BDJ InPractice
May 2016

The Dental Contract: 10 years on

BDA

Generating goodwill ■ Botox in practice ■ SWOT analysis ■ Advice pages

Anatomy of a champion.

Unsurpassed Access: An ultra-thin back and headrest allow you to work in a comfortable position—legs under the patient, elbows at your side.

Easy Positioning: Chair swivels 60° for better positioning and easy patient entry and exit.

Effortless Adjustability (Left/Right): The delivery system easily glides on either side of the chair.

Ergonomic Flex Arm: Rotating arm easily moves up and down for precise placement.

Exceptional Lighting: State-of-the-art LED provides brilliant, balanced light for an accurate view, and cure-safe mode for working with composites.

See what makes A-dec 500 the best-selling dental chair, year after year.*

* Based on research by *Strategic Data Marketing*.

Superior performance. Proven solution. No compromises.
It's all of these attributes that make dentists continually choose A-dec 500.

a-dec
reliablecreativesolutions

A-dec Dental UK Ltd
Austin House, 11 Liberty Way, Nuneaton, Warks, CV11 6RZ. Tel: 024 7635 0901 Fax: 024 7634 5106 Email: info@a-dec.co.uk Web: www.a-dec.co.uk

BDJ InPractice

MAY 2016

Cover illustration Danny Allison

Editor David Westgarth | **Production Editor** Sandra Murrell | **Art Editor** Melissa Cassem | **Publisher** James Sleigh | **Global Head of Display Advertising & Sponsorship** Gerard Preston | **European Team Leader – Academic Journals** Andy May | **Display Sales Executive** Alex Cronin | **Production Controller** Natalie Smith | **Editor-in-Chief** Stephen Hancocks OBE.

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

Acceptance of an advertisement by *BDJ In Practice* does not necessarily imply endorsement by the British Dental Association. ISSN 2057-3308.

BDA

Automated patient marketing with instantly measurable **return on investment...** it's now possible!

BRAND NEW EXACT V12

The revolution in patient marketing

Revolutionise your marketing and **grow practice revenues** through automated, multi-channel communications. Brand new **EX**ACT **V12** has the tools to not only computerise your entire practice workflow; but also help you attract new patients, promote your services to existing patients and monitor your **return on investment** with brand new **Marketing Manager, Online Reputation Manager** and **Channel Track.**

Talk to an Expert today about transforming your practice with EXACT V12

t: 01634 624267

info@thrivewithsoe.com
www.softwareofexcellence.com

SOFTWARE OF EXCELLENCE
A Henry Schein® Company

An end to publishing registrants' addresses is finally in sight

The BDA is pleased that the GDC has agreed to end its policy of publishing registrants' addresses online. This new approach follows extensive lobbying by the BDA.

However the decision cannot be implemented immediately because the rules and regulations governing such a change mean that there will have to be a public consultation first.

The BDA anticipates that the consultation will ask whether respondents favour publishing the registrant's name, number and town/region, or just their name and registration number. The final decision will be made at a Council meeting after the consultation.

In addition to this long awaited change, there will be a stronger focus on registrants displaying their registration numbers in work places and on paperwork.

BDA Chair Mick Armstrong said: 'It is good news that the GDC has made this step in the right direction. The publication of addresses was unnecessary, and out of line with other regulators, as well as a potential risk to registrant safety.

'The BDA has campaigned long and hard on getting this policy changed.

'The process of change is slow, but we expect the GDC to remain on course and implement this vital change. We hope that the GDC continues to adopt such a proportionate approach to all of its regulatory responsibilities.' ◆

© Varijanta/Getty

Implementing NHS England's Accessible Information Standard

Dental practices in England are reminded that they are expected to follow the Accessible Information Standard by the 31 July deadline.

The Standard, which aims to ensure that disabled people have access to information they can understand and the communication support they may need, applies to service providers across the NHS and adult social care system and contains the following five key requirements:

1. Ask patients and carers if they have any information or communication needs, and find out how to meet their needs
2. Record those needs in a set way
3. Highlight those needs in the patient's records, so it is clear that they have information or communication needs, and clearly explain how those needs should be met
4. Share information about a patient's needs with other NHS and adult social care providers for example when referring the patient, when they have given their consent or permission to do so
5. Make sure that patients receive information in an accessible way and that they receive communication support if they need it.

