, and not too many people step back and realise how difficult it is to treat patients properly. Look at the stress dentists find themselves under. UDA targets play a role in that.'

So how does his patient experience differ?

'Any new patient that comes in is treated exactly the same. I ask 'when was the last time you visited your dentist' and check they are dentally fit to have treatment. Not everyone can answer the first question, and not everyone is dentally fit. If they have underlying periodontal problems I don't do treatment – I send them back to their dentist to get dentally fit. Only then will I push on and treat them.

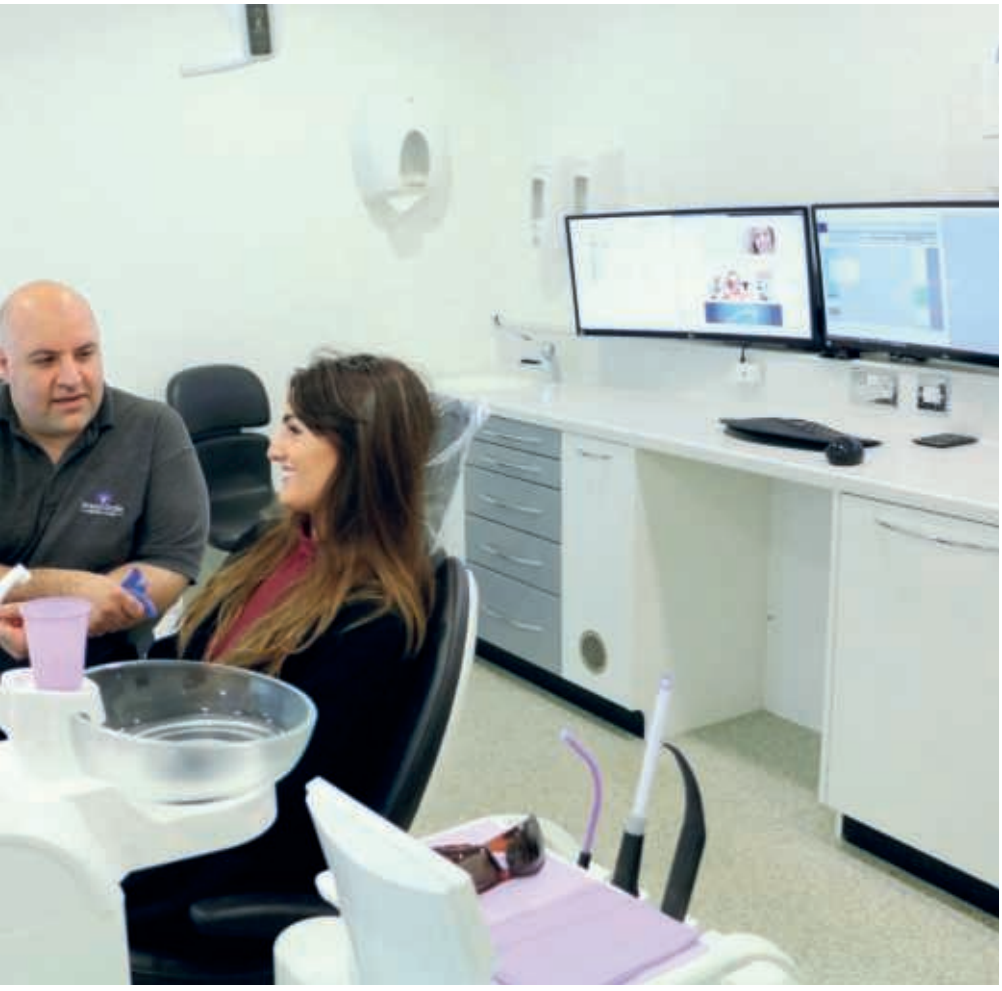
'I find in a curious way this reassures patients it's not all about the financial gains. Finance is an important part of running a clinic, but you have to enjoy it. If you enjoy it, and if you stick to the principles that got you where you are, then financial gains will naturally follow.'

It is these very principles that play a crucial role in the running of Mohsen's practice. For example patients use a tablet for recording their details, which cuts down on problems caused by illegible handwriting and the time it takes his reception staff to input the data. To further free up their time to spend with patients there's an online booking system. Patients have already received a detailed brief via video of how the procedure works and what they can expect, so Mohsen can maximise his time treating them. Everything is optimised for patient care.

'Time is money to the patient, and they don't want it being wasted. I want to give them as much value as I can, so pre-visit preparation is absolutely key. If you prepare the groundwork patients will come.'

And they do come, from far and wide. Although he's based in Lewisham, Mohsen has patients travel from as far as Southampton and Sheffield for treatment. I pushed him on the reason behind such a wide-ranging patient base.

'If you put as much effort in as you can, patients will tell friends and it spreads. When I opened I didn't have a patient base. Some patients have tried to seek me out. They have found me and followed, which is very pleasing. Yes Invisalign is still viewed by many as a luxury, but if you can approach it with patients that you know will stick to the treatment, there is every chance you will soon establish trust. I like to think that's why so many patients come here.' ◆



Managing an older workforce

Jo Davis

Partner and Practice Group Leader for Employment at B P Collins LLP, is well versed in all areas of employment law. She specialises in senior executive and partner exits, tribunal and High Court litigation, partnership disputes and advises on the employment aspects of mergers and acquisitions. Jo has also established a reputation in the field of age discrimination, having acted for partner Leslie Seldon, whose case went to the Supreme Court on this issue.

It has long been recognised that people are living longer. In 2009, just 16% of the population was over 65.[1] This is predicted to rise to 23% by 2034.[1] This is supported by research from the British Dental Association, which found that the average age of dental practice owners is now around 50 years old.[2] At this age they need to start thinking about how to manage their own exit when the time comes. Moreover, as people are working for longer, they need to consider the management of older employees across their entire practice – from admin teams right through to practice nurses.

Managing an older workforce

After 1 October 2011, when the default retirement age of 65 was abolished, employers who forced employees to retire could find themselves on the wrong end of an age discrimination claim. The only way they could avoid a sizeable pay-out would be to demonstrate that the retirement was justified. There was great uncertainty as to what that entailed and many practices simply abandoned a retirement age completely.

However, as time passed, some of the employees who were in their early sixties have stayed on and are now approaching their seventies. Some will still be performing well, but there are situations where performance has dropped off. Younger colleagues may regard their prospects as blocked by these sexagenarians and may be ruing the day that their practice did away with retirement as a way of exiting older workers.

