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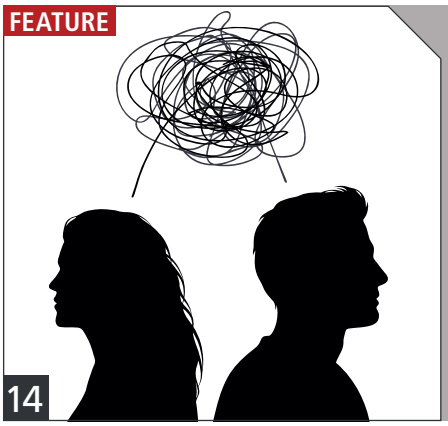

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COLUMN

Looking back at Conference

By Mick Armstrong

Bad contracts and shameful health inequalities.

At conference Health Minister Alistair Burt name-checked all the right issues. What his speech was missing was what the Department intends to do about them.

Successive governments have often forgotten that dentists are even part of the health system. So it falls to us to show Ministers consequences of their casual disregard, in the huge variation in oral health across the UK and the growing numbers of children lining up for tooth extractions in our hospitals.

While Scotland and Wales have dedicated national preventive programmes that are already making headway in the fight against childhood caries, we heard that England is set to get 10 new pilot schemes.

We can only welcome effort to target areas of high deprivation, but it looks like these areas will not be recipients of new money. So recycling rather than investment is to remain the order of the day.

As I told delegates in Manchester governments like to talk about prevention. What we've not seen is real commitment on oral health, backed up by a coherent strategy and dedicated funding. Gestures delivered through top slicing existing budgets do not quite cut it. It is clear that the NHS monolith, and local commissioners in particular, do not understand that dentistry is a vital part of primary care, something that our patients and the public do understand. Ministers need to get their own house in order, and ensure proper full commissioning of dentistry.

If you're going to talk prevention – and I've never met a health minister who doesn't – you have to put your money where your mouth is.

Prevention is of course a word that means something to every dentist. And it's the principle we are applying not just to our patients, but to this profession.

For me it means addressing problems before they rear their ugly heads. Get it right, and it means your patient requires less invasive treatment.

I look at this profession, the assaults we've been under in recent years, and the toll that's been taken on many of the colleagues I met in Manchester, and I'm clear the BDA cannot simply offer sticking plasters.

We're committed to helping colleagues who are increasingly feeling the pressure and under stress. And I know their interests are best served by tackling root causes, be it failed contracts or overweening regulators.

> 'We can only welcome effort to target areas of high deprivation, but it looks like these areas will not be recipients of new money'

Yes, we will always be there to help you deal with the symptoms. But at the BDA our objective is to stop bad decisions or bad regulations in their tracks, before the pain is felt by colleagues.

On amalgam we've played a long game, and won a supposedly unwinnable fight, derailing an unworkable blanket ban that could have caused chaos.

Emerging challenges mean we have to work together, across the profession, with our sister associations and health campaigners, at local, national and global level.

Already we've shown what we can do. The sugar levy saw a debate kick started by this profession win the day. Whether it's on oral cancer, the next NHS IT project they dream up or the coming fight over bursaries our goal is to confront problems before they are felt at the chairside.

We don't know what's round the next corner. But the best way to meet new challenges is with strength.

We will speak up for dentists, work alongside our healthcare colleagues, and stand up for our patients. And we will remind Ministers why they cannot treat this profession as a sideshow. ◆

NEWS FROM THE BDA

BDA responds to appointment of new GDC Chief Executive

The BDA has responded to news that Ian Brack has been appointed as the new Chief Executive at the General Dental Council (GDC).

Mick Armstrong, Chair of the BDA, commented: 'After endemic failures in both leadership and governance the GDC's new management team must now show they have learned the right lessons so we can all move forward.

'Dentists want to see an efficient and effective regulator. We will require hard evidence that the GDC now clearly understands its role and it remit, as without these firm foundations we cannot expect progress.

'Ian Brack is right to acknowledge that rebuilding trust will be fundamental to that process. An understandably sceptical profession will look to judge his team on the basis of deeds not words.' ◆

NEWS FROM THE BDA

CQC must stick to flexible registration pledge

The BDA has said it will hold the Care Quality Commission (CQC) to its new pledge to 'develop a more flexible approach to registration'.

In its new strategy launched today the regulator committed itself to ensuring that by 2020 all new registrations will be risk-assessed against set criteria, recognising practices' track records on safety and quality.

BDA Chair Mick Armstrong said: 'We are winning the argument for a streamlined approach to registration. At present any change to a practice, like moving from a sole trader to a limited company, prompts an interview or site visit - even if it has no bearing on patient care. The CQC have now pledged to deliver a more flexible approach, and we intend to hold them to it.' ◆

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Where are the courses held?

There are three remaining courses taking place in 2016 at venues in London and Nottingham:

London	17 June 2016
London	23 September 2016
Nottingham	18 November 2016

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Women in dentistry survey reveals gender gap

A survey into women in dentistry has revealed that for dentists under the age of 35 there is a strong perception that there is a gender gap in dentistry, with over 40% agreeing with that statement and only 23% directly disagreeing. Older clinicians, however, felt that the gender gap was less prevalent.

Minford's national survey into women's attitudes regarding their dental careers is the largest of its kind. The contributions ranged across all ages and locations, and attracted respondents of both sexes.

The survey also revealed that nearly 25% of the dentists who responded were planning on leaving the dental profession in the next 10 years for reasons other than retirement. It is amazing that people are willing to give up the years of work they have put into dentistry. Set against the fact that over 97% of respondents claimed that their career was either very or quite important, which presumably means the participants of the survey value their jobs highly, this begs the question – why?

The survey further indicated that almost 65% of participants are working full-time, 28% are part-time, with just 4% on maternity leave, and the remainder stating a non-specific reason for their absence from the workplace.

Of those engaged in part-time hours, childcare requirements were the most common reason stated. This has the potential to have a negative impact on women within the profession, because they are predominantly the ones who have to take 'time out' of their careers to look after their children. This is in line with recent figures from My Family Cares; their survey suggested that less than 1% of fathers took shared parental leave.

When asked what they would change about dentistry in the survey, there were a few popular answers. Most complained about the amount of paperwork that has to be completed and felt that this time could be better spent caring for patients.

©Cultura RM Exclusive/jackSTAR/Getty Images Plus

Another major concern that was expressed by dentists in the survey was the constant fear of litigation and lack of help and support from the professional bodies such as the BDA, as well as the CQC and GDC making dentists feel like they were on their own.

The positive news is that most women in dentistry are happy with their career growth. The main reason cited as to why women are unhappy is related to the consequences and situation that they face when taking time out to look after their children. This says a lot about the professionalism of women over the lifetime of their career, and may surprise more than a few male dentists.

Minford Principal Johnny Minford said about the results: 'I think the survey shows that people are looking for an opportunity to make their voices heard in the profession in which they have invested so much time, money and energy. We are proud to give them that voice.'

BOOK REVIEW

Management models

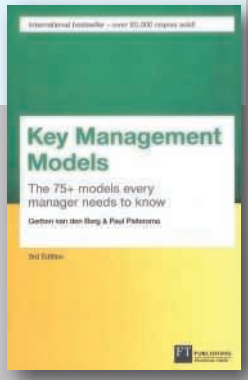
Key management models - the 75+ models every manager needs to know (3rd edition)

Gerben van den Berg and Paul Pietersma

Pearson Education, 2016

ISBN: 978-1-292-08176-2

£16.99



Despite the somewhat intimidating title and subtitle combined with an arid, academic-looking cover, there is much to glean from this surprisingly revelatory management book. Spanning 300 pages, this paperback is actually not aimed at chartered accountants but at managers in general. It provides an insight into the fascinating world of business model jargon and offers lucid explanations in everyday, comprehensible language.

Determined to dispel any misconceptions concerning the subject, the authors make clear in the Preface, '*To us management models are nothing more and nothing less than useful tools – useful for problem-solving, for analysis, for supporting and facilitating decision-making and/or for improving efficiency and effectiveness of organisations and teams*'.

In improving upon the two previous editions the authors, in addition to expanding the range of models, have also, very sensibly, grouped them into eight functional categories such as finance, marketing and sales, HR and change management and leadership. This undoubtedly leads to greater clarity and ease of use for the reader. This is definitely not a 'cover-to-cover' book nor is it intended to be so and the eight categories are supplemented by a comprehensive subject index.

The first section, on corporate and business strategy, discusses models such as core competencies. But there are many more technical models too such as the DuPont scheme and the capital asset pricing model (CAPM). Another bonus is the succinct way subjects that have often taken an entire book to discuss are dealt with in just three or four pages. Good examples here are Six Sigma, Lean thinking and Stephen Covey's Seven habits of highly effective people.

Most of the models are illustrated by charts, diagrams or figures, and each model is arranged into paragraphs outlining an explanatory 'big picture', when and how to use the model and a final analysis. This is an excellent anthology, but the subtitle could just as accurately read: 'everything you wanted to know about management models but were afraid to ask'.

Think patient safety: buy the genuine article

GDC action and a recent criminal conviction highlight the dangers of using counterfeit and non-compliant devices. The risks to you, your patients, colleagues and practice are very real.

As part of an industry-wide response to the issue the British Dental Industry Association (BDIA) operates the Counterfeit and Substandard Instruments and Devices Initiative (CSIDI).

CSIDI facilitates the reporting of those selling such products and promotes responsible purchasing throughout the dental supply chain.

The key is to get to know your suppliers.

BDIA members adhere to a strict Code of Practice giving you confidence that the products you purchase are of guaranteed quality and provenance.

Download the latest tips on how to spot fake dental products, find trusted dental suppliers or report anything suspect now at www.bdia.org.uk

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T: 01494 782873 **E:** admin@bdia.org.uk **W:** www.bdia.org.uk

Image of counterfeit products confiscated by the MHRA.

Chief Dental Officers intervene on sedation standards

A joint letter has been issued by the four UK Chief Dental Officers on the 2015 Standards for Conscious Sedation in the Provision of Dental Care published by the Intercollegiate Advisory Committee for Sedation in Dentistry (IACSD).

The CDOs have asked the Scottish Dental Clinical Effectiveness Programme (SDCEP) to review the IACSD standards document and advise how best it might be taken forward; particularly taking account of risk to patients, the practicalities of implementation, and potential impact on current services and training.