©MAURO FERMARIELLO/SCIENCE PHOTO LIBRARY/Getty

For detailed guidance on these requirements visit www.england.nhs.uk/ourwork/patients/accessibleinfo-2. If you have any questions then please contact the BDA's Advisory Services team on 020 7563 4550. ◆

Employers requesting the wrong PVG information from Disclosure Scotland

The body responsible for vetting staff to check whether they can work with children and vulnerable adults has reported that some employers are asking for the wrong type of check, which is costing them more money.

Disclosure Scotland have said that some employers have been requesting a PVG Scheme Membership Statement, a statement they have said is not suitable for the dental practice.

There are two possible types of records that a dental practice could request:

- A PVG Scheme Record Update – this would be requested if someone has already been vetted and checked by the PVG Scheme
- A full PVG Scheme Record – this would be requested if the person does not have the above record.

For more information go to www.disclosurescotland.co.uk/faq/. ◆

BOOK REVIEW

Innovative Teams

Innovative Teams (20 Minute Manager)
Harvard Business Review Press, 2015
ISBN: 978-1-63369-004-2
£7.99

This one hundred page paperback isn't going to solve all the problems a manager can face when leading a team. Some of the ideas mooted here clearly originate from a theoretical or academic standpoint, hardly surprising considering the provenance of the book's publisher. For example, the 'sidebar' which within the space of quite a lengthy aside, attempts to deal with the thorny issue of handling interpersonal conflict, ultimately gives up by the end by recommending the introduction of a 'facilitator' if all other avenues fail. Hardly a practical solution.

However, there are some very good ideas thrown up here. Beginning with some reasonable suggestions about enhancing the team's creativity, this is an aspect which is applicable to all team members and also includes vital areas such as innovation.

Next, there's an ensuing, critically important chapter, on building your team. This is divided into two halves; building a team from scratch provides the ideal opportunity to assemble a 'dream team' using various methods including the Myers-Briggs (personality) Type Indicator. More often though there's a need to enhance the creative potential of an existing team and this chapter covers that too in the form of suggestions to visit other teams, attend conferences or even for the team to watch a TED talk for inspiration (popcorn optional). Also discussed are the key areas of idea generation, choosing the right option and promoting a creative culture within your company.

FINANCE

New sustainable dentistry e-learning resource launched

A new session on sustainable dentistry has been released on the e-Learning for Healthcare (e-LfH) platform.

Released to coincide with NHS Sustainability Day 2016, the resource provides an introduction to climate change and explores the main principles of sustainable practice and their application in dentistry. It encourages clinicians and managers to make sustainable choices and identifies practical tools and resources to support this.

The material can be accessed by the dental team free of charge on the e-LfH website which provides 24/7 access to nationally quality-assured materials on a wide range of topics in health and social care including dentistry. These sessions utilise an engaging and interactive presentation style using images, video and animation as well as self-assessment to help build knowledge and understanding.

The NHS has a carbon footprint of 22.8 million tonnes CO2e per year. This includes emissions from building use, travel, purchasing of goods and services and commissioning[1]. Dentistry contributes 3% to this footprint[2] which equates to 0.9 million tonnes CO2e per year. With climate change reported to be the biggest threat to global health in the 21st century[3], sustainable healthcare is more relevant now than ever. Training in this area is becoming increasingly valuable as the need to improve value from finite resources and move towards low carbon, high-quality models of care becomes more apparent.

The e-learning resource has been developed by dentists, Dr Devika Vadher and Dr Divya Verma, working with the Centre for Sustainable Healthcare (CSH) as Sustainable Dentistry Scholars – part-time roles funded by Health Education Kent, Surrey and Sussex.

Dr Divya Verma, KSS Dental Public Health Sustainable Dentistry Scholar, said: 'There is no doubt that climate change will impact health, the delivery of healthcare and access to services in the UK. As health practitioners, who are concerned with the well-being of patients, it is imperative that we consider the environment whilst providing healthcare. Although it can seem insignificant, every action we take is helping to make a difference and there is great potential at the moment to bring about change and empower dental teams to integrate sustainability in their practice as well as create change makers in dentistry for the future.'