It may be that now is the time to revisit that decision. However, practices need to ensure that if they reinstate a compulsory retirement age, they can justify that decision. Fortunately, a series of headline-grabbing cases at the Supreme Court has given greater clarity as to how practices can clear that hurdle.

It's now clear that a business has to show that it has a social policy aim for having a retirement age. The Supreme Court identified social policy aims as falling into two categories: 'intergenerational fairness' and preserving the 'dignity' of an older employee. Cost alone wouldn't be enough.

The first thing to bear in mind is that you must justify the rule, not the application of the rule on a particular individual. If you're going to have a compulsory retirement age, you have to apply it. You can't make a judgment call in each case; to do so would undermine the fact that you need the rule to achieve your aims.

Intergenerational fairness

In terms of retirement, this is likely to mean facilitating access to employment for younger workers and allowing all workers to progress to the next level. Effectively, if a practice sets a retirement age and can show that it needs it to retain younger staff who might otherwise leave to achieve promotion, they'll be able to defend an age discrimination claim. However, practices can't simply trot this out and retire older staff with impunity. Tribunals will look at such arguments carefully and only find the retirement age justified if it's proportionate.

Preservation of dignity

The Supreme Court also recognised that setting a retirement age could help preserve an employee's dignity and avoid awkward discussions about their professional ability. It's worth objectively evaluating if older employees are taking longer than necessary to carry out certain activities, then setting an agreed retirement age moving forward. It'll help employees know where they stand and enable practice owners to plan ahead.

Planning an exit strategy

So what about your own retirement? Not only should consideration be given to managing an older workforce, but it's also vital to decide in advance when it is best time to step away from your own practice. Admittedly, this is difficult, as the most immediate needs of a practice are all consuming. The thought of an exit strategy is usually way down the list after patient care, balancing budgets and managing employees. However, the creation of an exit strategy is always recommended for two hugely important reasons.

Firstly, a practice owner who decides to announce his or her impending retirement might not want to face the prospect of no successor. Secondly, a sudden deterioration in their health may make it essential for responsibilities to be abruptly transferred to someone else. If there is a plan already in place to mitigate the effects of such seismic changes, they may not be as disruptive to the practice.

Create an exit strategy from the outset

It is important to have a plan from the beginning that outlines the preferred exit strategy. There are a host of options available for owners to consider but if the preferred option is retirement with a well-managed succession, certain questions should be addressed so that any risks and fears can be, where appropriate, alleviated. They include:

1. If there is still a role for the owner in the future
2. How the departure will affect employees and patients
3. How a management change will impact on the structure of the practice; and
4. If the practice will alter its name or location.

Successor selection

It is tempting to maintain secrecy when deciding who the chosen successor will be for fear of offending, but support will be required from those acutely affected by the outcome. Observe potential candidates to ascertain if they could be the next leader. If there is not an obvious successor, then coaching and developing employees could help to identify one. Interviewing all candidates is also important as it will help to ascertain those that are (and indeed those that are not) willing to manage the practice in the future as they can face a number of external barriers to taking ownership. According to the British Dental Association's 2012 survey 'Becoming a Practice Owner: The Challenges facing UK Dentists'[2], difficulties with borrowing or raising capital to maintain a practice, regulation or bureaucratic barriers or issues associated with NHS contracts or relationships with PCT can prevent willing candidates from taking over the reins.

Retain good dentists

Having identified potential successors, it is important to retain those key employees as they will contribute to the practice's success and take it forward when the owner wants to take a step back – or move on completely. By incorporating financial incentives, such as an employee share schemes into the plan, key managers could be encouraged to stay and develop the practice, with the promise of a share in its success.

Train and develop the team

Alongside retaining key staff, it is important to develop the next leader so that the owner's departure doesn't have a negative effect on the practice. Knowing the team can handle the practice in the event of an illness or during a prolonged absence is reassuring.

Risk Management

It is essential to plan for the possibility that the practice owner could pass away or become incapacitated before implementing the devised exit strategy. Owners should ensure that they have a power of attorney and made a will, which identifies what should happen to the practice in these circumstances. They must also ensure that someone knows where these documents are and what insurance they or the practice have put in place, to keep the practice moving forward. ◆

1. Chris Smith. 2010. Pg.1, Older People's Day 2010, Statistical Bulletin, Office National Statistics, www.ons.gov.uk.
2. British Dental Association. 2012. P.10, Becoming a Practice Owner: The Challenges facing UK Dentists.

Living in a digital world

During the analogue era we probably sat around a table and thought there would be no way we could improve technology at the time. And then things started to change. We waved goodbye to analogue and said hello to digital, and digital is very much here to stay. But what about the next phase, the evolution (or replacement) of digital?

For decades, digital technology has been used in many different ways by dental professionals. In dental practices today, digitisation plays a key role in patient record keeping, treatment planning, imaging as well as fixed and removable prosthetics.

Most practitioners have made the decision to incorporate digital dentistry into their practice or laboratory, but some are still asking themselves 'when is the right time for me?' We spoke to Colin Campbell, Clinical Director at the Campbell Clinic about the 'big switch'.

'The switch from analogue to digital is not instant, it is a progressive switch and very few people jump from analogue to all digital', he said. 'Most people have a gradual drift towards the digital side of things, some more slowly and some more quickly.

'If you look at case notes for example, some people jumped early onto digital case notes, some people are still on analogue case notes and are looking to jump whilst some people still run both systems (the local major trauma and teaching hospital in Nottingham has only just gone on to digital case notes entirely). The same applies to radiography; many people had a digital OPG machine many years ago but some people are still running analogue OPG machines so the switch is not absolute and instant.

> 'The switch from analogue to digital is not instant, it is a progressive switch and very few people jump from analogue to all digital'

'In our practice we have been using digital in case notes since I arrived in 2008 and have also been completely digital in radiography since that time. There was then a transition through to Cone Beam CT which was followed later by a transition through to intraoral scanning and a combination of intraoral scanning with Cone Beam CT. The journey from CBCT to intraoral scanning for us took five years.'

Karen Gangotra, Director and Principal Dentist at Smilessence, has a different take on the transition.

