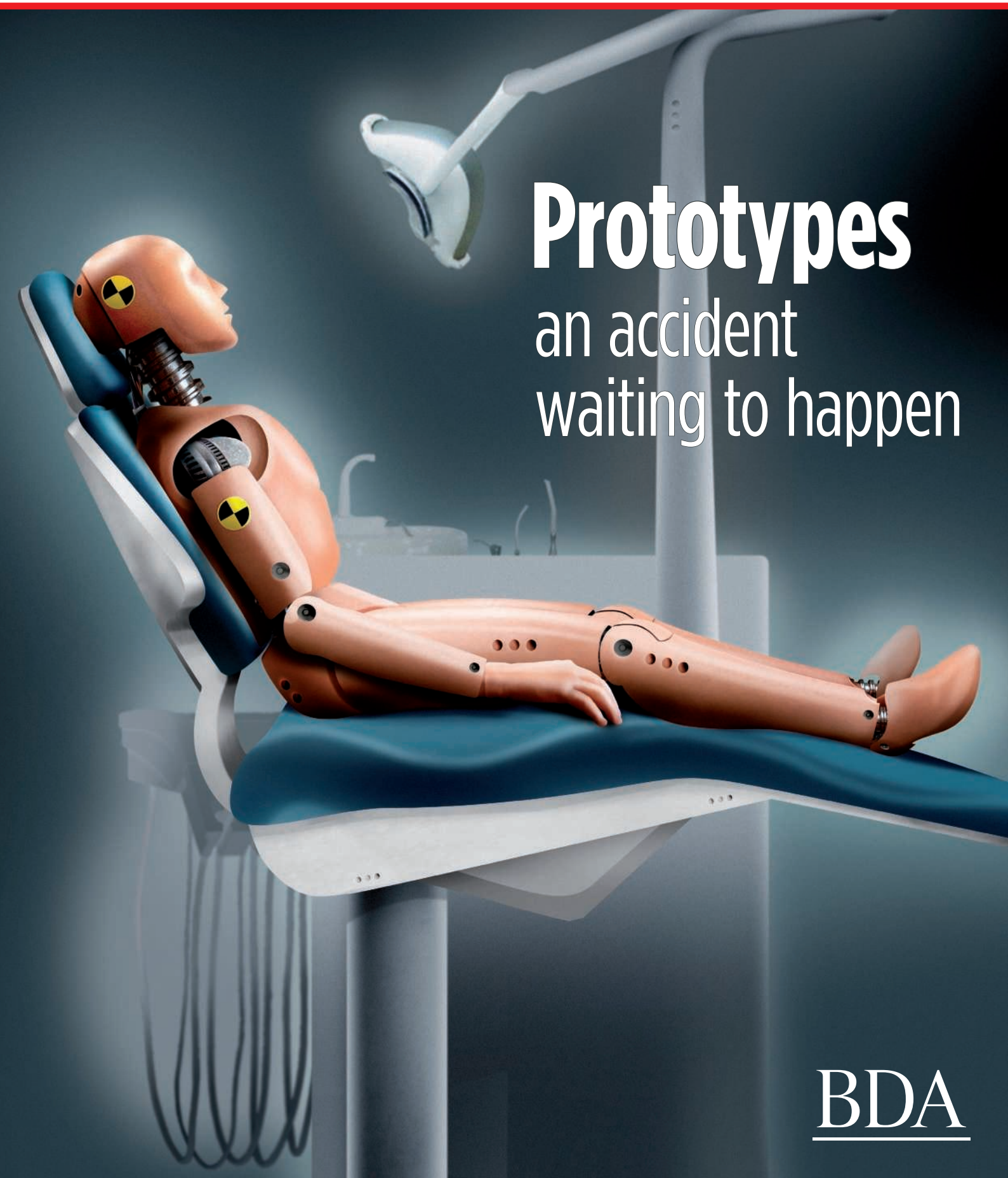
BDJ In Practice
June 2015



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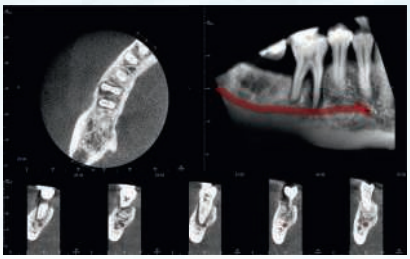

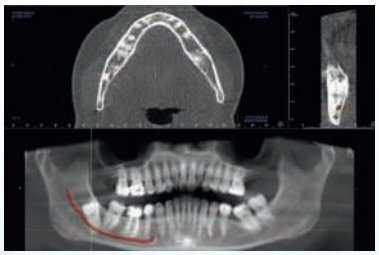

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JUNE 2015

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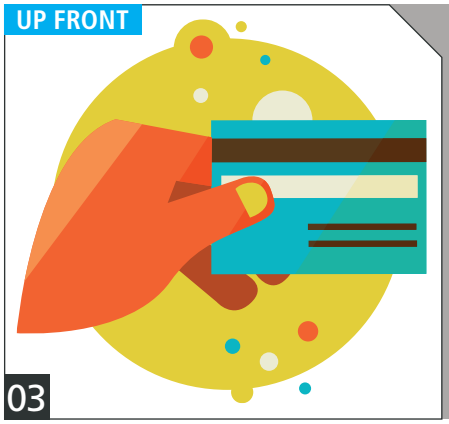

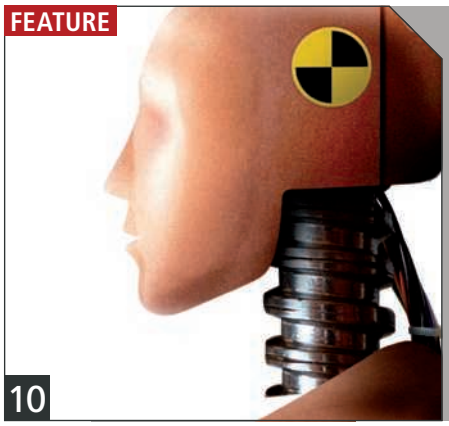

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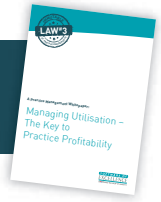

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Consumer-credit rules **relaxed**

PRACTICES CAN NOW allow patients to pay for their treatments in more than four instalments without needing authorisation from the Financial Conduct Authority (FCA).

Generally, if you allow patients to pay for treatment by instalments or introduce them to a third party who will provide loans or other credit facilities the practice needs official consumer-credit authorisation from the FCA.

Now letting patients pay by up to 12 instalments is exempt if you comply with all three of the FCA's precise conditions (**see right**). But authorisation is required if you let even only one patient pay in 13 or more instalments or over more than one year. This affects any arrangements made since 18 March 2015.

Practices are still most likely to need FCA approval if they: lend money; collect debts; introduce patients to a loan company to help them to finance their treatment; arrange credit through a third party; or administer agreements for creditors or assignees, even if this does not involve collecting debts. Authorisation is required even if the practice does not charge for providing the credit.

> "Now letting patients pay by up to 12 instalments is exempt if you comply with all three of the FCA's precise conditions (**see below**)."

It is a criminal offence to carry out activities requiring authorisation without permission and can lead to two years' imprisonment and a financial penalty. ◆

Exemption criteria

- → Payment is made in 12 or fewer instalments and the debt is settled within 12 months

and

- → the arrangement is for the purchase of specific goods or services that are provided directly by the practice

and

- → the payments are for an overall fixed amount with no charges, interest or administration fee

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Industrial-action threat

AT THEIR ANNUAL conference, the British Dental Association's Accredited Representatives opened the door to potential industrial action.

It passed a motion which said: "We ask conference to vote to override a previous conference motion on industrial action and to consider each opportunity on its merits. If there are issues which aggrieve salaried dentists on a national level, perhaps we should take a leaf out of Unison and Unite's book and strike for a couple of hours. We feel this would make our views known whilst only causing the same disruption to patients as a staff meeting."

Conference chair Linda Dunlop said: "In all my years as a dentist I have never seen such strength of feeling across our profession, and today's ground-breaking resolution reflects that. This is not about money, but making sure that our patient services are protected.

"Our delegates are not militants. They are consummate professionals, determined to leave all options open when it comes to resolving future disputes." ◆

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UNUSUAL CLAIMING

Dental-activity review

FROM THIS MONTH, the NHS BSA Dental Services is beginning a programme to look at unusual claiming patterns in England in relation to two or more courses of treatment claimed for the same patient within a 28-day period. Urgent courses of treatment will be excluded.

The BDA has been told that the BSA will be writing to all contractors to give them the figures for their own contracts, with benchmark comparisons.

We understand that, subsequently, about 300 contractors who have the highest incidence or proportion of these claims will be asked to provide a sample of between 10 and 20 records for patients named by the BSA.

For about a further 700 contracts, the contractor will be asked to audit their claims and to consider if any have been submitted incorrectly.

The BSA has told the BDA that the aim of the exercise is to understand the reasons for unusual claiming patterns and to educate contractors where necessary. The exercise will be overseen by BSA Clinical Services dentists.

Any Expert and Extra members receiving requests for records or to account for why claims have been made can contact the BDA for advice on contact businessteam@bda.org ◆

Scottish conference

THIS YEAR'S SCOTTISH Scientific Conference and Exhibition takes place again at Glasgow's Crowne Plaza hotel on 4 September 2015.

The event will offer delegates up to six hours of verifiable CPD and speakers include Simon Whitley and Nayeem Ali, both from Barts Health NHS Trust, London; and Alex Crighton from the University of Glasgow Dental School.

Full details can be found online and places can be booked by calling the BDA Events Team on 020 7563 4590, by email events@bda.org or online at www.bda.org/scottishscientific ◆

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FtP CONCERN

Faculty's FtP concern

CONCERN ABOUT HOW its dental-care standards are being interpreted by General Dental Council (GDC) fitness-to-practise (FtP) processes has been expressed by the Faculty of General Dental Practice (UK). The Faculty believes this may be leading to inappropriate assessment of registrants' competencies.

It has also suggested that the FtP process is overloaded and unsatisfactory, with widespread reports of unfair and disproportionate judgements following patient complaints.

GDC processes must recognise the need for individual clinical judgement and widely differing circumstances within dentistry, the Faculty has said, and it is seeking clarity about how the standards are being applied as part of the FtP process. Prompted by these concerns, the FGDP (UK) is undertaking a fundamental review of its guidance.

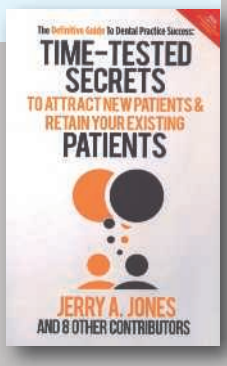
Chair of the BDA's Education, Ethics and the Dental Team Working Group Judith Husband said: "The BDA supports the Faculty in highlighting these concerns about the potential misuse of its guidance. Clinical standards should belong to the profession. We must always strive to improve patient care but, at the same time, must be judged against a reasonable standard."