When the SDCEP process is complete the CDOs will consider the findings and provide guidance to dental teams. The CDOs do not wish to discourage those that already have, or may wish to, implement the 2015 IACSD standards – however, sedation practices that have not done so should not be penalised. Pending further direction from the CDOs, sedation practices in England, Wales and Northern Ireland are expected, as a minimum, to meet the standards set out in the 2003 Department of Health guidance. In England, the CQC is aware of the intervention by the CDOs and will inform its inspectors accordingly – it will also be reviewing the range of sedation standards available.

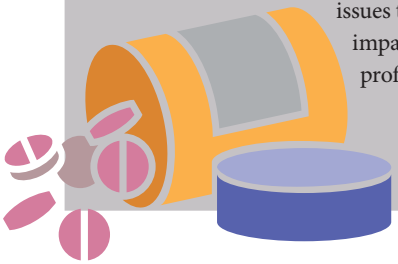
Sedation practices in Scotland should follow the 2012 SDCEP guidance Conscious sedation in dentistry. In Northern Ireland, confirmation of the minimum sedation standards to be adhered to is provided on the Department of Health, Social Services and Public Safety website.

Prescribing guidance updates

Why isn't the government listening to dentists' concerns that a reformed contract will still contain the much discredited UDAs? As the dental budget is limited to treating just over half of the population, is the government going to increase funding for the roll out of the reforms to improve access to dentistry?

These and other questions are expected to be raised with the minister responsible for NHS dentistry, Alistair Burt, MP, when he addresses the Local Dental Committees' Annual Conference in Manchester taking place 9-10 June.

The conference, which will run over two days, will also feature a presentation from England's Chief Dental Officer, Sara Hurley, followed by a Q&A session. Delegates attending the conference will also receive an update from the GDC's director of strategy Matthew Hill on issues that impact the profession.



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The UK's most and least 'smiliest' times revealed!

As part of National Smile Month's 40th birthday celebrations, the Oral Health Foundation took it upon themselves to find out on which of the 10,080 minutes in a week the great British public are most likely to smile.

Perhaps unsurprisingly, the most popular answer was exactly five o'clock on a Friday afternoon. Maybe it's the promise of two lie-ins over the weekend, of not having to be rudely awoken by the sound of an incessant alarm, of breakfast in bed, or even the thought of getting outside for some fresh air.

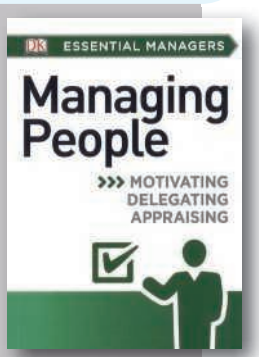
It might even the prospect of spending quality time with our family and friends; but it would seem that once the working work is finally over, the majority of us are beaming from ear-to-ear.

The nationwide survey involving more than 2,000 UK adults also discovered the time which we are least likely to smile. In what is the complete antithesis to the most popular, it's bang on seven o'clock on a Monday morning. It would appear that the prospect of a tenuous and often strenuous commute before embarking on a whole week of work really is enough to wipe the smile from our face.

BOOK REVIEW

Managing people

Managing people
Philip L. Hunsaker and Johanna Hunsaker
Dorling Kindersley, 2015
ISBN: 978-1-4654-3543-9
£6.34



Publisher Dorling Kindersley has been producing books on management for several years. The DK *Essential Managers* series first started in the late nineteen nineties and was followed-up by the excellent, if rather bulky, compendium edition, the *Essential Manager's Manual* (2008). At nearly nine hundred pages this hardback was hardly a pocket book. By contrast, the newly republished *Essential Managers* series of which *Managing People* is one of the titles is most definitely pocket-sized. Weighing in at a mere ninety six pages and smaller than A5 in dimension, it is a very easy and quick read and ideal for a train journey or even a coffee break.

The compact Managing People covers a lot of useful ground which is easily digested and clearly explained. Beginning from the idea that understanding yourself is critical to being a good manager, it rapidly develops to discuss the finer points of management. Giving feedback, for example, is one such element. It's vital to talk about the job's demands and its specific goals as opposed to lambasting colleagues with general and subjective criticisms. Similarly the art of delegation is carefully explained and the need to assign goals by delegating responsibility and authority to other staff members.

Another aspect of management is the ability to ensure that team members meet their objectives and, in addition to regular monitoring, this can also be done by appraisal meetings. The basics of this are given here, from putting the appraisee at their ease to setting action points for the future. An equally important function of managers.

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However much we'd like to, we cannot often predict life events taking a turn for the worse.

Dentists, just like everyone else, do not have a stash of 'get out of jail free' cards for use when life deals a blow to their finances, often as the result of critical illness, bereavement or accident.

The huge emotional and psychological demands within the dental profession following unprecedented numbers of medical negligence complaints are also widespread. In one 2014 speech given by Chair of the GDC, William Moyes, he stated that the instances of these claims have risen by 110% since 2010.

The case of Dr M is just one example. A complaint was lodged against him with the GDC Health Committee. Although it was later found that he had no case to answer, his life had been put on hold during the investigation and he suffered with mental illness under the strain. He now suffers with severe depression. The Fund awarded him a loan to clear some of his debts and he now receives a monthly grant whilst he recovers.

The BDA Benevolent Fund is a voluntary group of dental professionals who both understand the pressures of the profession and can offer financial assistance to dentists in dire straits. Their tireless commitment to dentists in need has spanned 130 years. Today, they are asking for dental professionals to consider leaving a legacy in their wills.

Indeed, if the decision to leave a proportion of ones estate to charity has already been decided, there could be tax break benefits for the remaining assets going to direct descendants. If 10% of the estate or more is to be donated to charity, the remainder of the value (even if it's still beyond the higher rate threshold) could be taxed at a reduced rate, down to 36% from 40%.

If you qualify for the tax reduction, it could mean savings of thousands in terms of tax owed, constituting greater financial benefits for surviving family members and partners. The government has an online calculator that works out whether an estate's owner qualifies for this discount. ◆

The BDA Benevolent Fund relies on your help to continue its work, so please contact us on 020 7486 4994 or administrator@dentistshelp.org, or to give a donation today go to www.bdabenevolentfund.org.uk.

Sale of orthodontic practices – good news?

There may be potentially good news for orthodontists who are looking to sell their practice – but as with so many issues in healthcare at the current time, it will come down to the attitude of the individual Local Area Teams.

Following NHS England's recent publication of Policy Book for Primary Dental Services, they appear to have opened the door for adding (and removing) parties to and from a PDS contract. This has always been the case with GDS contracts which provide guaranteed access to the 'partnership route'. PDS contracts don't include such clauses and this does mean that these fresh provisions will only provide discretionary access to the partnership route. However, the new guidance prompts all parties to consider switching to the new policy, 'if there is a natural transitional point in the matter and provided all parties agree.'

Russell Abrahams, Senior Partner at Abrahams Dresden explained, 'This could be good news for those orthodontists seeking an exit but the fact that it is discretionary will mean that we are in postcode lottery territory. Success will be on a case by case basis and area team by area team basis. However, this guidance does provide a potential new course of action away from increasingly difficult incorporation applications. Early applications have had mixed success. Where the Contractor is a 'friend' of the relevant division of NHS England, the application runs through pretty smoothly. In other circumstances, NHS England is relying on their old chestnut of agreeing to the proposition, but only in exchange for a chunky reduction in UOA value.' ◆

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The EU referendum and dentistry

Martin Woodrow,
Director of Member Services

The referendum to decide whether the UK should stay in the European Union or leave has been set for 23 June, 2016. The BDA as an organisation retains a neutral position on the issue. We do receive questions, however, about how the result may affect dentistry. Some of the main issues are outlined below, and a recent article in the British Dental Journal[1] looks at Brexit and dentistry in more detail.

These points are not exhaustive, nor are they meant to be alarming. However, as Brexit would mean changing the status quo without any previous case to compare, the article below outlines some general changes that could reasonably be expected. The answer to any concrete questions has to be 'we don't know' at this moment in time. Only time will tell once the result is in. Much of what will and will not be possible will depend on the deal the UK government would negotiate with the EU and individual countries.

Two consequences that are regarded as relatively likely have been acknowledged by both sides of the argument. One is that there is likely to be an effect on the UK economy, and the other is that any future access to the EU single market will need to be renegotiated. Both points are entirely relevant to the dental profession, and supporters of both scenarios have put forward their interpretation of what this may mean.

Economic effects on dental practices

There are predictions from both camps about the economic fallout from the referendum, including claims of likely recession or savings from our EU contributions. Members may remember the effects of the most recent recession, and how the dentistry profession was affected. Many patients, in particular those paying for private treatments, found that they could no longer justify the expenditure. This serves to demonstrate that, predictably, the dental economy acts as a subset of the general economy. So any effects on general economic performance, be they positive or negative, are likely also to be reflected in patient spend and consequently the earnings of dentists. Assertions about whether the Remain or Leave lobbies will result in better or worse economic conditions are untested and therefore impossible to prove. But whatever those consequences are, dentistry will be affected in the same way as everything else.

Workforce

Workforce is also an area to consider. There are around 7,000 EEA dentists currently on the register, although some will be UK nationals with EU degrees. Any EU dentist working in the UK will not have to leave, as per the Vienna Convention on the Law of Treaties (VCLT). As for UK nationals undertaking their dental degree in other EU countries and wishing to return, it remains the GDC's remit to decide whether they accept foreign qualifications or not, as they do not have to subscribe to any EU directive. In a Brexit scenario, it would be for the GDC to determine if any additional examinations would be required for EU dentists entering the UK. Would this diminish the appetite for EU dentists wishing to work here? The answer to this depends on which box you intend to tick.

EU legislation and representation of the profession

EU legislation affects dentists in the UK in many ways, some more obvious than others. Medical devices, data protection, amalgam and other restorative materials, tooth whitening products, eHealth and mobile health (mHealth), basic dental education, recognition

of undergraduate and specialist diplomas, tobacco product regulation and employment law are some of the themes at European level, and are dealt with in a variety of ways. At the moment, the UK government contributes in shaping new and reviewed legislation at EU level through the European Council, representing the fourth largest EU member country. It would be for the UK government to decide which areas of UK legislation it wished to amend in the event of the removal of the requirement to enact EU legislation.