'I qualified in 2001 and as a VT1 was pushing my trainer for new equipment and computerisation but the expense was considered too great. They just did not see the value in this transition. I worked as an associate and lasted nine days because I had no control over how I was treating patients. The technology was so outdated it was difficult to really provide the best care and improve their oral health.

'I made it my mission to improve things. I set up on my own and started a dental practice from scratch. I started to invest in equipment I believed was ahead of the curve. For me it was the only way to keep ahead of the competition. My new set up was to be an eye opener and ahead of the game. Everything in my practice had to be computerised and digitalised. I realised things had to change and change fairly dramatically if I was to be a forward thinking individual.

'I then come across CAD/CAM, which I found particularly interesting. I started doing a course on it and eventually invested in it. Back then, it was a huge investment, but I realised the potential it had. You have to take that leap of faith sometimes, and this was me moving from one era to the other.'

As with any transition, issues may arise. As Colin pointed out, there are several challenges in the transition to digital, 'not least the financial investment associated with it and which route is best for which practice'. There are many providers on the market and what works for one does not necessarily work for another. He said: 'Seek unbiased, impartial and valuable advice from people who have been through the process. It is essential for success.'

Karen agrees. 'You have to carefully assess what is out there and what it will mean for your patients. Many patients don't see the changes, but they experience them. That helps to drive awareness and the speed at which change occurs. Without them you can get bogged down in day to day practice.'

While dental laboratories have been faster to adopt CAD/CAM technology, more and more dental practices are integrating digital solutions at an increasingly faster pace. Companies like Henry Schein Dental are constantly reviewing their dental arsenal, looking to feed ambitious dentists the right equipment to keep ahead of the curve.

Mackenzie Richter, General Manager of Henry Schein ConnectDental, commented: 'It is critical that every decision-maker across the country ensures that they upgrade at the right time for them. ConnectDental exists as a resource for dentists and laboratory technicians to understand what technologies are available and then to assist them identify which of those technologies are the best path forward. We recognise there is not a one size fits all solution. It is also important that we help our customers be successful with these products so we have partnered with the best educators in the UK and we have 44 field based service engineers to keep our customers up and running. Our goal is that being a resource and a partner makes it easier for people who are still waiting to make the leap.'

New digital dental technology can greatly enhance the practice workflow and patient experience, but its success hinges on the interoperability between the digitally driven products within the workflow. So when did Colin and Karen feel the digital penny dropped?

'I think there have been several occasions where that has happened for me', Colin said. 'Bringing CBCT into my everyday practice was a game changer; it was the biggest change in practice from starting implant dentistry.

'Utilising the first guided surgical guide in the practice milled by our own CEREC machine was also a huge step forward. While that system is not perfect (no system is) I could really see where the future of the practice was going.'

> 'The real cutting edge practices though will understand that there are some cases where digital dentistry is not appropriate and they will be able to filter patients into each pathway appropriately.'

And for Karen?

'The introduction of Omnicam and CBCT in my practice allows me to fully integrate the scan with CT. The potential is absolutely massive. We are now able to precisely place implants using accurate surgical guides, milled in approximately 45 minutes chair side. This treatment is prosthetic driven allowing you to be consistent and precise every single time. It was the moment I realised technology could change regulations. Guided surgical tools could – and in my opinion can cause the GDC to review standards and protocols with implant placement procedures. It is safer, provides less post-operative complications and if everyone is using surgically-guided technology, then why not?'

As with any new technology in any industry, its adoption can sometimes cause frustration based on its often disruptive characteristics. Some people reading this will be thinking their way is best, and some will already be searching for the replacement for digital. Whatever the outlook, there are some merits to retaining analogue ways and integrating digital. Karen explained: 'The reason I will always put forward for adopting digital dentistry is how different the experience is for the patient. Even in some complex trauma cases, it enables me to provide treatment in one visit. Everything we do should be about our patients, whether you're using digital software or a pen and piece of paper.'

Colin, meanwhile, is more philosophical. 'I completely understand why people continue to keep paper records. I continue to read paper novels and like to write my lists on paper. I think that the functionality of digital records, the ability to search through them and the ability to ensure they are not tampered with are really key issues associated with this. From our perspective in the practice, the ability to dictate case notes and letters to be typed by practice PAs is essential in getting through the workload without killing us. It is just more efficient all-round.'

Looking forward we will see new materials that will be used for digital efficiencies and improved patient experiences. A laptop of today is faster than the laptop from last year. However, we will still implement today's best offering as it works well and helps us in our day to day work – it is the same with CAD/CAM, it makes a difference in the practice. So where will technology be in 10 years' time?

'There's every possibility we will have robot dentists! For me it will be the precision surgical procedures changing and improving standards', Karen said. 'Less-experienced dentists will be able to make bigger, more significant contributions straight away. I have spent a lot of time in America, and I think they are probably five or ten years ahead of us. We all need to play catch-up, and that process will be exciting.'

Colin said: 'I believe the advance practices will be independently owned and will be using cutting edge digital processes. The reason they will be independently owned is because the large corporations in dentistry will not see the advantage of investing heavily because they won't be able to calculate an appropriate return for their spread sheets.

'Independently owned practices will allow progressive individuals to push forward the development of digital dentistry based around a highly trained team (not just dentists). The ability to enhance the team for nurse-lead radiography and CBCT and intraoral scanning from in-house technicians and nurses trained to do this will change the work flow entirely and allow all patients entering a cutting edge practice to experience the advantages of digital.

Dentist meets dentist

Joe Sullivan

Joe Sullivan, as a GDP worked all his practising life in in a mixed NHS/private general practice. Since 1975 he has provided domiciliary care to the housebound elderly and those in care/nursing homes. Now in semi-retirement he provides domiciliary care to elderly patients.

Mili Doshi

Mili Doshi is the Consultant in Special Care Dentistry at East Surrey Hospital and Clinical Lead for 'Mouth Care Matters' – Improving the Oral Health of Hospitalised Adult Patients.

The growing number of older people in the UK presents a unique set of challenges to the profession. The number of people with Dementia and Alzheimer's is on the increase[1], and care homes are under growing pressure to cope. Alzheimer's Society called it 'one of the top three challenges facing the UK', and that's before we even consider the mouth. With that in mind, *BDJ In Practice* talks to two experts in the field, Joe Sullivan and Mili Doshi, about the needs of the ageing population and what's out there for them at this very moment.

How would you describe the landscape for vulnerable adults requiring a high level of mouth care in the community?