The Faculty has also announced that its dental standards and guidance documents will now be available for all dental professionals through the Open Standards Initiative. ◆

BOOK REVIEW

33 "trooths" of advertising

Time-tested secrets to attract new patients and retain your existing patients
Jerry A Jones (and eight other contributors)
Novus Venalicium, 2014
ISBN: 978-1-49593-998-3
£7.96



Dental-business-specialist Jerry Jones, although not a dentist himself, owns a growing dental office – Wellness Springs Dental – with four practising dentists. He wrote the first seven chapters – nearly half – of this 220-page paperback: the rest were written by other experts in this field, some specialising in dental sales and marketing, and a couple of dentists, Dr John Busby and Dr Darold Opp.

Although the book is written by Americans for their domestic market, there are some interesting parallels with UK dentistry. For example, Jones says that the most important person in the dental practice is the office manager or "Chief Operations Officer" as he prefers to call them. He also argues, somewhat contentiously, that no practice is too small to have one.

Each of the other eight co-authors manages to bring something useful to the party. Fred Catona discusses the 33 "trooths" about advertising by dentists, some of which are useful, some possibly impractical (in the UK), but his conclusion emphatically insists that the more consistently you advertise the more patients you will get.

Dentist Darold Opp says that it is possible to generate new patients just by having a marketable practice name (increased name recognition), which in his case is "SmilePalooza". His local newspaper refers to it as "South Dakota's version of Disney World", he says, and he created the child-friendly practice to be a "one-of-a-kind, fun-filled extravaganza" aiming to attract parents with small children and, by his account, it has been extremely successful in generating hundreds of new patients.

Despite some sections of this book being irrelevant to UK dentists there's enough practical marketing exposition to be of universal interest.

For more: www.bda.org/booknews ◆

BDA NEWS

BDA's new president

EMINENT DENTAL ACADEMIC, author and teacher Professor Nairn Wilson has become the British Dental Association's president for 2015/16, its 129th.

Currently honorary professor of dentistry at King's College London, his 45-year career includes senior positions in dental education, research and publishing. From 2001 to 2012 he was professor of restorative dentistry and dean and head of King College London's dental institute. He was also deputy vice principal of King's College London from 2009 to 2012.

Previous BDA honours and awards include a Dentistry Lifetime Contribution Award and the BDA's John Tomes Medal.

In his inauguration address Professor Wilson highlighted the importance of co-ordinated healthcare with dentistry an integral part of whole-person care. He said he hoped there would be a move from episodic to preventive, continuous patient care with dentists and their teams rewarded for saving, rather repairing, their patients' teeth.

"In the challenging, ever-changing world in which the profession seeks to deliver the best possible oral healthcare, there are many issues and uncertainties.

"However, whatever 'time of need' may lie ahead for us, suitably resourced, professionally led prevention of oral and dental disease, along with a fully integrated approach to healthcare will pay great dividends." ◆

SMEs' post-election wish-list

OVER ONE-THIRD (35%) of small-business owners want a sustained economic recovery to be the top priority for the new Conservative Government in the next parliament.

And respondents to the first survey, of 2327 small firms, since the 2015 UK General Election by the Federation of Small Businesses (FSB) has identified another 10 items on these SMEs' wish-lists (**see right**).

National policy chairman of FSB Mike Cherry said: "This response from FSB members shows first and foremost businesses want stability and certainty. This requires putting public finances on a sound footing, and then for Ministers to give a comprehensive vision for how they will support enterprise followed by a clear timetable for when they will deliver it."

Other key priorities for business owners were lowering the cost of doing business and ensuring growth in every nation and region of the UK, not just London and the south east.

When asked what issues they would like the Government to focus on over the next five years, over one-half (53%) said they wanted Ministers to reduce the regulatory burden on business. Simplification of the tax system came a close second, at 51%. Business owners were also clear that reforming business rates and improving the employability of young people were important benchmarks for the next five years.

FSB members were also asked how confident they were that the new Government will deliver for small businesses. Just over one-half (51%) said they are either confident or very confident; but over one-quarter (28%) were either unconfident or very unconfident.

"Today's wide-ranging research sends a very clear message on what small businesses want from the new Government – a supportive, light-touch, tax-and-regulatory environment in which to grow their business, creating prosperity and jobs," Mike Cherry added.

"Over the five years of this Parliament, our member's top priorities are to lighten the burdens of regulation and tax, reform broken business rates, support the development and skills of young people, and improve broadband and mobile connectivity." ◆

Wish-list top 10

- → 1 Reduce regulatory burden (53%)
- → 2 Introduce a more simplified tax system (51%)
- → 3 Reform business rates (44%)
- → 4 Improve the employability skills of young people (41%)
- → 5 Deliver improved broadband/ mobile connectivity (39%)
- → 6 Help UK small businesses to create more jobs (34%)
- → 7 Tackle late payments (33%)
- → 8 Lower energy costs for businesses (30%)
- → 9 Ensure better access to finance (28%)
- → 10 Increase investment in infrastructure (26%)

Call for **fundamental review** of regulation

HEALTH SECRETARY JEREMY Hunt has been urged by the BDA to tackle the "unfinished business" of professional regulation through a fundamental review.

Chair of the BDA's Principal Executive Committee Mick Armstrong said: "Professional regulation cannot get bumped to the bottom of the in-tray for the health team. The unambiguous and sustained failures at the General Dental Council are unfinished business, and require a clear response."

He added that the election must not offer a chance for the failing regulator to wipe the slate clean.

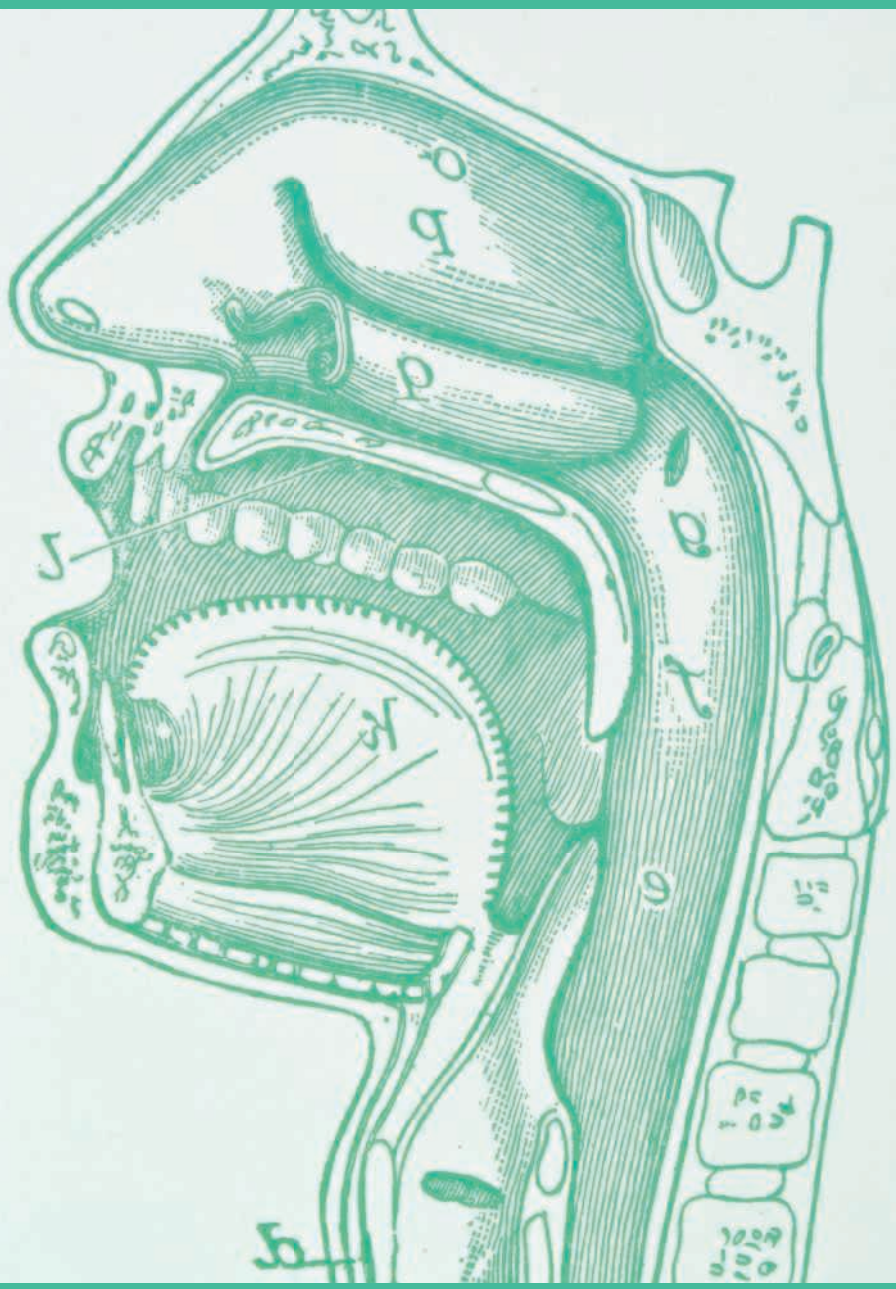
"In spite of near universal criticism, the current office-holders have failed to show insight or contrition," he said. ◆

Oral medicine

THURSDAY 2 JULY 2015 | 10.00 – 16.45
BDA HQ, LONDON

The event is open to all BDA Armed Forces Group members including retired members*

BDA
British Dental Association



Professor Mike Lewis

Professor in Oral Medicine and Dean of the School of Dentistry at Cardiff University

BDA Armed Forces Group members, please book through your Regional HQ by 12 June 2015.

For Retired BDA Armed Forces Group members, please contact Fraser Sneddon:

fraser.sneddon582@mod.uk | 01491 827123

*Retired BDA Armed Forces Group members are those who have retired from the Defence Dental Services having accumulated at least 20 years of service, either in uniform and/or as a DDS Civilian Dental Practitioner (CDP).

Being nice avoids complaints

by Graeme Jackson, Editor

Most complaints reaching the Parliamentary Health Service Ombudsman (PHSO) fall into five broad categories: poor communication; poor attitude to patients; treatment; misdiagnoses; and dental charges.

"In fact, most complaints are a combination of the five and it is the way you then treat the patient that helps generate the complaint," dental advisor in the PHSO Philip Martin told *BDJ In Practice*.

"If something has gone wrong it is best to be honest and straightforward about it. It will help to resolve the problem if you explain," Martin, a general dental practitioner who owns two dental practices in Leicester, continued.

A dentist for 32 years, he has worked in the PHSO since 2010. There are two dental advisors within the PHSO and external advisors for specialities. But decisions are made by lay investigators with advice from the dental advisors not by the advisors themselves.

So, a key element in avoiding patient complaints is managing patient expectations. Here, following the guidance of the General Dental Council, explaining the risks and benefits of treatment, can help.

"But when doing this the dentist has to be aware of their tone of voice and their body language. It is not just the information you give them but how you present it," Philip Martin said.

"We need to give clear and concise explanations and avoid talking in dental jargon. If we use jargon it is easy for people just to sit there and look like they have understood."

Projecting the right attitude is important, too.

"Patients are far less likely to complain if the dentist comes across as sympathetic and approachable – if they like the dentist," Philip Martin said. "We find that patients are more likely to complain about a dentist they don't like, even if the dentist has done a good job.