The BDA is currently a member of the Council of European Dentists (CED), a representative organisation for the profession with an expert in-house legal and policy team. The CED directly lobbies Members of the European Parliament and senior staff at the European Commission to explain the issues important for dentists, and discuss solutions favourable for the profession. Doctors, pharmacists, nurses and veterinarians have similar organisations, and these bodies work together where there are mutual areas of interest. Thus the professions are represented very well at EU level at this moment in time.

The BDA has had involvement in the CED Board for the last six years. We have led important working groups (amalgam, tooth whitening, antibiotics) over many years, and put issues such as the need for a policy statement on sugar on the agenda of the organisation. The information that the CED Office provides to its members through monitoring activities at EU level has proved to be useful in enabling the BDA to make reasonable, well-informed representations to the UK government, as well as directly to the EU Commission, and with some real results. On the other hand, in case of Brexit, the UK would no longer be bound by EU decisions. The BDA would seek to influence the UK government directly, in many ways as it does already.

UK dentistry may change in a Brexit scenario. It may be as you were should voters decide to stay. Whatever your personal views, these points are open to interpretation. Like most things in life there are positives and negatives to both sides of the argument. Whatever happens after 23 June, UK dentistry is going through a period of change. Whether you believe they are for better or for worse depends whether you're a glass half full or half empty kind of person. And rather like Brexit or Bremain, it's entirely personal.

Reference

1. Sinclair E, Shah S, Stagnell S. Brexit and Dentistry. *Br Dent J* 2016; **220**: 509-512.

This is our view. What's yours?
It's an issue that is splitting the country. At the time of writing the Financial Times' opinion tracker has 46% stay and 40% leave, with the remaining undecided. With the polls so close, we ask two members of the profession to put forward their argument for camp leave and camp stay.

COMMENTARY

Leave

I do not believe that leaving the EU will have any particular effect on dentistry, but I believe there are other more fundamental issues that will make me vote to leave.

Firstly I believe passionately in democracy and the importance of the whole population believing they can influence policy. Every five years we are able dispense with our politicians and elect new ones. That is not possible when we are members of the EU. We cannot get rid of the politicians that make the majority of decisions in the UK (139.000 laws between 1980 and 2009) because legislation is proposed by the European Commission who are not elected. The European Parliament is elected but even 100% of the UK population wants to change a European law it can't as the UK MEPs only hold 12% of the votes.

I also do not believe we can have a democracy for 550 million people speaking 24 different languages.

We have to remember that voting to remain does not mean status quo. The EU is officially moving towards a federal system (5 President's Report) by 2025. All members of the EU are obliged to join the Euro, apart from the UK, Denmark and Sweden so 25 out of 28 member countries will be using the Euro and it is recognised that this requires fiscal, political and economic integration. If you then add the five candidate members, including Turkey and Albania, you will see that huge amounts of the EU budget (we are net contributors to the EU budget) will be needed to help the economies of these much poorer countries coalesce with Western Europe. I believe this will marginalise and impoverish the UK if we remain in.

Why will the dental profession be better off leaving the EU?
The major difference will be that the rules for EU graduates working in Britain might change, as no longer will there be an automatic right for them to work here – but it would be up to our UK government to decide how many dentists they needed in the country. However, EU citizens already living here will be entitled to stay under the rules of the Vienna convention so the changes would apply to new entrants only.

Fewer EU dentists would mean an improvement in the negotiating position of performers and one would hope that a slight undersupply of dentists would mean the government might be more likely to give higher pay uplifts for NHS dentists.

Will there be an impact on dental research?
A lot of dental research is being supported by grants from EU and it will be up to our government to decide whether to continue these grants, decrease or increase them. At the moment UK is paying £161 million per week *net* to the EU (BBC figures), i.e. we are paying £161 million more to the EU than we are receiving back in research grants, agriculture support etc., so the UK government would have the means to support any area the voting public agreed to at an election.

> 'But remember these are exactly the same arguments we heard from exactly the same politicians when they told us we had to join the Euro in 1997 and none of it ever happened'

What about general levels of dental health?
Any changes to this would depend on whether the trade deal with US (TTIP) is agreed. TTIP would mean that companies can take the UK government to court for loss of profits due to new laws. This has happened in Australia about plain packaging of cigarettes where Philip Morris is seeking damages for losing brand value. This could happen in UK f.ex. in relation to the new sugar tax if Coca-Cola can prove less sugar will lower their sales in the UK. TTIP would also mean that the NHS would have to be opened up to competition from the US, so Kaiser Permanente would be able to bid to run large hospitals, and subsequently this could include dentistry as well – both private and NHS.

> 'Fewer EU dentists would mean an improvement in the negotiating position of performers and one would hope that a slight undersupply of dentists would mean the government might be more likely to give higher pay uplifts for NHS dentists'

Will it affect dentists' contracts?
Apart from TTIP mentioned above I believe Department of Health would be the least affected after Brexit so even though the government might have other things to deal with, the introduction of the new contract would probably not be affected.

And the vast quantities of products and trade?
As there are no formal trade agreements between EU and US or China it means that our trade with US and China will be completely unaffected by Brexit as it would continue as it does now. The only difference would be a probable short-term weakening of sterling which would be very good for our exports but bad for imports and people going abroad on holiday might pay more for their currency. It is very difficult to say how a Brexit will affect our trade with EU as all our EU partners want us to stay and they are therefore telling us that they will make a trade deal difficult after a Brexit.

I don't believe this, as it makes no sense. The UK has a £195 billion pounds *deficit* with EU (2014), we buy £195 billion more in goods from the EU than we sell to the EU, it means that the rest of the EU will have a keen interest in coming to a speedy trade arrangement with us after Brexit.

At the moment we are hearing a lot of scary arguments against Brexit - the City of London will move to Frankfurt, no-one will trade with us, we will lose jobs and influence. But remember these are exactly the same arguments we heard from exactly the same politicians when they told us we had to join the Euro in 1997 and none of it ever happened. I n fact the UK has a much better economy and lower unemployment than the rest of the EU, so I didn't trust them then and I definitely do not trust them now. ◆

COMMENTARY

Stay

Why will the dental profession be better off staying in the EU?

I think the main question here depends largely on what would happen financially if we stay or leave. There are lots of very sophisticated modelling techniques and the results have been claimed to support each side's argument. It's worth noting that economic models such as these were used to vouch for the safety of pooling sub-prime mortgages and debts into 'Collateralised Debt Obligations'. According to these models, the chances of these markets collapsing as they did in 2008 were equivalent to winning the lottery twenty-one times in a row. So I think we need look more at what's happened recently to make any guesses about what might happen. I think there are four possible scenarios for the NHS as a whole:

1. We remain and the amount of money 'in the pot' doesn't change
2. We leave, the country are worse off and the NHS has to shoulder some of that loss
3. We leave and the country are better off, but priorities for spending are similar to how they've been in recent years and the NHS doesn't see any appreciable increase
4. We leave, the country are better off, and the government simultaneously decide that the NHS is now more of a priority than, for example, reducing the deficit.

I understand that even people in the 'leave' camp are acknowledging that we may be worse off in the short term, but that in the long term well be better off. My concern is whether the NHS and those working in it could weather the storm that an exit could bring.

Will there be an impact on dental research?

The UK's output in terms of dental research is huge; with high quality research coming from every dental school in the country. This means graduates from UK dental schools are likely to be equipped with the most up to date knowledge and practice. Britain receives more for research from the EU that it puts in. There is obviously the argument that overall the UK puts in more than it receives, and that some of this could be redistributed back into research. But again, this depends both on there being more money available and this being directed into research rather than eg clearing a deficit. On balance I think research is safer with the current distribution of resources.

What about general levels of dental health?

Obviously there are lots of variables when looking at the dental health of the population. Two key areas that spring to mind are the availability of NHS dentists, and prevention strategies.

> 'I understand that even people in the 'leave' camp are acknowledging that we may be worse off in the short term, but that in the long term well be better off'

There has already been some debate in the *BDJ* about the effect leaving would have on dentists trained elsewhere in the EU being able to work in the EU [Paul Batchelor's editorial British Dental Journal 219, 513 (2015) and letter from C.Lister British Dental Journal 220, 154 (2016)] In summary, it was pointed out that over 10% of UK registrants trained elsewhere in the EU, but that leaving the EU would not stop EU trained registrants being able to work here, only that the decision to accept them would rest with the General Dental Council. Again, there are arguments for and against each option, but it seems certain that if we were to leave, there would be a reduction in the number of EU trained registrants able to work here and in the short term at least that's likely to have an effect on availability. From my point of view, from having lived and worked in several areas of high dental need in England and Wales over the last few years, I've met a lot of EU trained GDPs working in areas of high need. In contrast, it seems my cohort from dental school seem to have gone for the areas closer to their dental school or in the more affluent areas where they did foundation training. This is a subjective view, but I would be concerned that these high needs areas may be the worst hit by any sudden drop in the number of EU trained registrants.

In terms of prevention, the statutory duty for oral health promotion now rests with local authorities. These are currently experiencing year on year cuts of 10% in their public health budget. Once again I find it hard to envisage a scenario in which leaving the EU leads to an increase in the public health spend.

Will it affect dentists' contracts?

In terms of the potential effects on contracts, the main contract of interest at the moment remains the contract for GDPs and the current protocols for the proposed new contract. At last year's conference I interviewed Jimmy Steele on the day of the General Election and he pointed out that progress on the new contract had been slower than expected and talked about his hopes for quicker progress now the election was over. It can often feel that dentistry isn't high on the list of priorities, and I think the seismic shift that leaving the EU would bring to the current government would be likely to push the proposed new contracts even further down the list of priorities.

And the vast quantities of products and trade?

I guess the arguments here are all the standard ones for any trade agreements, and again, each side has been arguing that this topic should sway us to their respective side. New trade agreements would need to be drawn up, and this could be lengthy and costly, and our bartering capability would likely be stronger as a member of the EU. I think some mention of the Transatlantic Trade and Investment Partnership (TTIP) should be made here and if I had to justify why we should remain in the EU based on this alone I would struggle. When general economic theory is applied to healthcare, and to the NHS in particular, it becomes apparent that the benefits derived from a totally free market simply cannot be applied to the NHS, as it violates the conditions needed for 'perfect competition' when the patient is seen as the 'consumer'. The King's Fund have some great resources on this topic. But I would be very keen to ensure that the NHS was exempted from any policy or agreement that aimed to apply market forces to the NHS, and I'm following the current parliamentary debate on this quite closely! ◆

Employment tribunal case – what can we learn?