JS There is a phenomenally high level of need. Not just for older people, but for people with a disability and the challenges they present. Alzheimer's Society are right to label this as one of the top three challenges this country faces. The number of people living with this disease has increased beyond recognition since I qualified, and I believe the dental challenge will only get worse.

We all know and have read how we are living for longer and keeping our natural teeth for longer, but the state of oral health isn't good. The dental contract has overlooked prevention and life-long treatment planning in favour of immediate treatment. The success of dentistry in helping people keep their teeth for longer can lead to problems when personal oral care falters due to age related illnesses. There is very little joined up thinking between dentistry and other health areas.

MD I agree with Joe. The complexities of maintaining good oral health for vulnerable patients is increasing all the time. Nobody wants a painful, unclean mouth, but barriers including a lack of priority of oral health in care homes and in society is a big problem.

I'm based in East Surrey Hospital and I see the impact poor oral health has on quality of life and overall frailty. Age-related issues such as dementia, mobility problems, polypharmacy makes it really challenging for us. A healthy mouth means more than clean teeth to older people – it means dignity, it means they can eat and drink, socialise and communicate. For this group of patients every contact counts.

How is care administered now?

MD At East Surrey Hospital my patients are referred in. We provide specialist treatment including treatment under sedation and

general anaesthetic, where necessary. Dental disease and poor oral health even later on in life is relatively preventable. Some patients do not get the right support they need when it comes to maintaining oral health in terms of diet and tooth brushing. For some patients this may mean a degree of clinical holding or denying them endless cups of tea with sugar. However this may prevent the need for treatment under sedation/anaesthetic later on when they are older and the risks are higher.

JS In the region I work in 40% of residents are expected to pay for their dental treatment. I attend 30 homes across Folkestone and the Shepway District. I take equipment to the care home however with lack of time, resources and funding am only able to provide the most essential treatment.

Of most concern is when I see patients with ulceration which are not routinely picked up by staff and could have serious consequences if not monitored.

Mouth Care Matters focusses on raising knowledge, and awareness, this would also benefit by being supported by general dental practitioners and dental teams who can deliver the treatment element of care for older people once need is identified. The future contract model will hopefully support primary care dental teams to deliver care to the most vulnerable in their local population.

What local issues prevent the delivery of care?

JS The large number of care homes. The high demand. The complexities of those demands. Take your pick. It all adds up to a bit of a perfect storm.

Each of these barriers has their own issue, but for me it's the lack of time I have with patients and with no new funding available, it's going to be a struggle. Ever since I qualified in 1975 I have been providing domiciliary care. I have witnessed the number of older adults living with Alzheimer's increase rapidly over that time, and it is difficult for the newly qualified to come in and provide the care they need. I have 'grown up' with the challenges and have found ways to cope.

MD You're quite right Joe. There are lots of barriers and one is the high turnover of staff in care homes and the lack of training and priority on oral health. Sometimes it can be relatively small things like ensuring each person had a toothbrush and toothpaste and recognising the level of support each individual needs.

What work is being done to liaise with other areas of healthcare?

MD There is some degree of crossover in an acute hospital setting. We work with doctors who have very limited training in oral health, speech and language therapists who are passionate about improving mouth care. We talk to local pharmacies about medication and xerostomia. We have worked very hard to raise the profile of oral health among allied healthcare professionals.

JS As I have previously mentioned this area leaves a lot to be desired. There are pockets of good practice where a joined up approach is in place and works but it is not enough. There needs to be a concerted, national strategy to tackle this problem, and let's be honest, the reality is that this is not going to come to fruition any time soon.

So many other areas of daily care for residential patients do not require consent, so I have to ask why intervention in the mouth should be different. I recognise the need to protect the vulnerable, but this very step is a misguided one. It prevents dental teams providing care in the care home setting.

How difficult is it to get oral health on their agendas?

MD It can be difficult but I feel we are getting there. At East Surrey Hospital we have raised the profile of oral health. If for example a patient is refusing food, health care professionals will consider that there may be a mouth related cause. This was not done in the past. Educating other healthcare professionals on the links between oral health and systemic health including diabetes and pneumonia is really important and not widely recognised. A holistic approach across all areas of healthcare is required at undergraduate and postgraduate level.

JS I certainly agree with Mili. It's massively difficult. I attended a meeting on dementia and oral care last year and came away believing more than ever that dentistry works in a silo. The nature of a dental practice does this.

Getting oral health onto the agenda of care home staff is extremely difficult, which is surprising considering how intimate some of the bathing and cleaning work care home staff have to do. In most care homes there are staff who care about oral health. Regular tooth brushing is not found generally. If such personal care is not high priority for the Manager or carer for themselves, this will be reflected in the care provided for patients.

Another concern is that many of my elderly housebound patients have their own funds; some have signed authority to their children to manage their money in particular because of dementia. We frequently have difficulty getting consent for the parents to have essential treatment, on the NHS, because the family will not allow the fee. Anyone who does not have funds will be exempt from costs so all disputed cases seem to happen where the parents have money but the family will not allow them to spend it. This issue concerns me constantly because it could be regarded as abuse, in my judgement.

What changes do you believe are needed in order to remove barriers and establish a nationwide platform for improving the oral health of the elderly?

JS Central leadership and guidance from the Chief Dental Officer's office is imperative. I attended a conference last year and heard the Chief Dental Officer speak about the challenges older people face. With a background in the military and dental public health and with a desire to improve collaborative working between healthcare professionals I am keen to see how these changes progress. Look at the current challenges; an ageing population likely to maintain their dentition for longer together with associated co-morbidities in this population present a future challenge for the workforce. To ensure these patients are not left behind, the profile of oral health needs to be raised for this group.

Perhaps the most urgent need is for anyone diagnosed with early dementia to have an oral healthcare plan developed where possible problems are identified and resolved and prevention is firmly established long before cognitive deterioration requires carers to take responsibility.

MD Joe is absolutely right. Strong central Leadership. Sara has been very supportive of initiatives such as Mouth Care Matters, which is good to get it on the agenda. More involvement with the CQC in Care facilities will help to put oral care on the agenda Passionate people in positions of authority will help to overcome these barriers.