"Extractions create a lot of issues especially around post-operative pain. Misdiagnoses are often a failure to take radiographs. Radiography does not seem to be done as often as it should be and it is not clear why.

"So, record-keeping is crucial. If asked by the PHSO, the dentist should be able to supply records that are clear and accurate and contemporaneous and it is useful if the dentist provides a typed transcript as well as a copy of any handwritten notes because the latter can be difficult to decipher sometimes. Also included should be radiographs and, for orthodontic cases, the models would be helpful."

Complaints about dental charges usually arise through misunderstanding between the patient and the practice. Solutions to these problems are improving the service to the patient and helping the profession to be interested in mentoring and developing colleagues. Changes to practice policies and procedures so similar issues can be avoided in the future help, too, Philip Martin believes.

"People have the right to complain to us under the NHS constitution if they have reached the end of the complaint process. So, for dentists, that would mean that they need to complain to the practice first. Or, if their complaint hasn't been sorted out after six months, they can complain to us," he explained.

PHSO dental advisor Philip Martin: be nice to patients and they will respond in kind and be nice to you back

"Around a fifth of the enquiries we receive are considered in detail. At this stage some complaints are resolved without the need for a formal investigation. For example, a practice might make an apology that resolves the issue to the complainant's satisfaction.

"We accept about two-thirds of these cases for investigation. When we launch a statutory investigation we look at all the facts, gather additional evidence from the complainant and practice concerned, and may ask for expert advice from our clinicians or legal team. Where there are indications of injustice aligned to fault or service failure, and if the injustice is still unremedied, we will investigate. Every complaint is different and, while our methods are consistent, the steps we take in an individual investigation will vary.

"Our investigations uphold, partially uphold or do not uphold complaints. We investigate 4000 complaints a year and uphold around 42%. Where we identify maladministration or service failure leading to an unremedied injustice, we make recommendations for the practice to put things right. Where we identify a wider problem, we make recommendations for the system to address the wider problem. We set a time frame for each recommendation we make to ensure that it is implemented."

Recommendations can include an apology from the practice to the complainant; a financial remedy; action plans to ensure mistakes are not repeated; staff training; and changes to policy and procedures.

"Avoiding complaints is about the way you treat your patients as people. Be nice to patients and they will respond in kind and be nice to you back. And the key to preventing and resolving complaints is attitude and about the tone of voice and body language. If you get that right, issues can be resolved internally and that goes for the whole dental team, from the receptionist through the dental care professionals to the dentists," Philip Martin concluded. ◆

Fighting your corner

Mick Armstrong, chair of the BDA Principal Executive Committee, sets out the agenda the BDA will be following during the new parliament's next five years

On 7 May I spoke to BDA members at our conference in Manchester. As millions of people headed out to vote in the general election, I outlined what we can do to rise to the challenge in the next parliament.

Many of the colleagues I spoke to that day – after weeks of relentless election campaigning – might have thought they missed the debate on dentistry. Well they didn't. Because there wasn't one. When politicians talked about health, they didn't mean oral health. When they banged on about "whole person care", that "whole person" didn't have teeth.

This means is we can no longer afford to be the quiet profession. Sitting back, on the fence or on the sidelines will not cut it. Politicians have been unresponsive to our issues so it's up to us to change. We need to get out there, set agendas and lead debates.

The BDA has always been in the business of change: whether it's offering practical support for your day-to-day struggles or trying to influence the political decision makers. In the next parliament, we will be even more politically active.

We are uniquely placed to do this. We can bring together the policy, the expertise, the evidence, and of course the people. Our member's experiences are invaluable. Thousands of professionals treating millions of patients. They give us a voice that must be heard.

We still face a professional regulator that has failed both patients and practitioners. I have already written to secretary of state for health Jeremy Hunt to remind him of this unfinished business.

Stress and anxiety is on the up – while job satisfaction is in decline. We want to tackle the root causes of stress in our profession, and make sure that those in need are supported.

Dental disease and deprivation still go hand in hand. The levels of disease in the UK's most impoverished communities are unacceptably high and urgent action is needed.

> "We can no longer afford to be the quiet profession. Sitting back, on the fence or on the sidelines will not cut it."

We know more about the state of the nation's oral health than we ever have. There is certainly no shortage of government spreadsheets describing it. But such *data* without *action* is just *trivia*.

The skills and technologies available to dentists have never been more sophisticated. But without a plan to unlock the true potential of these enormously potent resources this is science without progress.

We've already shown what we can do. We stopped a planned £200 pay cut for foundation dentists. We have put the General Dental Council under the spotlight: our campaign saw the dental regulator hauled in front of a Health Committee scrutiny hearing for the first time.

Now we have a new government, we must work to ensure that oral health isn't sidelined. We will be calling on the Westminster government, and its equivalents across the UK, to give oral health the status it deserves.

We are not asking for special pleading, just for dentistry to be part of the discussion, for government to listen to us and focus on the things that matter. Address the nation's addiction to sugar; tackle health inequalities; put prevention at the heart of policy – especially in contract reform; and, for the profession's and patients' sakes, fix dental regulation.

Our world is as it is. But it doesn't have to be. Whether it's shoddy regulation, contracts that aren't fit for purpose, low morale, or the lack of priority that's been given to oral health, we are determined to take a stand, and fight battles we can win.

The question now is not so much what does the future hold for UK dentistry, it's what do we want to do to shape it. Our members are what makes the BDA.

And what will continue to drive it in the five years of this parliament. ◆

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*2014 independent visitor research carried out by Serendipity Sales Solutions

Prototypes

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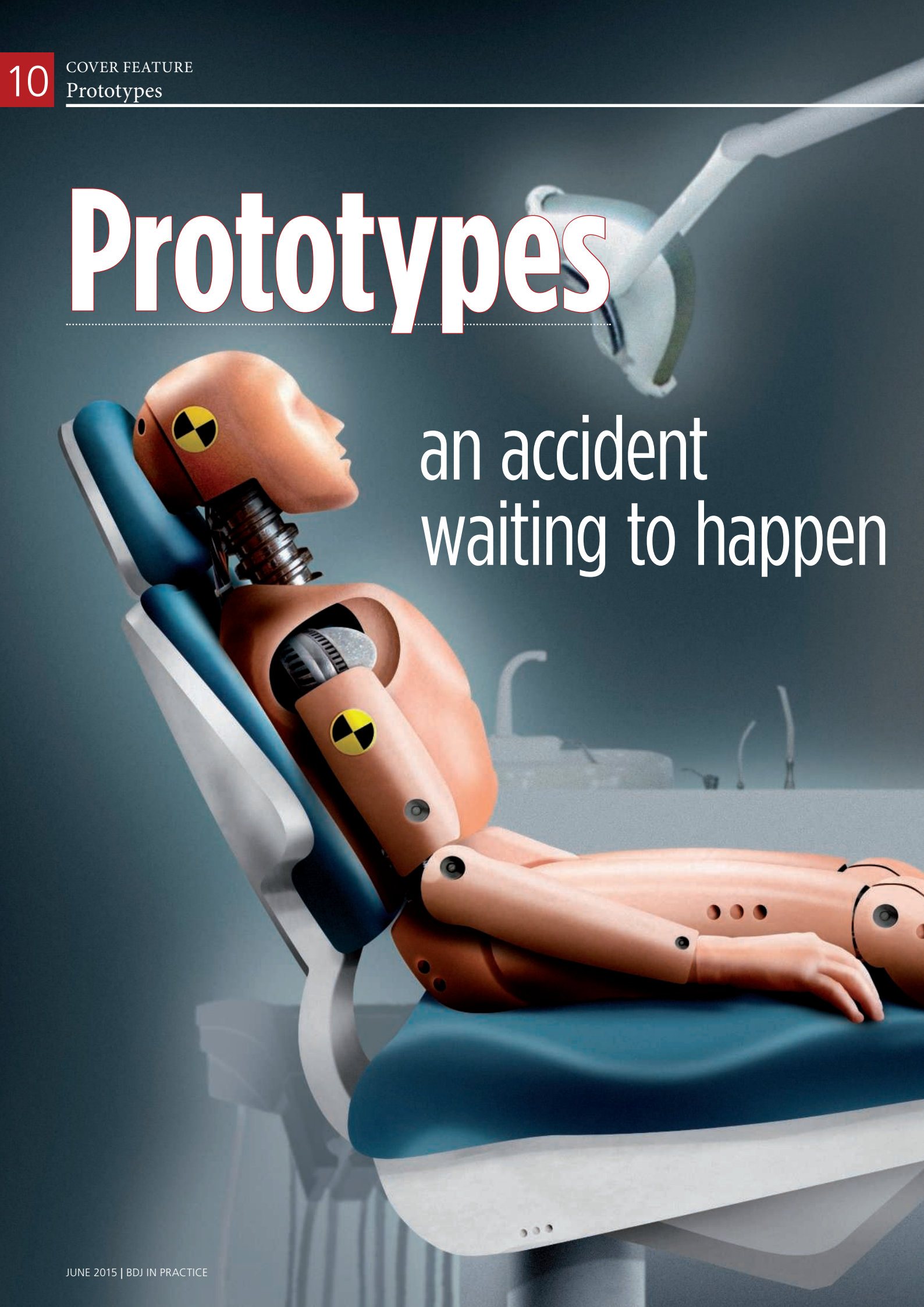


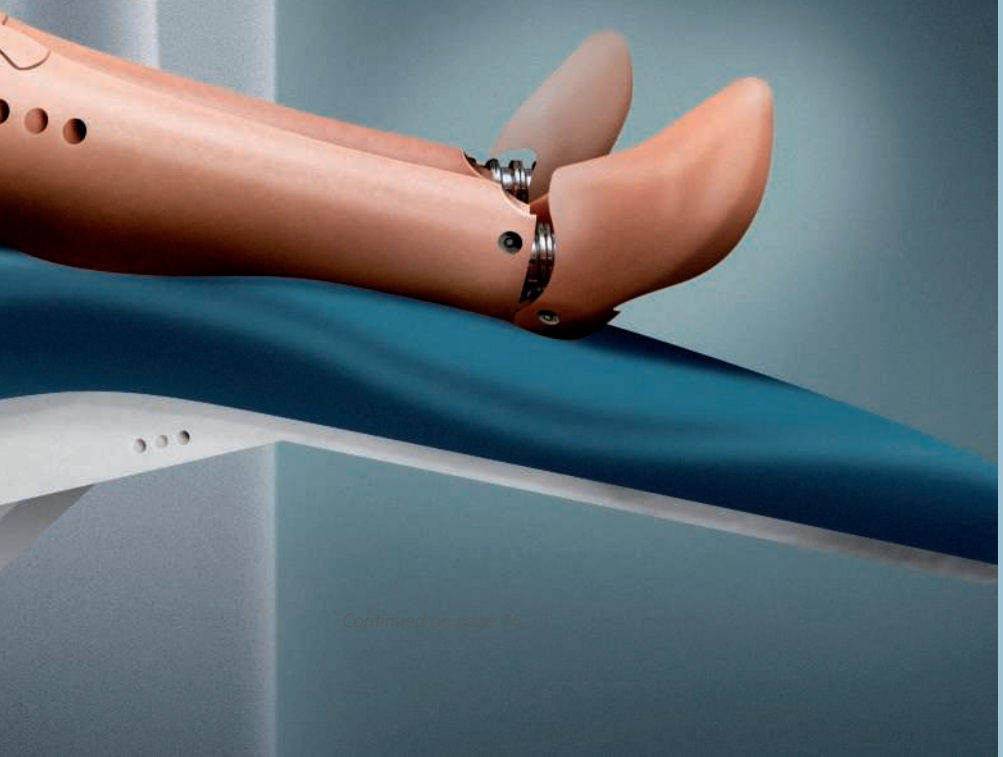
by Penny Whitehead, the Head of BDA Policy and Research

For the past six years the Department of Health in England has been developing a reformed contract for general dental practice based around a preventive-care pathway. The BDA has been very supportive of the move away from activity measures and has been active on behalf of dentists in seeking to shape the direction of contract reform. The project is now moving into a prototyping stage following four years of piloting. We expect that, if government ministers and NHS England are happy with the prototypes, the contract will begin to be rolled out gradually in 2018/19. It looks like the slow going will continue.