Here follows a tribunal case where the practice manager – in this instance the spouse of the practice owner – was accused of not following the correct procedure regarding the discipline of a dental nurse. **Ayesha Khan** tells David Westgarth what practices can learn from the case.

There are perils and pitfalls in all forms of life, particularly at home and at work. I recall – albeit fictionally – an episode of one of my favourite shows where two lawyers in question are dating and living together, but end up on opposite sides of the negotiating table. They make a pact not to discuss the case at home, thereby separating work life from home comforts. Naturally things start to disintegrate, and before they know it things start to get personal.

The moral of the story here is working with partners or spouses can open up the possibilities of unwanted complications. One recent employment tribunal claim against a general dental practitioner shows the mud that can be slung at you, if, as a small family business, you employ a relative in the practice. But it also illustrates the benefits of having, and scrupulously following, practice procedures to the letter.

Unfortunately it has become par for the course for an employer to get a letter from a solicitor along the lines of 'We write on behalf of our client Ann Employee, in relation to the recent disciplinary proceedings against her…' as one BDA member did recently. The employee in question was a long-serving dental nurse, whose time-keeping was becoming increasingly poor. Eventually, the practice manager, who also happened to be the practice owner's wife, decided to take action.

The background

The practice did not keep time sheets, but the nurse in question was late at least twice a week, and almost always on a Monday. The lateness was not much, usually only 10 to 15 minutes, but was frequent enough that the staff sometimes joked that the nurse had 'Monday-itis'. The practice manager never acted on it, in part because they had recently taken over the practice and the nurse had been there for nearly 20 years, and they didn't want to create bad feeling. However one day the receptionist became exasperated and complained about the nurse coming in late on two consecutive Mondays. The practice manager decided to take action and invited the nurse into her office. The nurse was told lateness was not acceptable, and it was not fair on the other staff. To the practice manager's surprise the nurse was totally unapologetic and denied that she had a problem with time-keeping.

What happened next?

Following the meeting the practice manager sent the nurse a letter, stating that if her time-keeping did not improve the practice would take disciplinary action. A solicitor's letter arrived at the practice in response, which came as an unpleasant shock. In this situation it can lead to you questioning yourself, particularly – as was the case here – had the practice manager not done the right thing? The practice manager had an informal discussion to informally resolve a minor issue and, because she felt that the nurse was not taking it seriously, sent a letter highlighting the consequences if the problems persisted. The practice manager had stopped short of using the formal procedure because she did not want to escalate the matter unnecessarily and potentially create divisions in their small practice.

However according to the solicitor's letter, the practice manager had 'issued a final written warning' without following the proper procedures (which include an investigation into the incident and written notice of a formal meeting, where the employee has a right to be accompanied). The nurse's solicitor was alleging 'breach of contract by failing to follow the practice disciplinary procedure', and hence a 'breach of the duty of trust and confidence' that is implied into every contract between an employee and employer. Had the letter been issued as a formal warning these allegations would indeed be accurate.

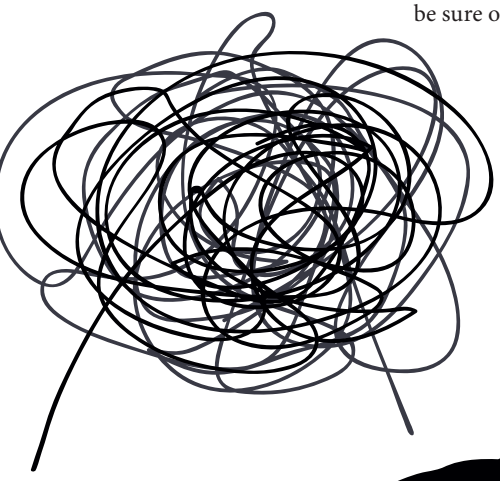
The legal bit

Ayesha Khan, Practice Management Consultant at the British Dental Association, said: 'As it happened, the situation was arguable on both sides. The practice manager had

generally acted quite reasonably in trying to resolve the matter informally. However, the practice manager had not followed the disciplinary procedure, and the practice manager's letter could be interpreted as a formal written warning to the nurse.

'Given the small nature of the practice and the potential complexities of the spousal connection, it was in everyone's best interests to resolve the issue quickly. We advised our member – the practice owner – to treat the solicitor's letter as an appeal within the meaning of the practice disciplinary policy. The practice owner did so, and from that point on, followed the policy to the letter. The practice owner even extended the right to be accompanied at the appeal meeting – which strictly only means by a trade union representative or a fellow colleague – to include the nurse's friend. At the meeting the practice owner listened to the nurse's account, both about the allegations of lateness and the nurse's complaint that there had been an 'unfair' disciplinary procedure. After the meeting the practice owner investigated the matter further, asking the receptionist for the dates and times the nurse had come in late.

'The practice owner then wrote to the nurse telling her of the outcome of her appeal. Because the practice owner could not be sure of lateness except on the two dates given by the receptionist, he reversed the decision of his manager (and indeed his wife) and formally withdrew the 'written warning' and replaced it with a verbal warning.'



> 'The moral of the story here is working with partners or spouses can open up the possibilities of unwanted complications.'

The aftermath

Following this the practice introduced time-sheets for all employees, and within weeks the nurse's diagnosis of 'Monday-it is' was confirmed. The manager decided to take further disciplinary action, and did so exactly by the book. The nurse received a written notice of a formal meeting, informing her of the allegations to be discussed and of her rights and responsibilities. This time the letter in response was a resignation. It was followed by an employment tribunal claim of 'constructive unfair dismissal'.

Ayesha explained: 'The weeks and months that followed were a worrying time. The nurse complained of having been picked on by the practice manager, that the staff had 'ganged up' on her to keep the manager happy, and that she had no one to ask for help because the manager was the owner's wife. The nurse's claim failed.'

Lessons for practices from this case

'An important factor in the tribunal's decision was that the employer had acted reasonably throughout', Ayesha added. 'The practice manager had exercised her discretion to handle matters in a way she thought was appropriate. When the employee complained about this the practice owner had acknowledged and addressed the nurse's concerns. When the practice owner saw a shortcoming – that the manager's letter could be construed as a written warning without a proper procedure – the owner held an appeal and corrected any potential unfairness. The practice owner carried out a reasonable investigation into the allegations. Where there was a lack of evidence – of lateness other than on two occasions confirmed by the receptionist – the practice owner did not uphold the allegations. The practice owner had not simply rubber-stamped his manager/wife's decision.

'When you are under attack – professionally, financially, and, as in this case, personally too – it is difficult to see things from the other side's point of view. Our advice would be to take a step back, be objective, and look at it from the employee's perspective. You may be very upset or annoyed by their conduct, but give them the benefit of the doubt. It may help speaking to an objective person such as a friend or colleague who is also an employer, an LDC colleague, or a BDA adviser. See if the employee has a point – even if it is a very weak or mistaken one. If you can see their arguments you can address them, resolve them, and, if they are wrong, counter them.

'Focus on the solution – for both you and the employee – not just the problem. In this case it would have been easy to get tied up in questioning the employee's motives for acting as she did. On the one hand, she may genuinely have felt that she was being mistreated yet on the other hand, maybe she wanted to leave her job and thought she could frighten her employers into giving her some undeserved money along the way (I took this more cynical view myself). Her motives may lie between those two extremes or be a mixture of them. But ultimately they matter little. If a problem is brought to your attention by an employee, no matter how petty it seems or how inappropriate the way the employee went about it, try to rise above it and resolve it as you would any other. In this case the employer's calm, professional, reasonable handling of the situation made the employee look all the more aggressive, unprofessional and unreasonable in comparison.

'If you do get a threatening letter from a solicitor, don't panic. That might be easier said than done – especially coming from a trained barrister – but remember that this is only one side of the story, presented in a way that is calculated to get the best result for their client and themselves (which usually means the most money as quickly as possible). You have the other side. In the vast majority of cases we deal with, even ones where things have gone wrong on our member's side, it is not as bad as that solicitor's letter would have you believe.' ◆

Stepping up

Bob Hughes

In the first of a regular series, CEO of the Forton Group Bob Hughes gives us his insight into high performance leadership

There's said to be a new book written on leadership every seven minutes, which suggests it's both important and complex. In this series, I'll be looking at changing definitions of leadership and outline a well-researched leadership model that supports people to be better leaders.

Leadership isn't just about hierarchy, position, or status, it's about success. People taking ownership and responsibility. And if you do manage people or you are providing thought leadership, then this model will help you be more successful. It will support your team to achieve more too. The people who rely upon your good work will benefit and your organisation will be more successful.

In the middle of the last century, what we needed from our leaders was stability and efficiency. Organisations that were run well, with good continuity, efficient processes and reliability, prospered. The pace of change was slow and business models were relatively simple.

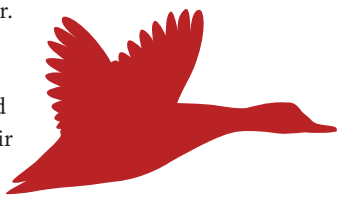
Organisations had the luxury of time to analyse what they were doing and make incremental change, often trialled through pilots before scaling up. Many were building on the successful models of automation and 'assembly-line' processes. They were able to grow through 'time and motion' studies.

The approach to leadership in this generation is analogous to what many people see as the management side of the 'management versus leadership' debate; doing things right rather than doing the right things.

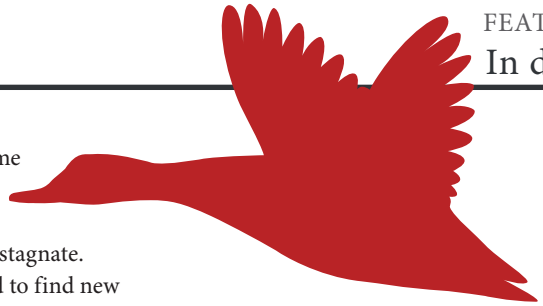
Leadership was often autocratic and commands were passed down. The managers in the hierarchy usually ran their teams in the same way as the company was run: the manager clearly in charge, and people weren't required to be creative - they delivered and followed orders. You would be deferential to the people above you in the hierarchy and dictatorial to the people below you.