1. Demography. Alzheimer's Society. Available online at https://www.alzheimers.org.uk/site/scripts/documents_info.php?documentID=412 (accessed June 2016). ◆

An overview of maternity and paternity rights for employed staff

by Jacinta McKiernan
a Practice Management Consultant in the BDA's Practice Support team. Based in the Wales Office, Jacinta advises general dental practitioners on associate contracts and a wide range of employment and other law.

The area of parental rights and family-friendly provisions has undergone numerous changes over the last six years due to the UK's demographic changing at considerable pace. As an employer you are now faced with four generations in the workforce, all on various life paths. Last year we witnessed a change in this area of law which is quite phenomenal. For parents of children born or placed up for adoption since 1 April 2015, mothers have been able to share their maternity leave allocation so that fathers can now take time-off whilst the mother returns to work. Fast forward a few more years and the government is considering extending shared parental leave to working grandparents too. Presently, employers have to potentially accommodate requests for maternity leave, paternity leave, adoption leave, shared parental leave and parental leave.

> 'The cornerstone of parental rights, maternity leave is to allow mothers time-off to deal with specific social and childcare needs of having and caring for a new baby.'

Maternity leave

All employees who have a baby are entitled to maternity leave, regardless of their length of service, or part-time or full time status. Fifty-two weeks' leave is available, which is technically split between 26 weeks ordinary maternity leave (OML), followed by 26 weeks additional maternity leave (AML). The cornerstone of parental rights, maternity leave is to allow mothers time-off to deal with specific social and childcare needs of having and caring for a new baby. For health reasons there is a compulsory period of maternity leave for two weeks after the baby is born.

Expectant mothers have to give their employers formal notice by the 15th week before the baby is due regarding the pregnancy, the week her baby is due and when she wants to start her maternity leave. She also has to provide a form from her doctor or midwife. Employers have to reply, in writing, within 28 days confirming the date on which the employee is expected to return to work, they should assume that the employee will take her full 52 week entitlement. The

employee can say that she is returning to work earlier as long as she gives eight weeks' notice before the new return date. Likewise, an employee may have said she doesn't want to take the 52 weeks, but she can extend this, up to the 52 weeks maximum, if she gives eight weeks' notice before her expected return date.

The start date can be any date from the 11th week before the baby is due up to the date of birth itself. Though this can change if an employee's baby is born early, her maternity leave will automatically begin the day after the baby is born. If an employee is still working within the four weeks before her baby is due her maternity leave can start automatically if she is off work for a pregnancy-related illness.

Adoption leave

Adoption leave is the equivalent to maternity leave for when a child is adopted. An adoptive parent is entitled to 52 weeks' statutory adoption leave. However, within an adopting couple only one person can take the full adoption leave – the other would be able to claim paternity leave.

To be eligible, the employee must have been with you continuously for 26 weeks by the time they were matched with a child and must formally notify you within seven days of being matched with a child. The employee must let you know how much leave they want to take, when they want it to start and the placement date. Adoption leave can start either on the day the child starts living with the adoptive parent, up to 14 days before the expected placement date or, with adoptions from overseas, when the child arrives in the UK or within 28 days of this date.

Paternity leave

Eligible employees are entitled up to two weeks paternity leave. This right applies to employees who will be taking time off to look after the child and will have formal parental responsibility for the child's upbringing. Although generally considered as an entitlement for fathers it is more complicated than that. The right may apply to the spouse (including same-sex spouses), civil or long-term partner of the expectant mother or the natural father of the baby. An adoptive parent whose spouse or partner is taking adoption leave might also be eligible for paternity leave.

To be eligible employees must have worked for you at least 26 weeks by the end of the 15th week before the expected week of childbirth. They must also have given you at least 15 weeks' notice. They do not have to state a precise leave date, they could ask for their paternity leave to start on the day the baby is born, for instance, but the leave must be taken within 56 days of the birth (or due date if the baby is early).

Shared parental leave

Shared parental leave allows parents to share statutory maternity leave or adoption leave. Employees on maternity or adoption leave can break their absence from work into separate blocks and share some of the leave with their spouse or partner. Potentially, eligible parents, in the first year of a child's birth or adoption, will be able to dip in and out of their job, taking time off to provide care for the child.

> 'Shared parental leave allows parents to share statutory maternity leave or adoption leave. Employees on maternity or adoption leave can break their absence from work into separate blocks and to share some of the leave with their spouse or partner.'

After the 2 weeks' compulsory maternity leave is taken into account, up to 50 weeks of outstanding statutory maternity leave or adoption leave could be available for shared parental leave. The actual amount of shared parental leave available depends on how much maternity or adoption leave is taken, so any week or weeks taken reduces the shared parental leave available by a corresponding amount.

It is the mother's initial choice over whether to opt for shared parental leave, but once that choice has been made, the couple must agree when they should take leave. They may take time off either at the same time, consecutively or alternately. Shared parental leave must be taken by the child's first birthday and any unused leave at that date would be lost.

Parents have to provide written notification of when they intend to take leave. Employees can make up to three different requests and could ask for more than one block of leave within each request. If they only request a single block of leave within their request, then the employer has got to agree to that request and has no flexibility. If your employee uses the notice asking for two separate leave requests which involves returning to work part way through, you have some discretion in how you treat it. You can refuse the employee's request but would then have to renegotiate a different pattern of leave that works both for you and the employee.

Statutory pay

Employees taking maternity, adoption, paternity or shared parental leave can be eligible for statutory payments. The rates are set by government each year and you need to check your employee's eligibility – normally they will be eligible if they have been employed by your for at least 26 weeks and they earn above the National Insurance lower earnings limit.

Parental leave

There is also a general right to unpaid parental leave at any point up to a child's 18th birthday. A total of 18 weeks leave is available per child, though no more than four weeks leave, per child, can be taken per year – so an employee with two or more children can take more leave (should they be able to afford so much time-off without payment). An employee must have formal parental responsibility for the child and give you at least 21 days' notice. If the request concerns a child who is not new born or newly adopted, a request for leave can, be delayed if the employer has a significant business reason for doing so. Whether a reason is significant or not would depend upon the circumstances but may include circumstances such as an unusually busy period or coping with reduced staffing levels.

Family friendly working policies

All employers need to be aware of the various rights that parents have to take leave for childcare purposes and to anticipate what their obligations may be. BDA advice on Employees' maternity and parental rights provides details on these circumstances. It will be useful if you develop clear written policies so that staff understand their rights and can see that you have a consistent approach to all requests for formal childcare related leave. ◆

To download Employees' maternity and parental rights go to www.bda.org/advice

NHS pensions – Dealing with 24 hour retirement

by Paula Slinger
a Business Adviser based at the BDA. Paula helps BDA members with all aspects of business planning, buying and selling practices, incorporation, conversion to private practice and other related areas.