Prototypes – the current models

A relatively small number of prototypes will begin this September, made up of some of the existing pilots and some new practices. They will test two different remuneration models. In the Type-A prototypes, what is currently Band-1 care will be rewarded through capitation payments, with Band-2 and Band-3 activity paid by units of dental activity (UDAs) as currently. In the Type-B prototypes, Band-1 and Band-2 care will be paid by capitation, with only Band-3 work paid by UDAs. Additionally, in both models, 10% of the contract value is to be paid for a quality element. The BDA believes that the prototypes are unambitious and that the best model for patients and practices would be 100% capitation. Prototype practices will be assigned to Type A or Type B and we believe that those in Type B will have a much better experience, with its lower emphasis on the treadmill of UDA targets.

But if our our concerns are ignored, we could end up with a rolled-out contract based on the Type-A prototypes.



Continued on page 16

Financial pressures

We expect that a national tariff of capitation values that will take account of a patient's age, sex and postcode deprivation will be implemented. This will help to address the cost of looking after high-needs patients. But it is also likely to bring equalisation in contract values and that will mean that some practices with currently high UDA values will have to take on new patients to maintain income.

This is going to be very difficult if, at the same time, practices have to implement a new way of working within an inadequate timeframe. Most at risk will be practices with low turnover of patients in affluent areas with higher-than-average UDA values. The BDA will continue to push for a long transition period. To avoid system meltdown, it is vital that there is time allowed for these practices to expand. There must also be a minimum-income guarantee for these practices and any others who may be at risk in a new system.

> "The pilots have shown that practices using skill-mix find it easier to keep up their patient numbers. This does not necessarily mean replacing associates with dental therapists, although this has happened in some practices."

Presently, practices have to achieve 96% of their UDA targets to avoid financial clawback. Under the prototypes this tolerance is likely to be the same, but total clawback cannot be more than 20% of contract value. We do not yet know what the tolerances will be in the final version of the contract, but in any practice's first few years under new arrangements it would be much more likely that targets will not be met as practices get used to a new system, particularly one with three separate targets to juggle: patient numbers, UDAs and quality.

Skill-mix and practice investment

The pilots have shown that practices using skill-mix find it easier to keep up their patient numbers. This does not necessarily mean replacing associates with dental therapists, although this has happened in some practices. Elsewhere it has involved using extended duties dental nurses. This will have implications for dental practices that

are short on space. It will not be impossible for smaller practices to meet the new access, UDA and quality targets but it may mean developing or moving premises, working longer hours or working collaboratively with other colleagues. IT investment will be needed: a full clinical system, even if not a specific requirement of the contract, will make delivering the care in the specified manner much easier.

> "Patient numbers are to be measured at the end of the financial year. If UDA targets have not been met then, with commissioner agreement, practices will be able to mitigate the loss by taking on new patients."

While in some pilot practices, associates have continued to demonstrate their absolute value, one expectation is that with rising costs and greater use of dental care professionals (DCPs), associate pay will come under pressure, particularly in areas where there is no shortage of associates. There is currently 15% associate under-employment and this may increase. We may even see dentist unemployment.

New ways of working

The prototypes will continue to work within a care pathway based on prevention. Prevention can work for patient and practices, but providing it takes time. Many of the pilots have had to work longer hours to provide care to the extent needed while trying to maintain access. It is absolutely inevitable that the care-pathway approach will lead to a drop in conventional activity, particularly laboratory work in the first few years. As well as fulfilling activity targets, more time will have to be spent on prevention. The prototypes will be measured against compliance with the National Institute for Health and Care Excellence's (NICE) *Recall guidance* and *Delivering better oral health*. If this continues in the roll-out, practice management will become very much more complex.

The BDA wants roll-out to be gradual at the beginning so only a proportion of patients will be given an oral-health assessment with a gradual progression to 100% coverage, otherwise there could be a sudden and dramatic NHS-access problem.

Managing patient numbers

In England, just over 55% of the population will have received NHS general practice care in the past 24 months. This percentage fluctuates slightly but remains relatively constant. We expect registration to be re-introduced with capitation, although the registration period has not been defined.

In the prototypes, patient numbers are to be measured at the end of the financial year. If UDA targets have not been met then, with commissioner agreement, practices will be able to mitigate the loss by taking on new patients. Within a national system this is going to be hard, particularly in areas where it can be difficult to recruit patients. It would be much simpler if there were no UDAs and practices just had to maintain patient numbers.

Will there be contractual change?

The BDA is still completely committed to contract reform – we want to see the vision of Professor Steele's 2009 review of NHS dentistry brought into reality. But we are deeply concerned that the lack of ambition in the prototypes, and the continued reliance on distorting activity targets in particular, threaten our chances of seeing that vision realised. The Department of Health needs to appreciate the benefits that a population-based approach can bring, recognise that the preventive work involved in treating patients properly is genuine activity in itself, and have the courage to let go of the UDA. ◆

COMMENTARY

Prototypes: the unambitious and the unacceptable

by Henrik Overgaard-Nielsen,
chair of the BDA's General Dental Practice Committee (GDPC)

This year's BDA conference saw the authors of the *Independent review of the NHS dentistry in England* gather together to discuss the progress of contract reform.

"Progress" is, of course, a euphemism. Professor Jimmy Steele, Dr Janet Clarke and Dr Eric Rooney signed off their opus in 2009 and since then we have faced dither and delay. The authors' vision of a contract founded on prevention has remained unrealised, while NHS practitioners have remained saddled with a failed, target-driven system.

So it was timely to bring the old team together in Manchester, as pilots are finally moving on to prototypes.

Professor Steele is a consummate diplomat. He told conference that the Type-B prototype is "closest to the balanced approach" he and his co-authors set out back in the day. He wasn't exactly dropping a rhetorical bomb on the Department of Health, but he was providing much needed clarity on the two options going into the field.

We now have two blends moving into prototypes. One is unambitious, the other unacceptable. The Department of Health's unwillingness to let go of discredited activity targets will undermine both reform models, fatally in the case of Type A.

> "If government really wanted to put prevention at the heart of NHS dentistry we would be looking at prototypes based on 100% capitation."

If government really wanted to put prevention at the heart of NHS dentistry we would be looking at prototypes based on 100% capitation. That option may not be on the table, but the further we move from that goal, the more our patients and our profession will lose out. ◆

COMMENTARY

From pilot to prototype: not feeling a "seismic shift"

by Len D'Cruz,
a member of the BDA's Principal Executive Committee who runs an NHS pilot practice. The Department of Health launched the contract prototypes when then health minister Earl Howe visited his practice in Essex in March

I've been pretty clear about my views on the intended direction for prototypes, so I was a little surprised, but pleased, when the Department of Health chose my practice in which to make their announcement about which pilots would be moving forward in the reform programme.

I signed up as a pilot practice in September 2011, excited about the prospect of being part of something new that moved us away the treadmill of activity, as Jimmy Steele had envisioned. And, in the New Year, when I saw what was proposed for the prototypes, I was hugely disappointed. I felt that I had wasted three years piloting a contract purportedly based on prevention, just to end up back with UDAs.

Make no mistake, Earl Howe was a gracious guest. He was genuinely engaged as my staff showcased the software they have used day in day out to make these pilots work, to help patients through their care pathway and manage their oral health and we explained in detail how we felt the preventive message was getting through to patients. I made the point that all this takes time and going back to 10-minute check-ups was a huge mistake.

What I do take issue with is the Earl's claim that the prototypes on offer represent anything like a "seismic shift" in dentistry.

I was also given the opportunity to offer a few words in the Department's official statement, and I stand by them today. I signed up as a pilot because I wanted to move toward models of preventive care. It's an approach my team has fully embraced from the outset.

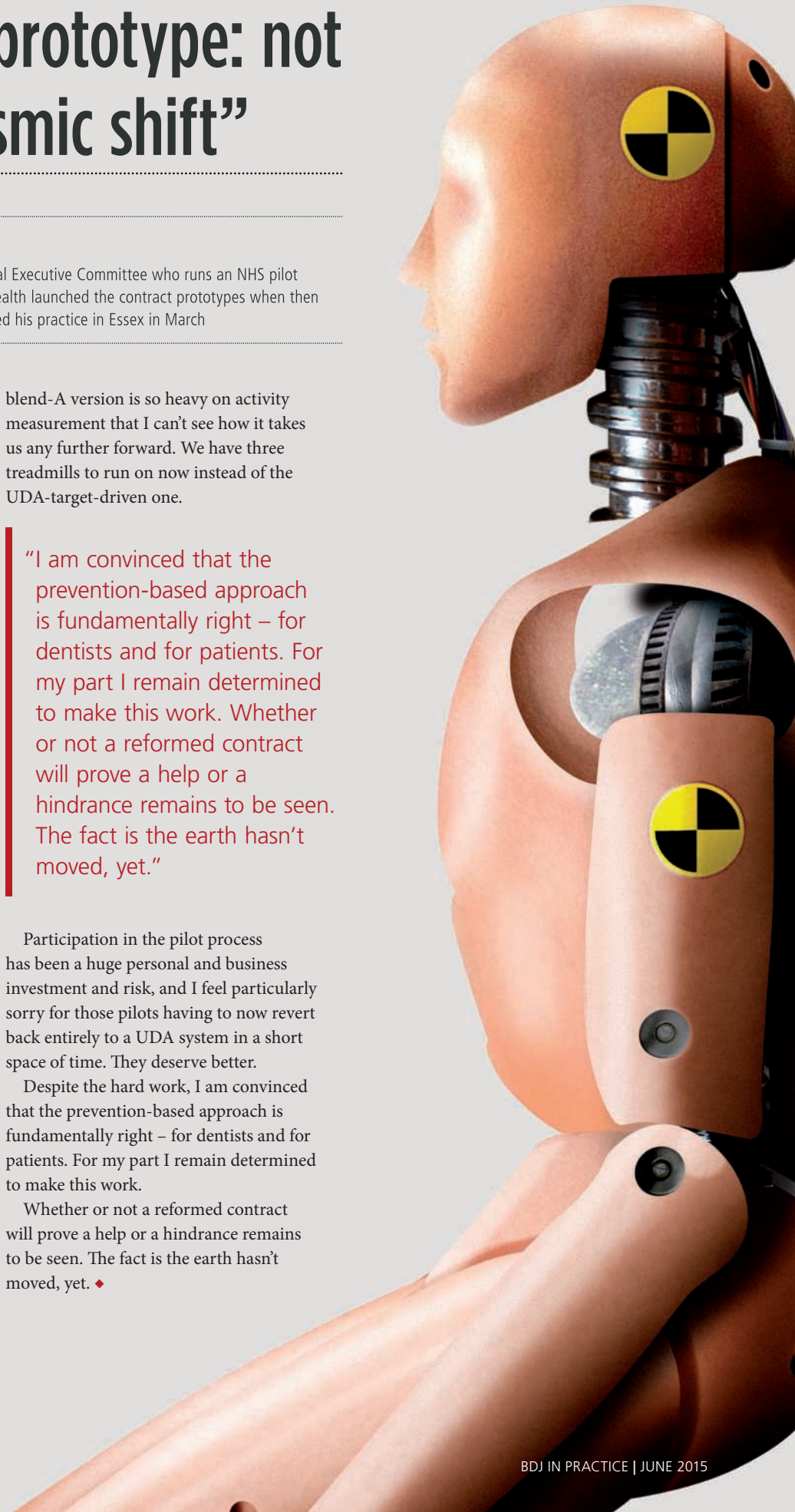
However, it is hard to see that being achieved through what is now proposed by the prototypes. In particular, the blend-A version is so heavy on activity measurement that I can't see how it takes us any further forward. We have three treadmills to run on now instead of the UDA-target-driven one.