In that environment it was usually a recipe for success. But the pace of change increased, complexity grew and the luxury of time became scarcer. This is, of course, a generalisation. There have always been great examples of good leadership in the way we would know it today and organisations that were more successful as a result.

In the latter half of the 20th century a new style of leadership began to emerge. In this phase, a single, all-action hero figure takes control and saves the day. We became familiar with the phrase of 'parachuting in' a new leader. At times you felt they could fly on their own and their cape meant the parachute was redundant.



Leadership books were littered with examples of how the chief executive had transformed organisation single-handedly. Case studies multiplied, extolling the virtues of firm leadership from the top. Those leaders became famous and much quoted; Googling 'Jack Welch quotes' returns around half a million responses. As Chairman and CEO of General Electric between 1981 and



2001, the company's value rose 4,000%. So inevitably people will look to these examples and try to copy them. I have no doubt that Mr Welch did a fine job. Equally you could argue that environmental changes contributed to the success of GE or that another person with a different style working in a more collegiate way may have had the same, or possibly better, impact.

I have no doubt that in some cases there were some great individual leaders who were more successful as a result of their style. However, there is enough evidence around to challenge this myth of strong leadership as the cause of success. The key message is 'correlation is not causation'.

We still read about companies poaching their new CEO because of that person's reputation elsewhere and paying huge sums of money to do this. Internally grown CEOs have a much better track record. And, if you look at the correlation between the charisma of the CEO and the success of the organisation there is no correlation. However, there is a direct correlation between charisma and the size of their pay package.

All of this shows how the world of work is changing radically. We can't stick to 20th century models of leadership; that too needs to change radically. Because as leaders, managers or business-owners, we will struggle to survive, let alone thrive.

We need people and organisations to be more creative, more adaptable, and to evolve more quickly than the competition. This won't happen with hierarchical, command and control structures. That worked when all we needed to know was how many widgets to make that day and commands could come down the line, but it's very different today.

There's a parallel with evolution here; Charles Darwin is often misquoted in talking about the survival of the fittest. What he actually said was 'It is not the strongest of the species that survive, nor the most intelligent, but the most responsive to change.'

So, organisations with a monoculture. rigid processes and well-tuned systems work extremely well until change happens. Diversity, creativity, entrepreneurial qualities and the occasional maverick may be more important. It's certainly true that you are less likely to have people challenge the status quo or come up with radically new ideas if there is a culture of conformity.

This is especially true when combined with a blame culture. When failure happens, as it inevitably will, if the organisational invests time and money in blame rather than learning from failure. then people stop taking risks and organisations stagnate.

With that backdrop, we need to find new ways of leading.

Prof Harry Schroder, a psychology professor at Princeton University, was fascinated to understand why some organisations were able to cope with increasing complexity and rapid change better than others. He concluded that there are core skills common to organisations; regardless of professional or technical skills.

He found a series of 'high performance leadership behaviours' that are better indicators of success.

> 'We need people and organisations to be more creative, more adaptable, and to evolve more quickly than the competition.'

Part of the elegance of this model is that applies to a chief executive of a global multinational and an individual managing no staff. This means it is widely applicable.

When leadership is about people taking responsibility and taking ownership wherever they are in the organisation, and about people creating success for themselves and the team, the organisation and indeed in society as well, then we find the high-performance model supports this well.

What I especially like about it is the understanding that we are never going to be great at all 12 behaviours. Most performance management systems have an implicit expectation that we should be excellent everywhere. That the way to achieve this is to focus on, and improve, our weaknesses.

This approach is fundamentally flawed. Not only is it impossible to be good at everything; it's also untrue to assume there is only one approach to successful leadership. Look at the diversity of approaches that different leaders take. No one would say that Winston Churchill and Gandhi shared the same style but equally no one could contest the huge successes that each brought in their own way.

The 12 behaviours fall into four clusters: Think, Involve, Inspire, Do. I'll be writing in more detail about each of the 12 behaviours every month, so here is a quick overview.

The **Think** cluster covers the qualities we use to gather information and make decisions. How broadly do we search for information when presented with a problem? How well do we create robust ideas, ideally tackling more than one problem? Finally, how flexible is our thinking? Do we have a plan B?

Involve is about getting other people on board; there's a great quote from one of my favourite shows, 'The West Wing' when the president seems not to be showing the leadership people expect. The Vice President says, 'You know what they call a leader with no followers? Just a guy taking a walk.'. Involve is about skills that build empathy, getting teams to work well together and working one-to-one with people, coaching and mentoring them. (Plot spoiler - the president superbly outflanks his opponents and his poll ratings surge.)

Once we have explored great ideas and have a team around us, we need to **Inspire** them. People need confidence in themselves and the leader has a huge role to play here. The leader also has to project confidence to the outside world. Communication skills are key and the more subtle art of influencing comes into play here too.

Finally, for success to happen the team actually have to **Do** something. This cluster is about taking action. It's also about continuous improvement, reviewing what worked well, and what you might do differently order to improve. Ultimately, it's about the focus you place on stakeholders, customers, patients, or service users - whatever term works for you.

There are five levels at which each behaviour is assessed. The lowest is called negative; actions here are potentially causing damage to the organisation. The second level is just undeveloped; we don't notice anything. Level three adds value through the use of a behaviour and level four shows strength consistently and at a higher level, in a behaviour.

Finally, the more senior you are, and the greater leadership responsibility you have, then you need to be demonstrating more of the behaviours, and at higher levels.

That completes the overview of high-performing behaviours. In next month's article, I will go into detail about each of these behaviours and how you can take steps to develop your leadership. ◆

The value of high staff morale

In 2012 the BDA conducted research into staff morale and motivation of dentists in the salaried primary dental care setting. That research discovered that more than half of people questioned said their morale was either low or very low. So why is it important to reverse this and develop a setting where morale and motivation can flourish? David Westgarth asked BDA Practice Management Consultant Natalie Birchall for her advice – and some suggestions on how to let it grow.

With the demands placed on general dental practices by patients but also the GDC, NHS and bodies like the CQC in England, good staff morale is very, very important. Having happy content employees who are motivated means they are more likely to work hard for the practice, which will show when patients visit. They are also likely to stay longer, which helps to improve efficiency and lowers staff turn-over. If you have a revolving door when it comes to staff retention, you are constantly in a hiring cycle, which is not a constructive use of time or money.

'If you create a happy practice or work in one, people will want to work for you and dentists will look to stay. The longer staff stay in one location means everyone will know their role, build rapport with patients and improve the delivery of care. It's a win for everyone.

'Everything that applies to dentists also applies to an associate. If you have one who is highly skilled, can bring two or three areas of expertise to clinic and is great with patients, it is clearly beneficial to keep them happy and on board. Matters of finance can play a role too, from both practice owner and associate point of view. At the end of the day they are generating money for the practice.

'In terms of team building holding social events, now that summer is here is an idea worth considering, but consider everyone's tastes. Going to a restaurant might be good but a team member might not like a certain type of food, so canvas everyone's opinion. On the other hand you may plan something more active, say a karaoke night, as your team may love the idea and camaraderie of belting out favourite hits together but watch out in case someone would find the whole event too embarrassing.'

More than just cakes

Keeping staff morale high isn't about buying cakes at the end of the day. Practice owners, managers, receptionists and dentists all have their role to play. Chris Barrow from 7connections believes team harmony and staff morale starts right at the top.

'You have to differentiate between management and leadership. You can lead people and manage a system, but you can't do the opposite', he said. 'People require clear leadership, so make sure every member of your team knows exactly where you want to go as a practice and how you will get there. You may not like to think it, but it's only natural for some people to think 'what's in it for me?' It's a very important question, and the answers help to map out your clear, defined vision for making the practice a successful one.

'Mapping out that goal and focus means you have to communicate it. Talking and communicating is so important in any industry, and dentistry is no exception. I often tell people the first thing they should do is just talk! Have a daily huddle, a weekly review, a monthly update. Every quarter take the team out of the office for training and every year celebrate. These things are so crucial to forming the backbone of success. I have a strongly-held belief that all problems exist in the absence of conversation. It's applicable to all forms of life – home, relationships, work. I have so many clients call up asking me for their help, telling me team morale needs to improve. My first question is always when was the last time you sat down as a team after a day in clinic and talked about how it went, what issues

they had or did not have. So often they can't answer, which could be why we see such low morale in certain areas.'

Natalie added: 'I think that is absolutely right. So often we receive calls seeking advice as they want to change something in their employee's contract which they're not going to like. We always recommend and advise them to take their time, explain all the reasoning to the employee, hold meetings, give them an opportunity to think about the suggested changes and have an open door policy so if they do have questions they can ask them.'

Rigid or flexible?

But what about when staff start to push their luck? Natalie explained: 'If, for example, a member of staff needs to take a day off at the last minute to deal with something personal, which may be against the practice's leave policy, you have a choice to make. Look at the situation, do the circumstances fall into the rules on compassionate leave or time off to deal with domestic emergencies? It not you will probably be entitled to enforce the practice's leave policy and refuse the request, or you can be lenient and allow them to have last minute time-off. There is nothing wrong with either approach, and both do depend on the type of manager you wish to be, but whatever decision you take will have a longer term impact.'

With his 20+ years in the business, Chris believes these kinds of incidents can be solved with one thing – telling the truth.

'This one is interesting, because from experience it's a common problem in practice. You cannot divulge personal details but try to dispel gossip and rumours. People will always make their own assumptions and interpretations, which can adversely affect morale. A de-motivated group will not help you achieve success. Too often I have found performance and behaviour of some staff has fallen well below expectations yet management are turning a blind eye. The short-term pain of confrontation is taking precedence over the long-term gain of dealing with the situation. It's human nature to do so, but the successful teams and happy teams tackle problems head-on.'

One of the best ways to encourage and develop staff morale is team building or networking events. It could range from having a staff barbecue if the practice is performing well to taking the entire team to a dental conference and exhibition and having an evening away. Whatever event you choose to run, Natalie believes it is important to remind all employees of their responsibilities from the outset.

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'This is an area where we get so many calls. Tribunal cases are often formed during these events, I dealt with a case where a team trip to the bowling alley ended in animosity after one team member behaved obnoxiously about beating their colleagues. It is easy to relax after a drink or two, so from an owner or manager's point of view, be very mindful of what relationship you want to have with staff. The same applies to staff. You may get on with the boss or you may not, but whichever camp you find yourself in, it is important to remember you will see these people on Monday morning.