You don't have to give up working entirely in order to access your NHS pension. Starting to draw your pension but returning to work, either full-time or on a part-time basis, can be option for many GDPs planning the transition from practice to retirement.

To claim your NHS pension you have to retire from work – it is not possible to reach pensionable age, start claiming your pension and continue working without a break. You must take a minimal break of 24 hours. This would normally mean taking one whole day out from the practice, though this could be over the weekend. Generally, once back to work you can continue more-or-less as before, though within the first month you should restrict your NHS work to 16 hours a week.

To ensure that you are able to return after 24 hours you must make sure you comply with NHS regulations. To start drawing your pension you need to fill in the application form (AW8) and, if you are a practitioner, send it to the appropriate NHS payment agency for your country (NHS Business Services Authority, the Scottish Health and Social Care Board or the Northern Irish Business Services Organisation) at least three months in advance. You should also talk to your Primary Care Organisation (PCO) about your NHS contract or list number.

In Scotland and Northern Ireland your existing performer's list number is closed on the date of retirement and a new number is issued after the 24 hour break. You need to talk to your Health Board about giving notice to close your list number and applying for a new one.

Within England and Wales 24 retirement is much the same if you do not hold an NHS contract, so if you're an associate it's a similar process to in Scotland or Northern Ireland. If you are a contract holder (that is an NHS provider), it can mean that your GDS contract or PDS agreement has to be closed. As an NHS provider your performer number is linked to your contract and your pension benefits, so closing it to get your pension also ends your GDS contract or PDS agreement.

NHS contracts held by limited companies and by partnerships are usually protected. This is because the company usually has a performer number separate to that of the retiring person.

To protect a GDS contract if it is held by a sole provider you might consider entering into a partnership with another performer.

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According to NHS England's latest Policy Book for Primary Dental Services, an individual PDS agreement holder can add more individuals to a PDS agreement. This protects your contract because you get a new number and when you retire, the new number stays active and you have someone in place to hold the contract whilst you are taken off the list for 24 hours.

You need to add someone who you know and trust and is willing to help out. You then need to draw up a thorough partnership agreement that protects both of your interests. You will need to serve notice to your PCO regarding the change in structure. This notice should be served in accordance with the regulations. Notices will need to be served to establish the partnership and then another notice required to add you back to your own contract and then to dissolve the partnership. Your PCO will also be concerned that the regulatory requirements are followed, such as having CQC registration in place for the new partnership. As a result the whole process of entering into partnerships or adding individuals to PDS agreements, regulatory compliance and then dissolving them can take a number of months!

The proposed partner needs to be a GDC registered dentist. You cannot use a GDC registered dental care professional (DCP) in this situation, because a DCP is not allowed to hold a GDS contract alone.

Get the partnership agreement drawn up by a solicitor with dental experience. The starting point could be the BDA template, available in BDA Expert Solutions, the agreement needs to be tailored to your circumstances. Set out the purpose of the partnership and steps to be followed. It would cover things like liabilities to protect the person coming into partnership to help you out. They would not want to be lumbered with any clawback or other debts. Equally, you would not want them running off with your goodwill. Make sure you get all documents signed in advance by both you and the partner so they add you back onto your contract after your 24-hour retirement and then agree to dissolve the partnership. You would not want to end up in a position where the partner reneges on this, so have these documents in place and ready to send. ◆

Dental nurse renewals

by Jacinta McKiernan
a Practice Management Consultant in the BDA's Practice Support team. Based in the Wales Office, Jacinta advises general dental practitioners on associate contracts and a wide range of employment and other law.

Dental nurses' GDC renewals have to be completed by 31 July, which begs the question; do you just rely on your staff to get it done, or should you make sure they renew their registration?

As an employer you are ethically responsible for ensuring that those working with you are, where relevant, registered with the GDC. The GDC states that 'You should make sure that relevant team members are appropriately registered with the GDC'[1]. You can check registration online but to be pro-active remind them personally and get them to show you their certificate of current registration. You may also need proof that you have checked, if any dispute arises or if a practice inspector asks for example.

One way of making sure is to pay the renewal yourself. To do so you would need the nurse's registration number and their unique ID verification code from their renewal notice. Registration and renewal is an individual responsibility so employers are not obliged to pay, though there are good reasons, other than certainty over renewals, for employers to consider doing so. On the other hand, however, paying for your nurses' registration directly may make them feel that they do not have personal ownership of their professional registration. Most other DCPs will pay it themselves – personal responsibility for maintaining your registration is a sign of professional status.

Cost is only one factor

The annual registration fee for dental care professionals is £116, though this is going to add up the more team members you have. The GDC is, however, listed as a professional body approved for tax relief under list 3, so you do not have to report anything to HMRC or pay extra tax and National Insurance, and the cost may be offset as a legitimate business expense.

The hassle

Do not underestimate the difficulties if a nurse fails to pay their registration. Not only will they be removed from the register, but they will have to go through the process of reapplying, which not only includes filling in the form and making the relevant declarations, but also showing that their CPD is up to date.


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The GDC says that restoration takes around 10 working days subject to the form being filled in correctly and there being no need for additional questions.

While they wait for the restoration to the register, they cannot work as a dental nurse. As their employer you would probably have to suspend them on full pay in the meantime, or find them other jobs around the practice, such as reception work, until their registration is active again. You may be justified in taking disciplinary action for breach of contract, but it might not be an instantly dismissible offence. Realistically, a formal warning requiring them to get reinstated on to the register may be as far as you can go in employment law terms.

Value to employee

For the employee the payment of an expense like their GDC renewal fee is a clear additional benefit. It adds to their remuneration package and whilst not part of the monthly or weekly pay statement, clearly has a value to the employee, providing for an actual need. Renewals are no longer a cost or something to budget for in their take-home pay. It also demonstrates that you care about them, leading to more loyal and engaged employees.

Value to employer

Having employee benefits over and above basic pay plays a tactical role in the recruitment, retention and motivation of staff. If you do offer GDC registration fees as part the remuneration package then you can communicate this as an extra, not offered by every employer. Include it when placing a job advert as an additional incentive.