> "I am convinced that the prevention-based approach is fundamentally right – for dentists and for patients. For my part I remain determined to make this work. Whether or not a reformed contract will prove a help or a hindrance remains to be seen. The fact is the earth hasn't moved, yet."

Participation in the pilot process has been a huge personal and business investment and risk, and I feel particularly sorry for those pilots having to now revert back entirely to a UDA system in a short space of time. They deserve better.

Despite the hard work, I am convinced that the prevention-based approach is fundamentally right – for dentists and for patients. For my part I remain determined to make this work.

Whether or not a reformed contract will prove a help or a hindrance remains to be seen. The fact is the earth hasn't moved, yet. ◆



How to challenge a rates-refund refusal

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

Many NHS practices in England have recently been refused refunds on their business (non-domestic) rates (**far right**). Dentists received letters from the Business Service Authority (BSA) telling them that their application for reimbursement, where they have paid their business rates by instalments, was out of date. But in many of those cases, it can be argued that NHS England and the BSA have been wrong in deciding that an application for a single reimbursement payment after the final instalment had been paid was made too late. Those who received such a letter may still be entitled to claim.

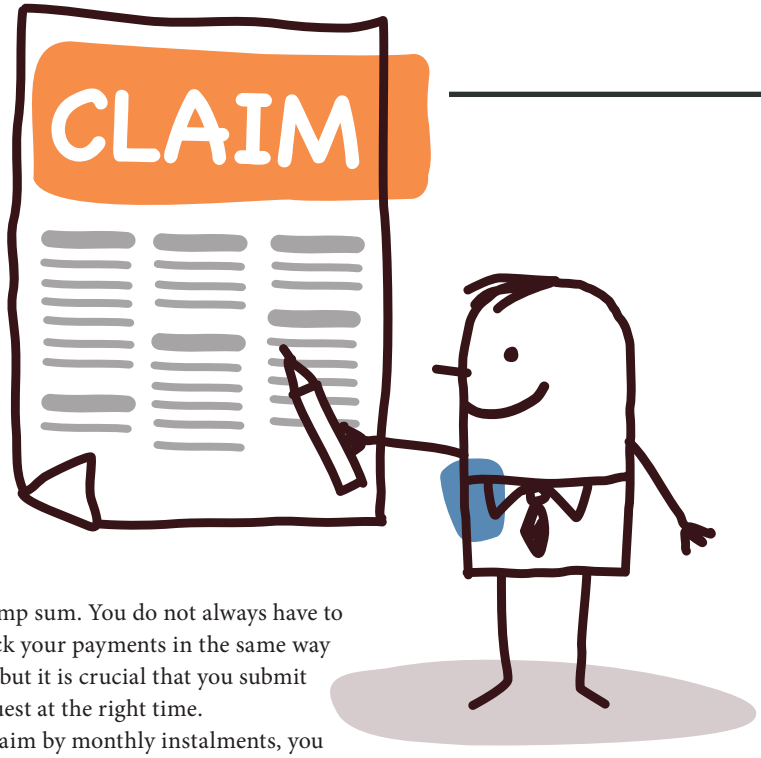
Your entitlement to reclaim

Dentists may be able to reclaim business rates paid for premises where services are provided under an NHS contract (**above**). Broadly speaking, the dentist claiming the reimbursement needs to: have formal rights in the property that can be inherited; and have provided NHS services there for a total annual value of £25,000 or more. The proportion of the payment that can be reimbursed depends on the proportion of the work attributed to NHS services.

The entitlement to reclaim non-domestic rates is included in the *Statement of financial entitlement* (*SFE*) for dentists. Those entitled to reclaim can do so in monthly instalments, two equal payments

How to reclaim

- Applications for reimbursement should be made on the *Application for Personal Payments under the Statement of Financial Entitlement* form. Download a copy from the BSA's website www.nhsbsa.nhs.uk
- Send the completed form to: NHS Dental Services, SFE Payments Team, PO Box 3179, Eastbourne, BN21 9PN. You must enclose any necessary documentation. This will usually be the Demand Notice from your local authority and a receipt from the local authority for the payment made. Where your business rates were paid in monthly instalments, details of the start date, end date, value of the monthly instalments and proof of the payment are needed.
- You will also need to present as a percentage the income generated by the NHS work for the whole practice premises for the last six months of the preceding financial year and you may be asked to provide evidence of this after the application. You will therefore need to ensure your practice accounts are prepared in good time.
- Separate applications need to be made for each business premises.



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or one lump sum. You do not always have to claim back your payments in the same way you paid but it is crucial that you submit your request at the right time.

To reclaim by monthly instalments, you need to have made your application to the BSA within three months of the date on which the *first* monthly payment fell due.

The option to seek reimbursement by two equal payments is appropriate where you have paid in two, normally, six-monthly payments. You should have made two applications – each within three months of the date on which the six-monthly payment fell due.

Reclaiming the full amount of your business rates in a single lump sum can arguably be done regardless of how you paid the initial rates. If you paid your rates in a single payment, you should have submitted your claim to the BSA within three months of the date on which that payment fell due. It is when you have not paid the rates in a lump sum that confusion has arisen at the BSA.

Properly understood, the *SFE* says that claims should be made within three months of the date the *full amount* fell due. So, where the rates were paid in two six-monthly payments, the claim should have been made within three months of the date the *second* payment fell due. Where the rates were paid in monthly instalments, the claim should have been within three months of the date the *final* instalment became due. The second approach is quite common practice but this is the scenario that has led to problems.

> "The proportion of the payment that can be reimbursed depends on the proportion of the work attributed to NHS services."

Some dentists have been refused reimbursement by the BSA, which has said that claims should have been submitted within three-months of paying the first instalment of rates. But this is not what the *SFE* says. So, if you have been refused reimbursement on this basis you can challenge this refusal. BDA Extra or Expert members can contact our NHS and Business Team for help at BusinessTeam@bda.org or on 020 7535 5864. ◆

Business rates

- Business rates are tax charges on properties used for non-domestic purposes. Often these are business premises but this is not a hard-and-fast rule.
- The charge is set nationally but collected by local authorities. Demands for business rates are usually sent out annually, often in April to coincide with the financial year. Business rates can be paid by monthly or six-monthly instalments or in a single payment.
- The amount due will be calculated by your local council according to the premises' rateable value set by the HM Revenue & Custom's Valuation Office Agency and the statutory multiplier set annually by central government.

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5 tips for time-efficient appraisals

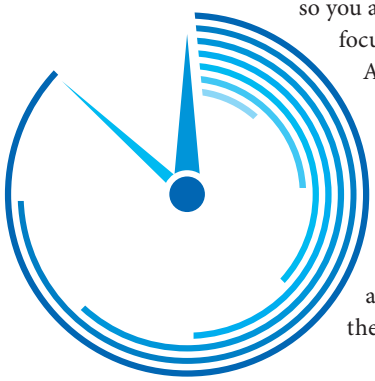
by Claire Bennett,
a practice management consultant in the BDA Practice Support Team. Claire advises general dental practitioners on associate contracts and a wide range of employment and other law

An appraisal meeting with an employee should help to establish and maintain open communications, which can improve employee motivation, efficiency and engagement. But preparation for such meetings is key to making the most of the time you should set aside for staff appraisals (www.bda.org/bdjinpracticeonline, *Appraisals can nip conflict in the bud*, March 2015, page 14). Getting ready for an annual round of appraisals with your team does not have to be overly complex or administratively burdensome.

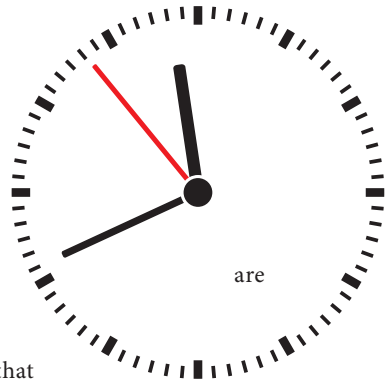
Follow five tips for getting everything organised: prepare time and space for the meeting to be undisturbed; encourage self-assessment by giving the employee a form to fill in; look back at previous appraisals, objectives and training; look forward to what you want to achieve; and plan the feedback you want to provide.

1 Be undisturbed

Meetings should not be rushed. You should ensure patient lists are cleared so you and the employee can fully focus on the appraisal. Adequate time should be blocked out in the diary to enable meaningful discussions to take place.



Where an appraisal takes place can be just as important in achieving an effective meeting as the time you invest. To encourage an employee to speak freely and openly, it is important that they believe they are being heard. Therefore, interruptions that distract you from the appraisal should be avoided.



> "Meetings should not be rushed. You should ensure patient lists are cleared so you and the employee can fully focus on the appraisal. Adequate time should be blocked out in the diary to enable meaningful discussions to take place."

Where possible, to help encourage dialogue, and not confrontation, furniture should be arranged side by side and objects that might be perceived as barriers, like desks or tables, removed.

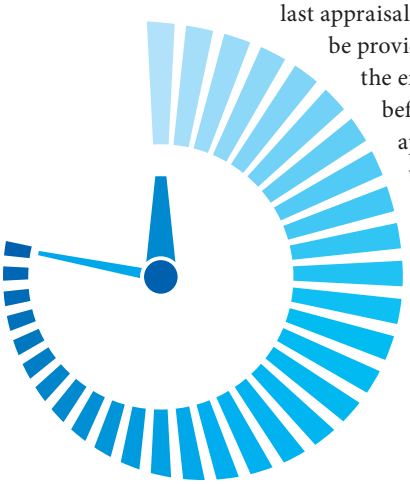
2 Encourage self-assessment

Employees should be given adequate notice of the meeting and time to prepare. Conducting appraisal meetings

represents an investment in the successful development of staff and thereby the successful development of your practice. Providing employees with a short self-assessment form before the appraisal can promote discussion.