'That's not to say victories of any form should not be celebrated – quite the opposite. The projection of a happy practice to patients gives potential customers reassurance and a reason to visit.'

Praise and appraise

As we have covered many times in these pages, the value of appraisals cannot be underestimated. Their purpose is to review and improve performance, regardless of current ability. According to Chris, if a practice wants good morale and harmony, these sessions should also be about identifying strengths.

'The great teams are those who utilise their skills to the max. Every member of the team has a strong suit, and appraisals are great for identifying those. If someone isn't performing well and you don't have appraisals, they won't learn and morale will remain low. If someone isn't performing well but you're in constant communication with them and have identified a strength of theirs, it will benefit everyone. For some people it is communication and for some it's analysing figures. The key is to position those people where their skills have the most impact. You wouldn't have a great communicator stuck in the back office, and likewise you wouldn't have someone great with numbers front-of-house. This idea comes from Strategic Coach in Toronto and is a fantastic way of maximising the potential of every member of staff.'

So what one message would both Chris and Natalie offer practice teams on how to improve team morale?

'Allow colleagues to bond' Natalie said. 'In the dental team throughout the day pretty much everyone in the team operates in their silo. It's not your traditional office environment, so social events allow time for that.'

Chris added: 'You will spend a lot of time at work, and if you can't find humour and fun in it then over a period of time it will become unsustainable. The great teams know how to party and have fun. There's camaraderie about their day, but when it's time to work and toe the line, they can do that with aplomb. Every team is different, but these tips will definitely bring about a change in atmosphere and environment.' ◆

Details on how to go about varying contracts are in the Variation of contract section of BDA Advice Employing staff.

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Dentist meets dentist

Marion English

Current Chair Herts LDC. Elected to GDPC. Middx and Herts BDA Branch Secretary and GDP Welwyn Garden City

The Annual Conference of Local Dental Committees is taking place this week (9-10 June), and as ever some of the motions put forward prompt debate and discussion. In our latest dentist meets dentist feature, we talk to Chair of the Hertfordshire LDC Marion English and Chair Elect of the LDC Conference Alisdair McKendrick about one of the motions put forward.

Alisdair McKendrick

Qualified in 1982 from Edinburgh. Chair of N'hants LDC for past 7 years. Chair elect of LDC Conference 2017

One of the motions put forward at the LDC meeting stressed that dentists 'urgently needed a fair and workable system in which to practise' – why so urgent? The contract has been in place for 10 years

ME From what we understand the new prototypes and contracts will put a heavy emphasis on the need for multi-surgery practices. At the minute there are around one in five single-handed practices, and I am very worried about their long term prospects. Many of these may be small, independent practices working in local communities and serving the needs of their locality. The few that do have value will probably withdraw from the NHS and go private, and I fully expect to see a huge number of holes appearing in NHS services locally.

There are very few prospects, and you see that reflected in morale. It is at an all-time low, and the profession suffers from many undiagnosed cases of stress. CQC inspections are having a huge effect, and this is why there is a need for urgency. We have voiced concerns about CQC inspections before, with tales of colleagues being bullied and treated with contempt. It is unacceptable. This also means there is an ever-increasing admin burden. First it was the friends and family test, and now the accessible information standards. Dentists work long hours and are now being paid less for doing more work, both clinical and paperwork. On the flip side documents like the HTM 01-05 that were supposed to be living documents have not changed for years. It becomes non evidence-based regulation.

AM IT has taken 10 years for the contract to reveal the true level of stress, unhappiness, low morale and disillusionment. The workforce has to deal with more regulation and more paperwork with no extra time. This takes away from treating patients, so it cannot possibly be a good thing.

We will find ourselves in a situation where the workforce is either too ill to complete their work or they are so unhappy they just do not care. No-one can make this contract work and quite frankly it has been a shambles from start to finish. The longer it carries on the more it will serve to alienate staff. That is why this is so urgent.

> 'There are very few prospects, and you see that reflected in morale. It is at an all-time low, and the profession suffers from many undiagnosed cases of stress. CQC inspections are having a huge effect, and this is why there is a need for urgency'

It's clear the 2006 dental contract is not fit for purpose. How would you summarise the previous 10 years of NHS dentistry?

AM Disastrous. It is dreadful for patients and for dentists. The only people who have benefitted have been the Department of Health. They have all the control. They have been able to cap dental budgets and expect us to do more for less. UDAs are a dreadful nonsense. You have the situation where in the same town on the same street UDA value is £18 in one practice and £30 in another. How can that possibly be fair? Statistics may show that everything is rosey in the garden, but they are misleading and always have been. Moving the goalposts does that.

The worst thing is in 2006 we predicted this would happen. Nothing good has happened. Nothing.

ME Simply put it's been chaos, confusion and underfunded. There has been a significant de-skilling of the workforce, and I am extremely concerned about the long term viability and education of those who have joined the NHS in the last 10 years. There has been increased demand and expectations from the public too, as they assume everything is available to them. This is not the case, but for one reason or another the message just is not getting through.

We have seen over this period stress increase, with the contract resulting in overworked, underpaid and isolated workers. You may be a team, but you work in silos. That has not evolved, and with the constant threat of UDA's hanging overhead, it shows no sign of changing.

How would you like to see the motion come to fruition in the new contracts once the prototypes and pilots have been completed?

ME The patient charter is a key vehicle for pushing through this motion. We firmly believe that any new contract should highlight and define patient rights and responsibilities. Patients may not think they have responsibilities, but they need to accept their responsibility for maintaining good oral health. If they open bottles with their teeth, they should not be surprised if their teeth break. These kinds of treatment are totally preventable, and would cut down on so many unnecessary treatments.

Having said that, it is not just dentistry that suffers from this. You would be hard pushed to find someone who – for instance – does eat five portions of fresh fruit and vegetables a day, or stays within the sugar consumption guides recently set out. If the patient charter set out and established these responsibilities, improvements in all areas of healthcare would be the next logical step.

AM Every workforce deserves fair working conditions. That is a no brainer. Look at what we have. We don't even have occupational health support. How is that even remotely fair? There needs to be acceptance from all involved at government level that this contract is awful and not fit for purpose. I would like to see services funded properly. I would like to see an end to the scandal that is childhood tooth extraction under GA. I want something that is fair and just, and I don't know why we don't have that already.

The LDC meeting also saw a presentation from CDO Sara Hurley. Do you think her appointment comes at a time where dentistry is going through changes, or do you think the CDO is behind the drive for change?

ME The agenda for change has definitely slowed down. I believe this is due to the lack of perceived long term access to dental care problem. Figures no longer show a problem, where they can be misleading. The total lack of appetite for change comes as a result of that, and it is based on figures.

I do hope however the new CDO oversees necessary changes to working conditions. The level of debt amongst general practitioners is alarming. We are concerned about the clawback of money. Recent changes to the prototype limit the amount of private work you can offer to patients, and that is restrictive.

AM I agree. I met Sara early on in her post and found her to be very, very passionate. She seemed determine to drive through change. She recognised there were problems to address, which was welcoming. Her attempt to forcibly put forward problems with the current contract was great, but little or nothing has come of this.

Do you think local issues are heard at national level?

AM 100% absolutely not. The system is a shambles, filled with weasel words. In our area the dental lead works for half a day and covers five counties. How is that going to work? How is that an appropriate use of time? It is all smoke and mirrors. Northants used to be responsible for 76 contracts, but now with no further funding or additional support is responsible for 700. That's not right.

> 'There needs to be acceptance from all involved at government level that this contract is awful and not fit for purpose'

This all happened when the PCT's went. We used to have a superb one. We had a voice. People used to listen to us. That has gone and now government don't listen. It's just a big Cinderella story.

ME Like Alisdair I think no, absolutely not. DH has little sympathy, and that is reflected in the lack of occupational health available for dentists. There is also very little support for NHS staff too. Here in Hertfordshire we used to have a very good sedation service, and that is now starting to struggle. If you head two counties north to Northants, they don't have one at all.

It is the same principle with sugar. People have been trying to impress how bad large levels are for teeth for years, and only now we see the effect it has on diabetes and obesity is it in the media. That is fundamentally wrong, and local voices must be heard. ◆

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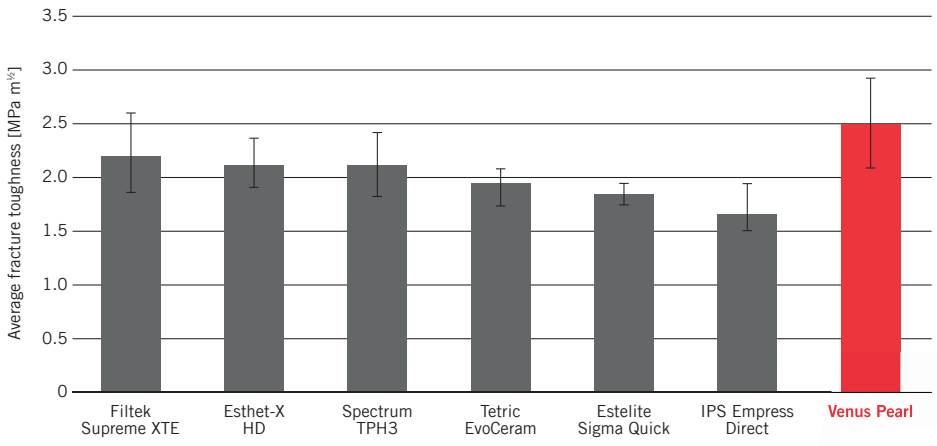

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Associates and practice procedures – acting as a representative of the practice

by James Goldman
the Practice Support Team's Special Adviser (Legal). James trained as a barrister and advises dental practices on associate contracts and a wide range of employment and other law.

Associates do best for themselves when they make the most of what the practice has to offer. When it comes to good patient or customer care, working as part of a team is essential. Practices may set the main parameters of customer care in their business but associates, despite being self-employed, need to consider how they fit into the processes used, how they can contribute and exceed this. It's in the interest of their livelihood at the practice and their professional reputation. While associates are self-employed and have full clinical freedom and responsibility, they are also part of a dental team.