Consistency

You must ensure that you treat all of your staff fairly. Paying GDC renewal fees for one but not for other dental nurses could be seen as discriminatory. By agreeing to pay this, you make a commitment to all relevant team members. It will probably become a contractual commitment, so if you offer to pay GDC fees you need to make clear the basis on which you are doing this, as even just paying them once could be seen as making an ongoing commitment. ◆

1. GDC, Standards for the Dental Team, 30 September 2013, paragraph 6.6.2 page 60.

Free online tooth wear CPD module

A recent pan-European study, amongst 3,187 subjects aged 18-35, concluded that 1 in 3 young adults suffer from tooth wear[1]. In a survey of 200 dental professionals completed in 2013, 84% said they see signs of erosive tooth wear on a weekly basis and 86% felt the condition is on the rise[2]. This emphasises how common erosive tooth wear is throughout the population.

To help raise awareness of the risk factors for tooth wear associated with eating and drinking acidic foods and drinks found in today's diet, Pronamel are offering dental professionals access to a specially developed online module. Topics include identifying signs of tooth wear, condition management advice, the use of the Basic Erosive Wear Examination tool (BEWE) and the role of Pronamel in protection from the effects of acidic diets.

The Pronamel online CPD module is available in an easy to use format which is free of charge. Available 24 hours a day, you can access this module whenever is convenient. Completion of the module can contribute up to 1.5 hours towards your verifiable CPD.

In addition, it provides information on the Pronamel range and how it can help protect patients from the effects of erosive tooth wear.

Visit www.gsk-dentalprofessionals.co.uk/pronamelcpd1 to complete the module today.

1. Bartlett D W, Lussi A, West N X, Bouchard P, Sanz M, Bourgeois D. Prevalence of tooth wear on buccal and lingual surfaces and possible risk factors in young European adults. J Dent 2013; 41: 1007–1013.
2. GSK Data on File, 2013.

Next generation recalls and reminders

iSmile have developed not only an automated recall and reminder feature, but a system which goes beyond simple automation. Clever three step automation now allows you to carry on with your day to day jobs while iSmile quietly targets patients in your database that you may not have seen in your practice for some time.

Admin users can set parameters for every stage of the automated recall process and also have the ability to check how the automation is performing in real terms, using a collection of highly detailed reports.

iSmile's three step automation can be used for contacting patients that haven't been into your practice for some time using a combination of letters, emails and SMS messages. The extensive reporting features allow you to keep a handle on budgets for these processes too.

Speak to one of iSmile's advisors on 0845 468 1287 to see how clever automation could bring you more patient bookings while keeping costs to a minimum. Visit www.ismiledental.co.uk for more information.

Were you sitting comfortably?

Were you at this year's British Dental Conference & Exhibition? If you weren't, you really missed out. That's because A-dec was on-stand this year, ready to discuss its range of innovative and reliable dental equipment solutions – from chairs to lights and stools. The expert team were also happy to discuss the new my A-dec app – the inventive new app service developed for dealers, to help ensure dentists can design and order exactly the chair they need to practice excellent dentistry.

What's more, the A-dec team gave delegates the fantastic opportunity to sit in and try out the premier A-dec 500 and 500 series stools – showing practitioners exactly how comfortable, ergonomic and functional these products really are.

For more information about A-dec Dental UK Ltd, visit www.a-dec.co.uk or call on 0800 2332 85.

Excellent software is here

Marketing experts know that targeting the right patients at the right time, depending on the treatment or service on offer, will give the best return.

Now, EXACT V12 includes a complete marketing resource, taking much of the guesswork out of patient marketing.

Using the new Marketing Manager module, practices can automate many marketing functions, targeting specific patients and educating them on treatments using the templates provided within the software.

Following activity practices can accurately track results, including numbers of phone enquiries, appointments and treatments that are the consequence of marketing activity. Creating and maintaining campaigns is a big challenge for busy dental practices and the campaign function can be set up to automatically re-communicate with those patients who don't respond to an initial communication.

Establishing a series of messages means that managers only need to act once to set up the campaign, which will then be communicated in a structured way unless interrupted by a patient's response.

By targeting patients and establishing a structured and dynamic communication plan for each campaign, it is possible for dentists to easily identify where and why a particular campaign might be faltering.

For example, if a campaign results in phone enquiries but these are not converted to appointments, it will be obvious by a drop-off at that stage of the campaign, alerting managers to a potential issue with the way in which calls are being answered.

Once identified, this problem may be alleviated by additional training for reception staff, for example. The Marketing Manager dashboard enables you to get instant visible access to the expenditure on a particular campaign, indicating success by reference to the treatment code within EXACT – thereby automatically calculating a ROI.

The dashboard also indicates whether the return is direct, indirect or secondary, reflecting the quality of the original messages and enabling assessment of the source of additional revenue.

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Channel track

Tracking response to marketing activity is an important part of assessing success and now thanks to Channel Track, Software of Excellence has developed a mechanism for accurately measuring response to every marketing campaign.

By allocating a unique telephone number to each campaign, Channel Track will record calls and monitor which campaigns are being most successful.

Crucially, the ability to identify those calls that did not result in an appointment, combined with the ability to listen to these calls, gives a unique insight into how staff and patients liaise on the phone and can be a trigger for additional team training if necessary.

This monitoring capability also extends to the performance of each provider in the form of analysis of the conversion of initial appointments to treatment ratio – providing another good indicator of individual performance.

The quest for new patients and the need to extend the reach of treatments to one's existing database requires management and monitoring.

The creation of effective communication is a vital part of patient education, helping to ensure that practices fulfil their obligations with regard to compliance and enabling patients to make the optimum treatment choice to meet their needs.

EXACT V12's focus on patient marketing now enables dental practices for the first time, to take control of an integrated patient communication plan, optimising their online presence and using digital platforms to maximum effect as part of a fully co-ordinated marketing strategy.

For more information on Marketing Manager, Channel Track or EXACT V12, visit www.softwareofexcellence.com or call 0845 345 5767.

No blood no sweat no tears

Haemostasis is crucial for lessening blood during procedures, and with Hygitech Haemostatic sponges, greater control beckons.

The biocompatible sponges can be used in various surgical procedures where the control of bleeding capillaries, veins and arterioles using pressure is required.