The form should follow the planned format of your appraisal discussion. The employee might be asked to answer questions around: what they think they have done well during the year and what not so well; what they have enjoyed; what they are least satisfied with; and what training or interests that they think they need or want to pursue.

Other relevant documentation that may be referred to during the process, such as their job description or the results of their last appraisal, should be provided to the employee before the appraisal, too.



3 Look back

Look at the evidence of previous appraisals, objectives and training and consider, for example, if the employee has met their objectives since their last appraisal or if training has been completed successfully.

Good performance management involves communicating and aligning the objectives of your practice with the objectives of individual employees. It involves assessing competencies and identifying any development needs to help an employee realise their objectives and thereby the objectives of the practice. To ensure this is being achieved and performance is being measured fairly and accurately, you should consider job descriptions, records of one-to-one meetings, any comments made by colleagues or patients, and previous appraisal outcomes when preparing for an appraisal.

4 Look forward

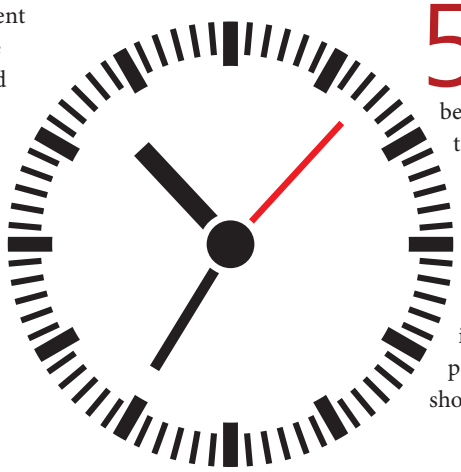
Think about what you want to achieve from the meeting on behalf of the practice. You may want to retain an able employee, encourage career development, acknowledge achievement, motivate a disengaged employee, reinforce good performance or seek improvement in performance.

You should decide what you are trying to achieve with each employee as an individual before the appraisal meeting. This will help you focus the discussion and avoid convoluted and unnecessarily protracted meetings. Such well-prepared meetings are also likely to yield the most effective results because objectives will be defined and any plans for personal development and how they will be achieved made clear.

> "You should decide what you are trying to achieve with each employee as an individual before the appraisal meeting. This will help you focus the discussion and avoid convoluted and unnecessarily protracted meetings."

Try to anticipate any issues that might be raised at the meeting and think about ways they could be resolved.

The employee might also be asked to consider these points as part of their self-assessment before the meeting.



5 Plan feedback

Know what you want to say beforehand. Think of the praise that you want to give and how to make sure it comes across sincerely. If you think criticism is justified in a particular case, it should be approached positively by looking at what went wrong and how that might be avoided in the future. If you think improvements in performance are needed, this should be addressed specifically within the meeting, with any thoughts you have had about how the issues may be resolved.

You may not be able to anticipate everything that could come up in the meeting. Be ready to alter your feedback in response to what your employee says.

Appraise to build trust

Throughout the performance-management process, and particularly at the appraisal meeting, it is important to remember that you are in a continuing relationship with the member of staff. The appraisal should develop this relationship and, hopefully, build trust.

BDA Advice, *Performance management*, is available to download at www.bda.org/appraisals. ◆

Key message

Appraisal meetings are an investment in the successful development of staff and thereby the successful development of your practice. Good performance management involves communicating and aligning the objectives of your practice with the objectives of individual employees. It involves assessing competencies and identifying any development needs to help an employee realise their objectives and thereby the objectives of the practice. You should decide what you are trying to achieve with each employee as an individual before the appraisal meeting. This will help you focus the discussion and avoid convoluted and unnecessarily protracted meetings.

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Image of counterfeit products confiscated by the MHRA.

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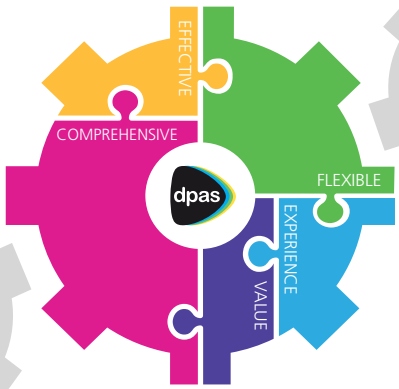

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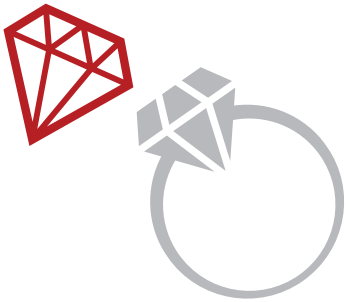
To find your diamond in the rough

by Luke Arnold

Luke has more than 10 years' experience working in the recruitment sector, most recently within the dental industry as recruitment manager at Dental Elite (www.dentalelite.co.uk)



The success of any business is predicated on the quality of the staff and colleagues working there. As a business owner you will be acutely aware that no matter how hard you try, you can't do everything yourself, and so you rely on the work and dedication of your team.

If you're lucky, you will already have a committed, professional workforce that is loyal and will stay with you for the foreseeable future. However, such good fortune is rare and, at some point, it is more than likely you will have to spend time recruiting and training new members of your practice team.

The process of recruitment can seem like an overwhelming and daunting endeavour. To begin with you will need to advertise the position and then, once the applications come flooding in, you will have to sort through the plethora of candidates' CVs, searching for that ever-elusive *diamond in the rough*.

At first the sheer volume of applications can make this seem like an impossible task. What's more, knowing what to look out for and being able to detect the warning signs takes some practice, and without experience in this field it can be all too easy to let an unsuitable candidate slip through the net and clog up your already busy schedule with an unnecessary interview.

The first things to look for in a CV are presentation, consistency and attention to detail. Although all the positions for which you are likely to be recruiting will not need perfect levels of spelling and grammar, typographical errors and simple and easily avoidable grammatical and spelling mistakes can be the first warning signs of someone who perhaps rushes through things and does not spend the time needed to check for quality.

Secondly, succinctness is important. If a candidate cannot sell themselves to you in fewer than two pages, this should set alarm bells ringing. Any applicant who keeps their CV brief but full of detail is showing a far greater respect for your time – acknowledging the fact that you may face many CVs to go through, and showing an awareness of the demands of your position.

When looking through applications keep a keen eye out for any unexplained periods of unemployment or gaps in work history. The lack of an explanation can often be revealing because it suggests some reluctance to divulge the information. However, you should also be aware that there can be many justifiable reasons for this and so should make a note to ask about any such periods if the candidate gets to the interview stage.

Preparing for the interview

By thoroughly going through each candidate's CV, you will ensure that only the most suitable are invited to interview and when it comes to that stage you will also have been able to prepare some specific questions to ask about their previous jobs, education, training and personal interests. Indeed, it is important to arm yourself with such avenues of inquiry to make sure that any decisions that are eventually made are based on all necessary and appropriate information.

It is also crucial to have a set of more generic questions to ask each interviewee. This will help ensure a level playing-field, guaranteeing every candidate is given the same chance to respond to each question. It helps differentiate between applicants because each can provide their own unique answers.

When interviewing for a dentist, your questions should be aimed at creating a clear idea of their professional approach and helping to see how you would work alongside each other. For example, asking them to describe their style of dentistry will help to shed some light on their clinical approach. It is a good idea to ask about any special interests they might have, and where they are at in their personal development.

It would also be pertinent to ask about their views on the current healthcare system: for example, how they feel about units of dental activity (UDAs) and the contrasts between NHS and private treatment. Do they think that the profession is overburdened by regulation and legislation? By asking such questions you will quickly see if a candidate will be a compatible match for your practice.

For interviews with non-dentist practice-staff members a similar approach to interview questions will be beneficial. Although perhaps less detail is needed on describing their clinical approach and special interests, more time should be spent on looking into their interpersonal patient skills. Questions should include: how they would feel when someone complains and what their approach would be to a nervous patient.

Whomever you are interviewing, it always pays to have a killer question up your sleeve. This can be anything that asks something that the candidate was not expecting. For example, you could ask a dentist: Do you see yourself as an employer or employee? Or you could ask a practice member if they consider themselves to be a natural leader or a born follower. Bear in mind that there is not necessarily a right or wrong answer, only that the responses will tell you how the candidate thinks on their feet. ◆

Use 5 Bs to get your practice seen and remembered

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

A business' shop front gives potential customers subliminal messages. Based on what they see, they will instantly judge, rightly or wrongly, what service or product it sells. They will gauge if the business is professional, clean, inviting, modern, state of the art, traditional, outdated, rundown, and expensive. They may even think it is closed or abandoned.

So, your practice's "shop front" is an integral part of how your business promotes itself. It is a platform to showcase who you are, what you offer and why you may be better than the competition.

Consumer decisions are heavily influenced by the visual packaging of goods or services, according to a study by researchers R Blythe Towal, Milica Mormann and Christof Koch, *Simultaneous modeling of visual saliency and value computation improves predictions of economic choice*, published by the American *Proceedings of the National Academy of Science*. The authors said: "Perceptual processes happen in the brain in parallel with economic value computations and thus influence how economic decisions are made."

The exterior of your practice is how you package your service. It is clear your shop front needs to make an impact.

> "A good shop front will tell passers-by what the business sells without them having to come in. It should be clear and concise. The use of dental-related logos and images can help."

Be good not bad nor ugly

A good shop front will tell passers-by what the business sells without them having to come in. It should be clear and concise. The use of dental-related logos and images can help. Make your shop front charming and decorative, so your practice will be the first image that springs to mind when a potential patient thinks they need to see a dentist. In short, it needs to be eye-catching (**opposite page**).

Avoid clutter. You want to aim for conciseness. Someone passing by in a car may have only seconds to grasp what you do. Too many things to look at will distract the brain from getting to the point. It could be a lost opportunity. Too much clutter can also suggest to a potential patient that your business is disorganised.

Have a consistent colour scheme across signage and paintwork. A recent feature in *Business Insider* (*How brands use the psychology of color to manipulate you*) discussing research by UK-based, business colour-and-branding expert Karen Haller emphasised the power colour has when used in branding. It was suggested that

black and gold is perceived to be exclusive and glamorous; red to be passionate; blue, calm and logical; and purple, luxurious.

Most of us can remember walking past a shop because the windows were dirty, letters were missing from its sign or a crack in the glass had not been repaired. There will be times we chose one shop over another because of the paint colour. There will even be times when we had no idea from the name or window display what a particular shop sold.

Do not allow dirt to build on the ledges or windows. Stop weeds from growing around the edges. Show passers-by that you have pride in your business. If the outside of your practice does not demonstrate this, a patient might lack confidence in the quality and standard of what you provide inside.

Think about letter sizing. Some people do not wear glasses even when prescribed. Is your sign visible? Does it stand out from the background? A good shop front will address these issues. When selecting the size of letters to use, a handy rule of thumb is to multiply the letter height by 10 to get the best viewing distance in feet. Then multiply the best viewing distance by 4 to get the maximum viewing distance. Choose an appropriate font. Different fonts convey different impressions: tradition, modernity, friendliness or precision. Have clear lettering: you do not want a font that makes a letter or word ambiguous.