Why it matters

Customer care is important in all business. In general practice, patients are happier when they have had a good experience visiting the dentist and are more likely to return. Figures for NHS dentistry in England[1] show that although 84% of patients were satisfied with the service received only 49% reported having a 'very good experience'. You are in a position to drive that figure up in your practice. Major factors for patients in having a positive experience include personal interaction with the dentist and the level of comfort during the visit and treatment[2].

The perception of patient comfort is related to the reassurance provided by the dentist and the practice environment. The tidiness, décor and modernity of the practice influence opinions about the quality of the care. While the practice environment may well be the practice owner's responsibility, associates are in a position to make valuable suggestions. General tidiness is everyone's responsibility. More precisely associates can make valuable suggestions about practice layout and equipment from their and their patients' experiences. Practice owners should value the input given by their associates.

Keeping to time is a key element of customer care. Many patients will have taken time off work to attend a dental appointment and may have to get back to their workplace or have commitments afterwards. Communicate with the reception desk about appointment times to ensure that appointments are booked for the appropriate length. You can best assess best how long will be needed for the patient's next visit. When things do overrun it is best to be clear about it. Keep the reception desk informed of how you are doing so the receptionist can set expectations about waiting time and can help smooth the flow of patients.

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Procedures

Practice systems for patient care and quality assurance are important commitments for associates. Typically associate contracts include a term on complying with practice policies and procedures. This may appear as limiting the clinical freedom of a self-employed associate but it is not. By using the facilities at someone else's practice you are agreeing to respect those facilities and the practice as a whole. Practice policies are important as they are not just lists but guides on how everyday things are done. These should be useful so associates and practice staff can present a seamless customer-focused experience to the patient. Those procedures should not be carved in stone. If an associate feels that a particular procedure is not working, it would be unwise for a practice not to consider the associate's suggestions for change and to respond constructively to those suggestions. ◆

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Accessing Occupational Health Services

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

After a wait of nearly two years, the *NHS England National Primary Care Occupational Health Service Specification* was finally published in March 2016. The specification was developed to ensure services are now accessible to all NHS contracted practices in England. This seeks to address inequity in the provision of services between area teams and before that primary care trusts.

Dentists on the NPL

NHS England will fund a core service for performers registered on the National Performers List (NPL). Access will be available five days a week covering normal working hours, Monday to Friday, 52 weeks of the year, excluding bank holidays.

Dentists on the NPL who are not already immunised will be able to access virology testing, vaccination for BBVs and a range of other immunisations. The inoculations available include Varicella, Tuberculosis (BCG), Diphtheria, Pertussis and Tetanus, Measles, Mumps and Rubella.

An enhanced occupational health assessment can be accessed either by self-referral or, with consent, on referral from their GP or designated medical director within NHS England. This will enable access to support in relation to a health concern, or potential concern, which may impact on the ability to work safely and effectively.

Screening

The occupational health screening for dentists applying to join the national performers list in England is also confirmed. Applicants will be required to use the Occupational Health services directly for their clearance and immunisations, rather than using, say, GP services (though they will have to pay for this).

Practice staff

The new specification ensures access to an occupational health facility for other practice staff. Your team members will be able to receive an occupational health assessment, virology testing for the presence of blood borne viruses (BBVs), immunisations, and referral for additional support where necessary to maintain health and wellbeing in the workplace. However, this provision will not be paid for by NHS England, except in the case of inoculation injuries. Practices should be aware of the range of fees charged in order to compare this to other commercial providers to ensure they access a competitively priced service that meets their needs.

Managing inoculation injuries

The specification provides a specialist tier of support for the management of inoculation injuries and potential exposure to BBVs. Providing urgent and longer term advice to all those working in primary care – including staff and trainees – upon injury or potential exposure to BBVs is a key part of the national specification. Assistance will be available to those healthcare workers in primary care settings who are or may be carriers.

All injuries resulting in potential exposure to BBVs should be classed as medical emergencies to ensure that, out-of-hours, dental staff get the appropriate priority when attending A&E. A 24/7 emergency telephone advice line will be in place to direct individuals to A&E for immediate management. Advice on this should also be available on the occupational health provider's website.

NHS England will fully fund the provision of occupational health services to those with needle stick injuries (including the provision of prophylactic management if required). On-going monitoring for 'fitness to work' should also be provided by the service. However where clinical treatment is required as a result of contracting a BBV, treatment will be provided through mainstream NHS health services.

Private practices

The occupational health services that are commissioned under the new specification should also be made available to non-NHS dentists on a fee for service basis. This provision will not be funded by NHS England.

Yet more delays?

Although published this March, in some areas there will undoubtedly be delays to the roll-out of the new specification. Some areas may be contractually bound to existing arrangements with service providers for many months, preventing them from implementing the specification in full. Where this is the case, practices should engage with their local dental committee (LDC) to ensure that access can be provided as soon as possible.

Northern Ireland, Scotland and Wales

In Northern Ireland, Health & Social Care trusts provide occupational health services to health service dentists and their directly employed staff. These services can be accessed through referral or self-referral.

In Scotland and Wales, health boards are responsible for the provision of services to NHS contracted practices. Fully private practices may find it more difficult to access the services they require and ultimately they may need to engage with a commercial provider. ◆

Weblinks

Information on the NHS England National Primary Care Occupational Health Service Specification is available at www.bda.org/occupationalhealth

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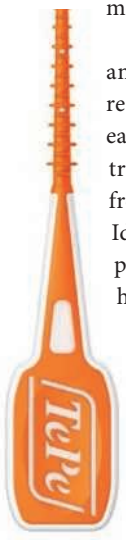
The design of the EasyPick Orange allows the user to access smaller gaps between the teeth, whilst its tapered head helps remove trapped food and any built-up plaque from between the teeth – helping to improve overall dental health. Launched at the Dentistry show. EasyPick will be available to practices from May onwards.

TePe EasyPick is comfortable to use, gentle on the gums and has a non-slip grip. It has been designed for on-the-go use to provide a cost-effective solution to remove trapped food and also to help patients reach the hidden 40 per cent of the tooth that regular tooth brushing misses.



TePe EasyPick Orange and Turquoise come in a re-sealable pack of 36 and each pack includes a handy travel case to encourage frequent, on-the-go use. Ideal for encouraging patient compliance and healthy habit formation.

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Join the implant renaissance

BioHorizons is delighted to announce that its unmissable one-day event – entitled 'A Contemporary Renaissance Awakening: Aesthetics in Implant Dentistry' – will take place in London on Friday 30 September, 2016.

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As well as exploring the art of achieving aesthetics through the architecture of treatment planning and questioning the importance of material selection to imitate nature, the presentations will consider potential complications, the challenges of case predictability and how to manage patient expectations throughout their personal journey.

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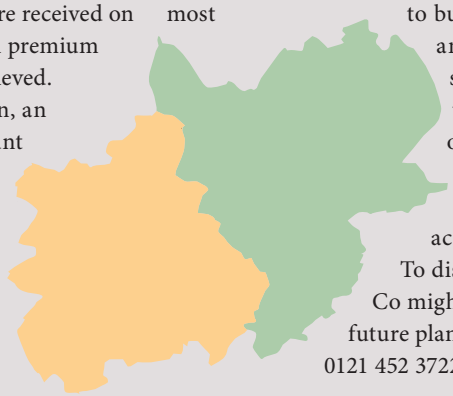

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Chewing sugarfree gum after eating or drinking is a valuable tool which can help support oral hygiene when patients don't have immediate access to more traditional oral care techniques.

The European Commission (EC) has approved five oral health claims for sugarfree chewing gum, one of the few food categories to gain such recognition. EC claims include three claims for general function (neutralisation of plaque acids, maintenance of tooth mineralisation, reduction of oral dryness) and two claims for disease risk reduction related to dental caries (neutralisation of plaque acids, reduction of tooth demineralisation).

Chewing sugarfree gum promotes the production of saliva, the natural protection mechanism of the mouth. It stimulates the salivary glands to produce a strong flow of stimulated saliva, a 10-12 fold increase over resting saliva rate during peak stimulation. Stimulated saliva enhances the mouth's natural ability to fight dental disease by neutralising plaque acids, and supporting tooth remineralisation.

Furthermore, new research published in the British Dental Journal showed that significant NHS cost savings could be made if more people chewed sugarfree gum after eating or drinking, thanks to the role it plays in helping to prevent tooth decay.

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Enabling you to make better use of your time and enhancing the patient experience, the membrane is resorbable requiring no further surgery for its removal. Designed to resorb safely over a prolonged degradation time,3 the aesthetic outcome is improved, providing convenience for you and your patient.

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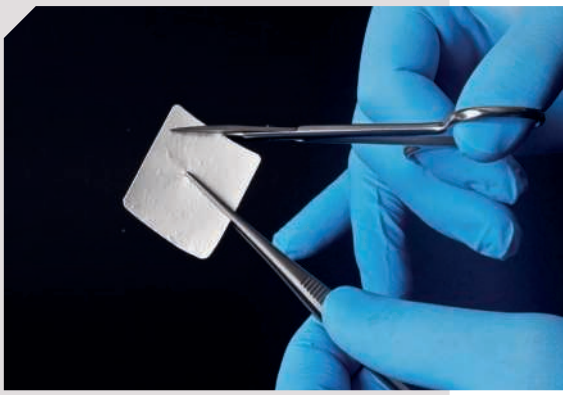
Croes Xenoprotect membrane acts as an impenetrable barrier against unwanted cells, paving the way for vital in-growth of osteogenic cells and blood vessel penetration. Key to its reliable success is its high mechanical strength and degradation resistance for prolonged stability and long-lasting protection of the graft material. It is also highly tear resistant and its elastin fibres create a flexible material that can be easily stretched over the defect4 and sutured without tearing.

Gateway to effective tissue regeneration

Created without any chemical cross-linking, the tissue integration and vascularisation properties of Creos Xenoprotect are not compromised3 and the ideal conditions for regeneration are achieved. Histology clearly shows the rapid formation of new blood vessels, leading to a faster and much more predictable tissue healing process.

To arrange for a free demo or for more information on Creos Xenoprotect from Nobel Biocare call 0208 756 3300 or visit www.nobelbiocare.com.



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2. Data on file, Nobel Biocare, Statistically significant lower size increase compared to standard cross-linked collagen membranes on the market.
3. Data on file, Matricel GmbH.
4. Bozkurt A, Apel C, Sellhaus B, van Neerven S, Wessing B, Hilgers R-D, Pallua N. Differences in degradation behaviour of two non-cross-linked collagen barrier membranes: an in vitro and in vivo study. *Clin Oral Implants Res* 2014: **12:** 1403-1411.