As a macro-porous sponge, the sponge is insoluble in water with a rapid absorption capacity equivalent to 40 to 50 times its weight in blood or other liquids. The haemostatic sponges are easy to use and malleable, and can be cut to fit the bleeding area and is combined with an antibacterial agent.

For more on Hygitech visit hygitech.uk or call 0203 808 1110.

Value: north-south divide, fact or fiction?

During the last few years it has been factually proven that London and the South East has achieved significantly higher values and multipliers of profit than any other part of the country. However when these areas are excluded from our analysis, the North - South divide is less evident with values across the country seeming relatively similar save for marginal wage variations and specialisms.

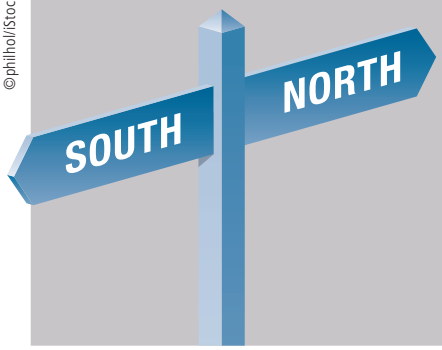
In the last six months Christie & Co has looked at over 45 practices (for banking purposes) with an approximate value in excess of £25m within the northern region of the country where values achieved have been extremely strong for all types of practices.

We often see achieved values being within the market guidelines/average, both as a multiplier of Net Annual Adjusted Profit (EBITDA) and as a percentage in the pound, although within certain circumstances multipliers and percentages are at significantly higher levels depending on the demand of the practice in question.

The market within the Northern portion of the country is considered to be extremely strong for all practices with a particular emphasis on NHS driven income although private practices are seeing more demand and as a result higher values are beginning to be achieved on a more regular basis.

Again it is common where a private practice has high insurance backed income (which creates less risk for a new purchaser) for values to exceed the industry norm.

To discuss any matters relating to your dental practice, please visit www.christie.com.



Committed to the care and comfort for your hands

As a leading manufacturer of top quality dental gloves, Unigloves is dedicated to the safety, protection and care of your hands.

After perfecting its production processes over 30 years, Unigloves use smart technology with online manufacturing complimented by additional hand-crafting techniques, including multiple wash cycles to offer exceptionally clean, strong, low-allergy gloves.

The Vitality range from Unigloves includes:

- **Vitality Latex** – 100% latex, powder free, single use gloves with a carefully formulated moisturising lanolin and vitamin E coating to protect and nourish the skin.
- **Vitality Mint Latex** – 100% latex, powder free, single use gloves with natural moisturisers and scented with citrus and peppermint for a pleasant aroma.

Unigloves supplies over 1.3 billion gloves to professionals every year and understands that clinicians need gloves that are easy to use with optimum grip and superior comfort.

Every glove features double-chlorinated beaded cuffs to simplify donning and removal and has a micro-roughened textured surface to enhance control and dexterity.

For further information about Unigloves products, please visit www.unigloves.co.uk.

Market reflections at BDA Conference & Exhibition

At the British Dental Conference & Exhibition 2016 in Manchester, Dental Elite distributed its latest goodwill and benchmarking survey for the Fiscal Year End (FYE) 2016.

With its expert knowledge and acute insight of the current market, the team was able to offer sound advice to those looking to buy or sell a practice.

Delegates to the Dental Elite stand also benefited from practical, up-to-date advice on the latest recruitment options and the importance of using a broker while enjoying a complimentary drink from the team's wine bar.

For those that missed the niche agency, the team are always contactable and will be available to speak to throughout the year at various shows and exhibitions.

For more information on Dental Elite visit www.dentalelite.co.uk, email info@dentalelite.co.uk or call 01788 545 900.

Habits of a lifetime

Creating awareness and imparting the importance of good oral hygiene habits from a young age is essential and Tandex can help clinicians build this into their practice ethos.

Having the tools to be able to demonstrate good brushing techniques with parents and children is essential. Tandex offers an array of gentle and efficient toothbrushes designed to suit children during the different stages of development. The handles are long enough for both parent and child to hold at the same time, to ensure supervision while children also learn how to brush. The heads are small enough to be able to reach all areas of the child's mouth ensuring thorough plaque removal.

Treating children in the dental practice can be challenging but also highly rewarding. Imparting good education to parents and children will ensure correct habits and regimes are in place to provide them with a lifetime of good oral health.

For more information on Tandex's range of products, visit www.tandex.dk.

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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

Midlands

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

PARK ROAD DENTAL PRACTICE

www.parkroaddentalpractice.co.uk

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

South East

LONDON SMILE CLINIC

www.londonsmile.co.uk

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

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

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

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

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

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

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

263521

TOOTHBEARY RICHMOND

www.toothbeary.co.uk

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

258051

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

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

209440

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

DENTAL SPECIALISTS ST ALBANS

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

239826

WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

266913

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

East Anglia

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

269120

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, Restorative and Cosmetic Dentistry, Sedation and Non-Surgical Facial Cosmetics
On Specialist List: Yes, Endodontics and Orthodontics

261006

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Seminar Series

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British Dental Association

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- Discuss the latest whitening protocols – is power bleaching dead?

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Business skills CPD

Q1: How many weeks leave are available for an employee having a baby?

A 13 weeks
B 26 weeks
C 39 weeks
D 52 weeks

Q2: When can maternity leave start?

A Any date from the 11th week before the baby is due
B Any date from the 8th week before the baby is due
C Any date from the 26th week before the baby is due
D Any date from the 20th week before the baby is due

Q3: How many requests can employees make for shared parental leave?

A One
B Two
C Three
D Four

Q4: What application form do you need to fill out to begin drawing down your pension?

A AM1
B AW8
C AO3
D BV8

Q5: When do dental nurses' GDC renewals have to be completed by?

A 30 July
B 31 July
C 1 August
D 31 August

'Child protection and the dental team' (www.bda.org/childprotection) is now available to help dental professionals recognise and respond to abuse and neglect. BDA members have free access to the online programme and can also gain three hours of verifiable CPD by completing the quiz on the BDA's CPD Hub (cpd.bda.org).

For further education, Essential and Extra members can now receive a 10% discount on online child protection and adult safeguarding courses. Expert members receive two free courses plus the discount for anyone in their team. The online courses are delivered by The Child Protection Company and fulfil the safeguarding outcomes as specified by CQC.

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