Check out regulations

When making changes to your shop front, you may need to get planning permission. Government guidelines *Outdoor advertisements and signs: a guide for advertisers* details the types of signs and displays that are allowed automatically and when, on the other hand, you need to get planning permission. As well as consulting the guidance, you should talk to your local planning office to see if there are any local requirements.

If you are an NHS practice then you will want to publicise this, but the use of the NHS logo is covered by strict rules that must be followed. Check the published *NHS brand guidelines – dentists* for information on how you can incorporate NHS branding into your practice frontage (or other advertising materials).

Be eye-catching

Be visible – use a large-logo sign, display information at eye-level, keep the frontage clean and well-lit

Be welcoming – consider your colour scheme, doorway and ensure the frontage is well-maintained

Be informative – quickly say what you are, provide details of services offered, opening hours and contact details

Be inspirational – highlight the professional care taken and outcomes achieved

Be a good neighbour – if possible co-operate with other local businesses or a council town-centre manager to ensure the whole area is attractive for shoppers. If you are in a residential area make sure that you fit in with the neighbourhood

Some councils will have set aside funding for local town-centre improvements. This can include grants to help you improve the look of your shop front. So, contact your local council to see what help may be available.

Say come on in

A shop front provides you with a chance to capture the attention of potential patients. It is a way to advertise your services without the cost and time involved in other promotional activities. It is your platform from which to shout and allows you to tell the local population that you exist. It tells them they can access dental services by walking through your door. ◆

New conscious sedation rules

by Daniel McAlonan

Daniel, a Chartered Safety & Health Practitioner, is a health and safety adviser, helping members on all aspects of health & safety law, infection-control requirements, practice inspections and compliance with professional regulations

New standards for those who practise conscious sedation techniques have been published by the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD). These *Standards for conscious sedation in the provision of dental care* apply to dentists, doctors, nurses and dental care professionals. They replace several previously published advisory documents on conscious sedation including those issued by the Scottish Dental Clinical Effectiveness Programme. And to help implement national standards in conscious sedation a new quality-assurance programme has been produced by an educational charity, the Society for the Advancement of Anaesthesia in Dentistry (SAAD).

When to use this sedation

The reply "dentists" is often given by people asked to describe their biggest fears and phobias (*Dental phobia still rife throughout the population*, British Dental Health Foundation, 2014). This perceived fear of the dentist on a population level is difficult to change but on an individual level dentists can do much to control their patients' anxieties about having dental treatment.

> "Where anxiety cannot be adequately controlled through behavioural techniques the use of conscious sedation techniques have had a great deal of success."

A *BDJ* article, *The management of dental anxiety: time for a sense of proportion* (**213:** 6, 22 September 2012), recommended techniques for the assessment and proportional management of dental anxiety.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For most patients with varying degrees of dental anxiety, behavioural-management techniques with a show of compassion, understanding, empathy and careful placement of local anaesthesia can be enough to control patient anxieties, alleviate fears and to allow treatment to be performed successfully. Where anxiety cannot be adequately controlled through behavioural techniques – so treatment would be unacceptable for the patient and impossible to achieve – the use of conscious sedation techniques have had a great deal of success.

Useful tool for phobic patients

Conscious sedation is a valuable, safe and effective tool for patients for whom treatment would be close to impossible and who may avoid the dentist because of their anxiety. The demand and need for conscious sedation techniques has increased in general practice and community dentistry, a trend identified by the 2003 Department of Health report *Conscious sedation in the provision of dental care*. In large part, this followed the requirement by the Department of Health's 2000 guidance, *A conscious decision*, that general anaesthesia may only be administered in hospitals that have critical-care facilities.

> "The first section of the new standards provides core information about options for care, preparation for sedation, the clinical environment and the composition of the clinical team required for each conscious sedation technique."

Forum for collaboration

Where conscious sedation is used it is essential it is provided to the highest possible standards. The IACSD defines standards for the provision of conscious sedation in dentistry in the UK. Established in May 2010, the IACSD is a forum for collaboration among the Faculty of General Dental Practice (UK), the Faculty of Dental Surgery of the Royal College of Surgeons of England, the Royal College of Anaesthetists, the Dental Faculties of the Royal College of Surgeons of Edinburgh, the Royal College of Physicians and Surgeons of Glasgow, and the Royal College of Surgeons in Ireland.

Though superseding earlier documents, *Standards for conscious sedation in the provision of dental care* should still be read in conjunction with *Safe sedation practice for healthcare procedures*, which was published by the Academy of Medical Royal Colleges in October 2013, and *Sedation in children and young people*, published by the National Institute for Health and Care Excellence (NICE) in December 2010.

Education and training

IACSD advocates that high-quality care can only be achieved through education and training to defined standards and by ensuring that the environment in which care is delivered meets similarly defined standards.

So, the first section of the new standards provides core information about options for care, preparation for sedation, the clinical environment and the composition of the clinical team required for each conscious sedation technique. The essential principles of safe sedation practice for each sedation technique are described with guidance on peri-operative care, clinical governance and audit. Care pathways, clinical sedation techniques, peri-operative care, patient information, education and training are discussed in more detail. Examples of patient information that can be given to patients or their parents and carers are also provided.

The programmes to be covered in the education and training of the dental team are described in Appendix 1 of the standards. For dentists, these cover basic conscious-sedation techniques for children, young people and adults; advanced conscious sedation for young people and adults; and advanced conscious sedation for children. A syllabus for dental nurses wanting to assist during conscious sedation has also been provided. There is also a syllabus for dental hygienists and therapists involved in inhalation sedation.

The IACSD advises that no healthcare professional should provide conscious sedation without first having satisfactorily completed the training described in the standards. There may, however, be experienced practitioners currently providing conscious sedation in dentistry who have not undergone such training. To maintain such a service for patients, IACSD has set out "grandfathering" arrangements so they can continue to provide conscious-sedation services, provided they comply with the guidance laid down in the standards.

The IACSD standards and accompanying guidance from NICE, the Academy of Medical Royal Colleges and SAAD can be accessed through the BDA website at www.bda.org/sedation ◆

Definition

Conscious sedation is defined by the IACSD's *Standards for conscious sedation in the provision of dental care* as: "A technique in which the use of a drug or drugs produces a state of depression of the central nervous system enabling treatment to be carried out, but during which verbal contact with the patient is maintained throughout the period of sedation. The drugs and techniques used to provide conscious sedation for dental treatment should carry a margin of safety wide enough to render loss of consciousness unlikely."

Creating a strife-free partnership

by James Goldman, the Head of Employment and General Practice Advice at the BDA. James trained as a barrister and advises general dental practitioners on a wide range of legal and practice-management issues

Being in a business partnership means you cannot do what you want all the time: you have to persuade your partner or partners to agree with you. It also means you have others off whom to bounce ideas and to stop you doing something ill-advised. So, while decision-making in a partnership is more difficult than if you are on your own, it is also a little safer.

Have shared objectives

It helps if the partners are all heading in the same direction. Decisions are easier to make if you have a set of shared aims and values. It is easy to see how problems can arise if one partner wants to invest in the practice and modernise it while another wants to cut costs and save money. Partners should, therefore, regularly discuss their aims and values and where they want to take the practice. If these can be agreed, then decisions should follow relatively easily.

Written agreement crucial

A written partnership agreement is a crucial element in the relationship among partners. Although it will not set out the aims and values of the business, it should set out who has authority to spend money. It may place limits on how much individual partners can spend or specify how much can be spent following a decision by the majority of the partners. It may have provisions on dispute resolution. The partnership agreement may, in some cases, contain the answer to a disagreement.

Talk through disagreements

Where partners do not agree, they should sit down and discuss their respective points of view and listen carefully to each other. Disagreements are likely to be caused by different outlooks, different business aims, differing information on how things are running at the moment, or differing interpretations on how things are going. Any of these can create interpersonal problems. In all but the most severe of cases, these problems should be resolvable.

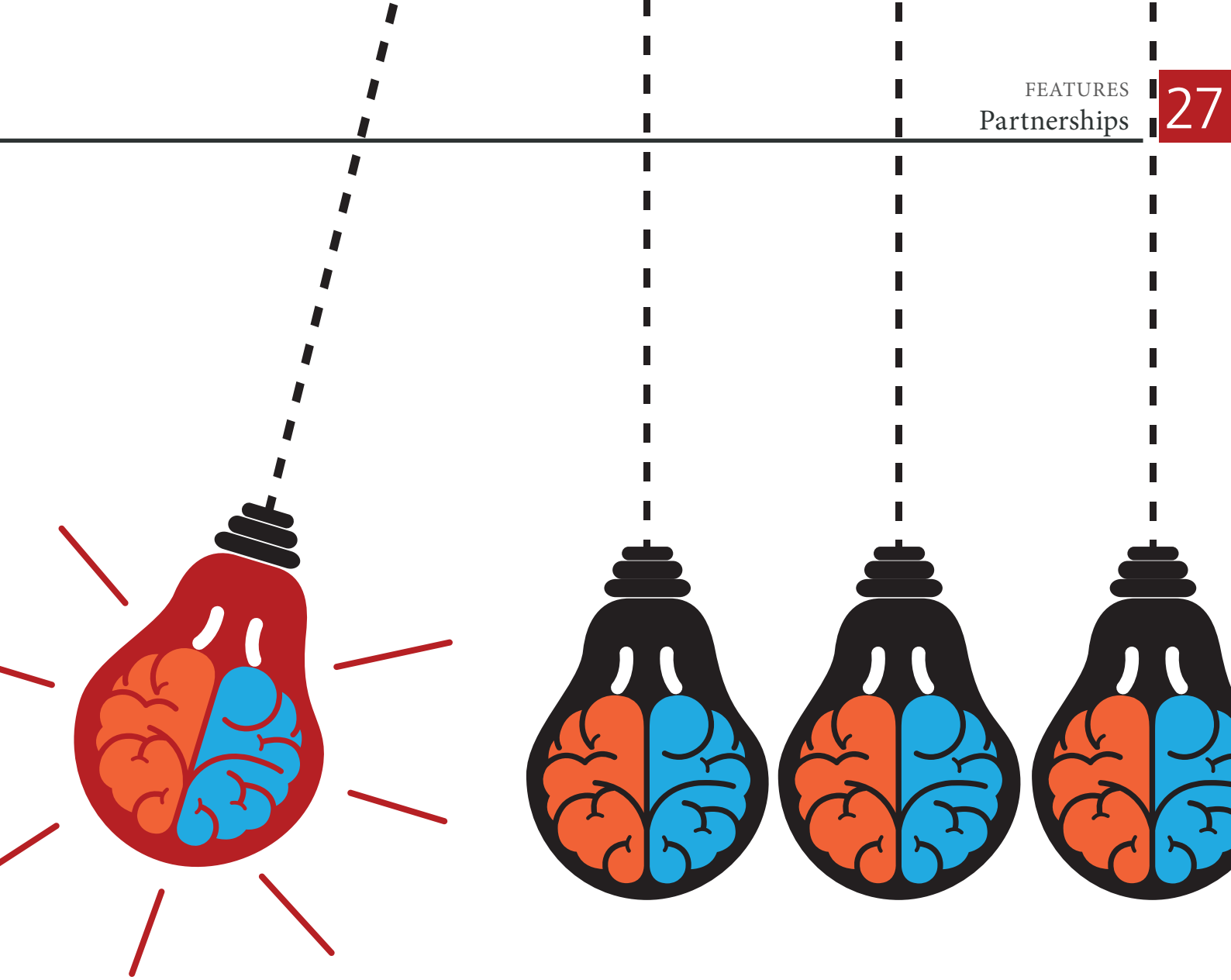
The first step is to determine the cause of the dispute. This can be easily achieved if the partners listen to, and question, each other with a view to understanding the others' points of view. Each partner must not seek to explain their opinion but try to understand the other partner's viewpoint.