New 3D printer announced

The Finnish dental equipment manufacturer Planmeca has introduced a 3D printer to expand its product portfolio. Named Planmeca Creo, the new 3D printer will allow dental laboratories and large clinics to perfect their craft and grow their business.

Planmeca Creo is a powerful 3D printer for creating dental splints, models and surgical guides with true precision and efficiency. In the near future, the device will also support the creation of other dental objects of intricate detail, such as temporary fillings and orthodontic models.

Planmeca Creo uses Digital Light Processing (DLP) technology to create objects out of UV curable resin. The 3D printer has its own dedicated software, which is included as part of all deliveries.

The new Planmeca Creo 3D printer is available for pre-orders, with deliveries expected to begin in June.

For further information visit www.planmeca.com.

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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

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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

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236739

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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

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Dr Nicole Sturzenbaum
Toothbeary Practice Richmond
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East Twickenham TW1 2DU
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Email: info@toothbeary.co.uk
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258051

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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

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www.dentalspecialistmk.com

259 Queensway, Bletchley, Milton Keynes MK2 2EH
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Email: admin@dentalspecialistmk.com
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On Specialist List: Yes, Orthodontics, Periodontics, Prosthodontics, Restorative Dentistry, Endodontics and Oral Surgery

209440

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239826

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

270171

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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 West

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19-21 St George's Street, Chorley, Lancashire PR7 2AA
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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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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:
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Specialist Periodontists:
Trisha Whitehead and **Puneet Patel**

Specialist Orthodontist:
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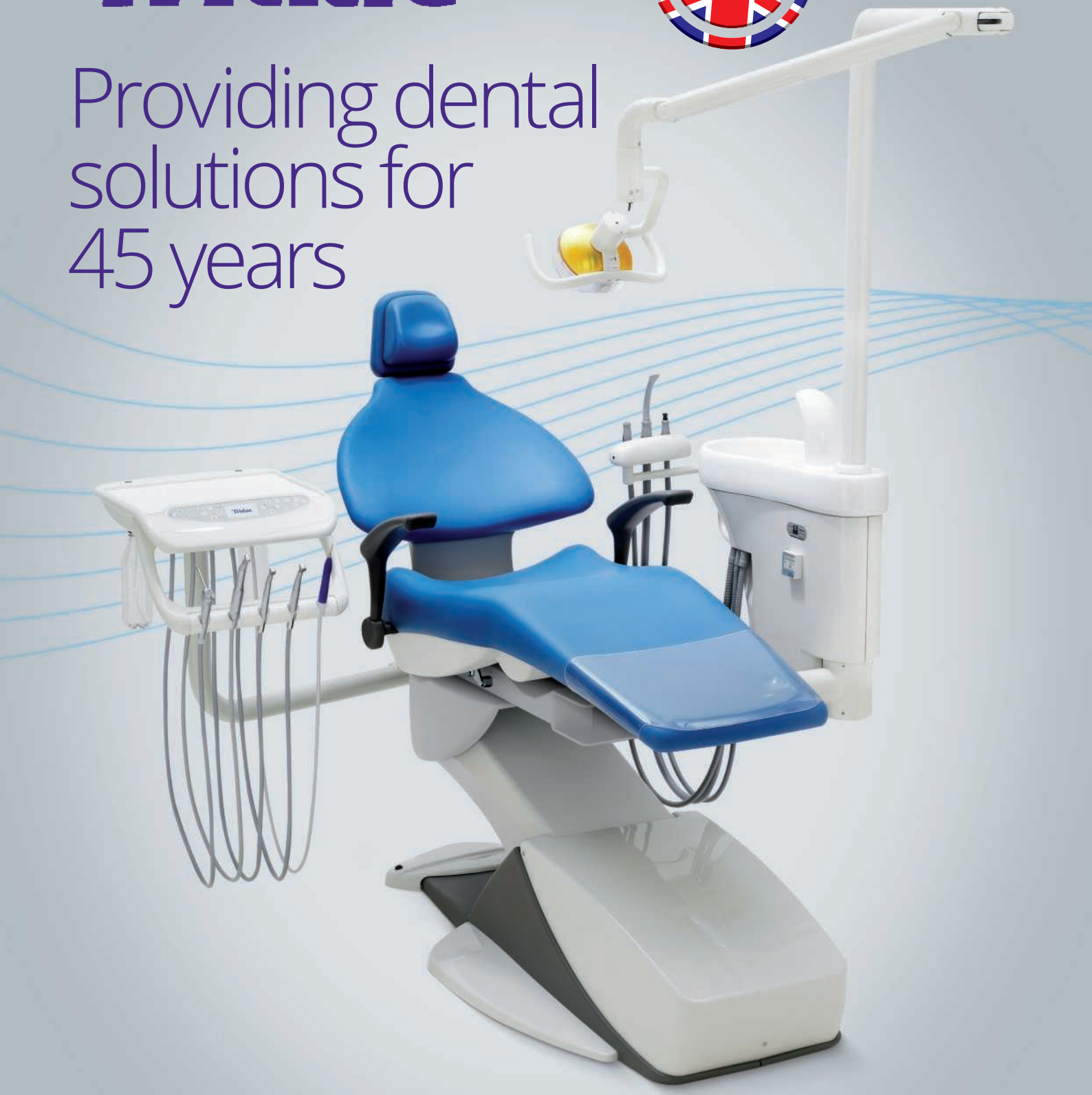

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Business skills CPD

Q1: Who would determine if any additional examinations would be required for EU dentists entering the UK?

A UK government
B NHS England
C GDC
D BDA

Q2: What is the best course of action if you find yourself under attack?

A Take a step back and assess the situation
B Meet the problem head on
C Leave it until it blows over
D Do nothing

Q3: If you are organising an event for staff outside of practice hours, which of these should you do:

A Inform staff they can let their hair down
B Remind staff of their responsibilities
C Not get involved
D Stay out for the duration of the event to monitor what happens

Q4: In the advice page on associates and customer service, what does it say you typically find in an associate's contract?

A A term on complying with practice policies and procedures
B A term that states the associate only rents space
C A term that says the associate is responsible for their own conduct
D A term that states the associate is not required to comply with practice policies for insurance reasons

Q5: Are private practices seeking occupational health services funded by NHS England?

A Yes
B Yes, but only if they offer NHS treatment
C No
D No, but you can apply for funding

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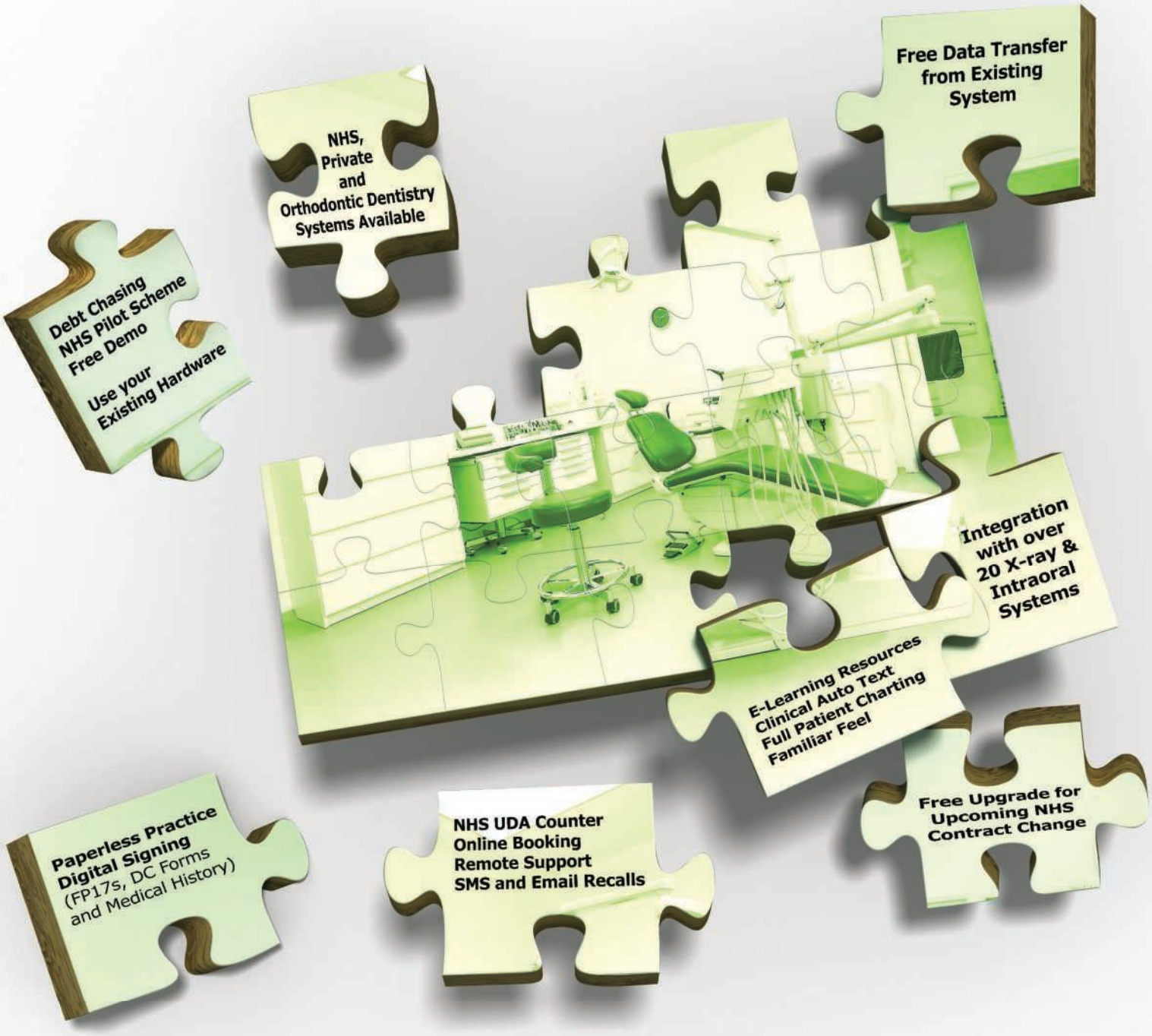

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