It is not easy to reconcile different business values and aims: for example, one might want to concentrate on an established patient list and another to expand and hire associates. But even in such apparently irreconcilable circumstances there is likely to be a lot in common among the partners' views, not least having satisfied patients. It may just be a question of timing. One partner does not want to invest in a new computer system *at that time* while another does. The reluctant partner may have personal financial commitments (say, childcare costs) so the proponent partner could agree to delay the introduction of the new system for a specific period of time.

> "If you do not agree with a partner's suggestions ensure you understand how they feel about it. It is not in a partnership's business interests to have an unhappy business partner because an unhappy partner will not function as profitably as they could, which might lead to a dissolution of the partnership."

Beware of presumptions

Sometimes partners will disagree because they have differing information. One partner may believe that one dental chair supplier offers great value for money: another may have heard negative comments about the supplier from other dentists. This information should be shared and evaluated. Find out if the negative comments are credible and can be substantiated. And look at the source of the information about it being good value for money: is this the supplier or a reputable



third party? Also look at alternative products or suppliers.

Consider neutral experts

Some differences of opinion, for example the interpretation of new regulations, should be easy to resolve. Partners may disagree on how to comply with the latest guidance on cross-infection control. That question can be resolved by taking advice from, for example, the BDA.

Negotiate trade-offs

Sometimes the partners may be able to negotiate a trade-off solution to their difference. One partner may be willing to agree to a new computer system if another partner agrees to have the reception area redecorated. They may be able to agree a rolling plan for when different upgrades or improvements should be done.

Deadlock means status quo

Practices may, nevertheless, find themselves unable to agree, especially where there is an even number of partners: any vote may lead to deadlock. This would result in no change, which could be what one side wants.

But being resentful if your proposal does not convince the others is a good way to take the business relationship into a nosedive – and potentially a messy and expensive "divorce".

If you do not agree with a partner's suggestions ensure you understand how they feel about it. It is not in a partnership's business interests to have an unhappy business partner because an unhappy partner will not function as profitably as they could, which might lead to a dissolution of the partnership.

Where there are three, or another uneven number of partners, who regularly outvote one, while legally sound, this can be unsettling. Review the decisions that have been made. If one partner is becoming isolated, discuss this and think of ways to ensure they are fully integrated into the way things are run.

It could be that one of the partners is disagreeing mainly because they do not like one or more of the other partners. These interpersonal issues need to be resolved as soon as possible. Left unchecked, they usually lead to extremely expensive litigation that leaves everyone worse off.

Mediation can help

Where partners cannot agree, some form of mediation may help. Often, a third party can help the partners understand the root cause of the disagreement and this often leads to a solution.

Sometimes disputes among partners can run deep and professional mediation may be necessary to help them resolve their problems. Professional mediation will certainly be cheaper than ending the partnership. The BDA provides mediation to its members in the Expert tier of membership and has an established track record of helping partners resolve their differences: contact practicesupport@bda.org ◆

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1 Page RC, Kornman KS. Periodontology 2000 1997; 14: 9-11
2 Kinane DF, Attstrom R. J Clin Periodontol 2005; 32(Suppl.6): 130-1
3 Bleeding Index Reduction DOF 1 – 2013 (LAEBBA0001), 50.9% Reduction in whole-mouth mean Bleeding Index at 4 weeks

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Visit http://www.listerineprofessional.co.uk/cpd-educational-programme to earn verifiable hours from our expanding library, including our newest pieces on: the challenge of dental anxiety; gum health: a systematic review update; and meeting the oral health need of an ageing population. Upon completing each module successfully, we will send you a CPD certificate by email within 14 days.

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Email: referral@woodboroughhouse.com

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

253003

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www.aspectsdental.com

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

257244

KAIZEN DENTAL IMPLANTS CENTRE
www.kaizendentalimplants.co.uk

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

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258516

North

THE YORKSHIRE CLINIC
www.mydentalspecialist.co.uk

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

261782

IVORY DENTAL PRACTICE
www.ivory-dental.co.uk

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

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

255221

South West

THE CIRCUS DENTAL PRACTICE
www.circusdentalpractice.co.uk

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

239371

North West

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

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

261006

DEVONSHIRE HOUSE

www.devonshirehousedental.co.uk

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

Specialist Referral and Education Centre

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

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

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

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

Specialist Periodontist:
Trisha Whitehead

Specialist Orthodontist:
Dirk Bister

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254718

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www.grantadental.co.uk

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

237823

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Managing the temporomandibular joint and facial pain
Nayeem Ali, Consultant Oral and Maxillofacial Surgeon, Barts Health NHS Trust

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Koula Asimakopoulou, Senior Lecturer in Health Psychology, King's College London

The GDC Fitness to Practice process
Aubrey Craig, Head of Dental Division and Dental Adviser, MDDUS

Oral medicine
Alexander Crighton, Honorary Clinical Senior Lecturer, Glasgow Dental School

The composite Dahl approach and beyond
Jeremy Rees, Consultant Restorative Dentist, Cardiff Dental School

Food, drink and erosion: a field guide for clinicians and parents
Jeremy Rees, Consultant Restorative Dentist, Cardiff Dental School

Managing and resolving conflict in the team
Sheila Scott, Business Consultant

Early detection of oral cancer: how the dental team can make the difference and save lives
Simon Whitley, Consultant Oral and Maxillofacial Surgeon, Barts Health NHS Trust

CV Clinic (new for 2015)
At this year's event we are offering a unique opportunity for you to have one on one advice to gain guidance on how to present yourself on paper within your chosen career path.

Early bird prices:		
BDA members	Non-members	DCPs/VDPs/GPTs/ Senior members
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Business skills CPD

Q1: Subject to complying with three conditions, practices can now allow patients to pay for their treatments in how many instalments without needing authorisation from the Financial Conduct Authority?

A Up to four
B Up to six
C Up to ten
D Up to 12

Q2: Which of the following is *not* one of the five broad categories into which complaints to the Parliamentary Health Service Ombudsman fall?

A Poor attitude by staff
B Misdiagnoses
C Practice cleanliness
D Dental charges

Q3: What is the minimum total annual value of NHS services that a dentist needs to have provided before they may be entitled to reclaim business rates for the premises in which the services were provided?

A £15,000
B £25,000
C £30,000
D £50,000

Q4: How long should a job-applicant's CV be?

A Fewer than two pages
B Fewer than three pages
C Fewer than four pages
D As long as it takes for them to give full details of their career

Q5: According to a colour and branding expert, which of the following perceptions of colour is true?

A Black and gold is perceived to be passionate
B Red is perceived to be luxurious
C Blue is perceived to be logical
D Purple is perceived to be exclusive

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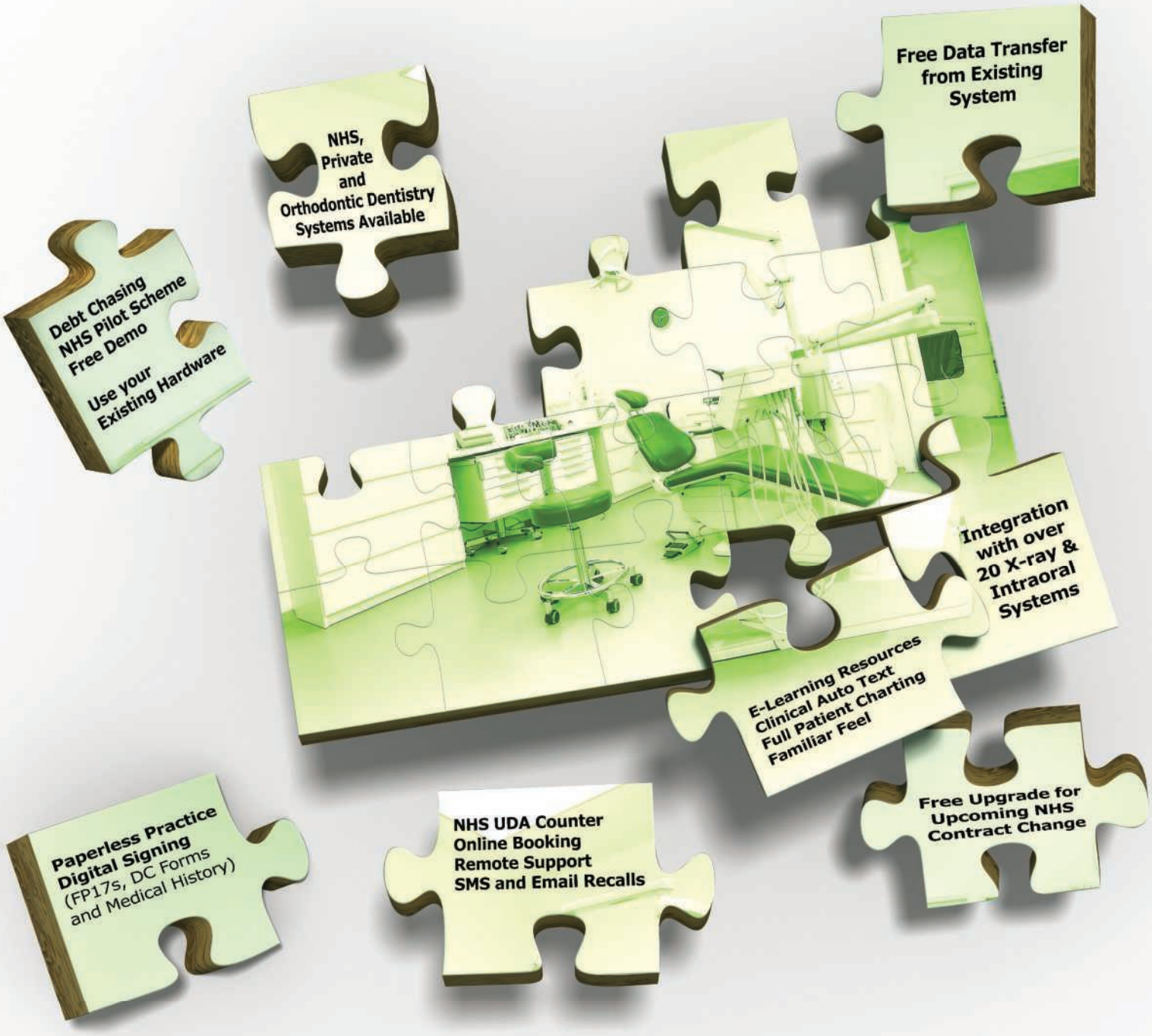

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