1. Sustainable Development Unit. Carbon update for the health and care sector in England, 2015
2. Carbon modelling within dentistry. Public Health England and Centre for Sustainable Healthcare, 2016 (in press).

1. McMichael A J, Woodruff R E, Hales S. Climate change and human health: present and future risks. *Lancet* 2006; **367:** 859-69. Review. Erratum in: *Lancet* 2006; **368:** 842.

Minister for dentistry to headline this year's LDC conference

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 on 9 June.

The conference, which will run over two days, will also feature a presentation from England's chief dental officer, Sara Hurley, on June 10th, 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.

BEN FUND

Help Is Always Needed

None of us can predict the future, and as a result, life can stop us in our tracks when we least expect it.

The BDA Benevolent helped Dr. R when she discovered this for herself early last year. Her life was turned upside down after a severe heart attack and although it wasn't life threatening, Dr. R struggled with the after effects of undergoing a coronary artery bypass graft. Between recommended rest and gradually restoring physical fitness, Dr. R had no choice but to take considerable time off work. Sadly, her husband also lost his job at this time and as there wasn't an income to support her husband and two young children, debt inevitably amassed.

Just as Dr. R had started to recover, her husband had a nervous breakdown. Although after several months he managed to recover, he was unable to find employment. Between the responsibility of looking after her husband and children and dealing with the emotional and physical aftermath of her heart attack, Dr. R found it increasingly difficult to cope. When the situation started affecting her daughter with extended periods of depression and poor performance at school, she was unable to continue working as a dentist.

Eventually, her debts forced Dr. R to declare bankruptcy and sell her home. During this process her husband left her and their children and has not provided any financial support since.

Circumstances like this are more common than you would like to believe. Dr R is now a support teacher in a local school and feels brighter about her prospects. By working together to provide financial support, the future for dentists doesn't have to be bleak.

Run by dentists for dentists, the BDA Benevolent Fund provides pecuniary support to current and former dentists and their families through all stages of their lives. The charity relies on the generosity of dentists, dental organisations and companies to continue its work, so your help is critical.

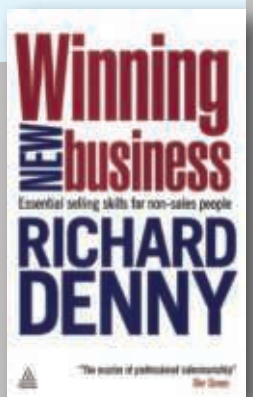
By making a monetary donation or participating in fundraising events you are helping a valuable cause. Thanks to the support of the profession, the BDA Benevolent Fund was able to help Dr. R, and who knows, maybe one day the Fund will help someone you care about.

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.

BOOK REVIEW

Winning new business

Winning new business - essential selling skills for non-sales people
Richard Denny
Kogan Page, 2010
ISBN: 978-0-7494-5988-8
£9.99



Richard Denny is a motivational speaker, consultant and author of over five best-selling books on business-related issues, specifically related to communication and selling issues. As Denny explains from the outset, 'selling' is recognised as a word with negative connotations together with 'profit'. However, businesses do not survive without making a profit or selling their services, so part of his goal is to de-stigmatise these words.

Denny takes the reader through the only four ways (in his opinion) to grow a business, increase the number of customers, increase average transaction value, increase the frequency of repurchase and acquisition (of other business).

He also recommends being a 'pully' person as opposed to pushy one. Patients should want to take your call and look forward to meeting you. He stresses the importance of dressing to your brand image, ie, in a uniform or 'whites', citing a negative example of a hospital in-patient being confused on ward rounds by informally dressed doctors and students.

Whilst not all the chapters here are relevant to the business of dentistry, many carry universal traits which, such as the importance of customer care and staff going the extra mile, which hold true in any business. The final very short chapter 'How to fail fast' is an amusing but cautionary take on the customary 'how to succeed'. Common pitfalls include denying it's your responsibility to win business, thinking life would be so much better without clients and whatever you do, don't plan your days!

What Denny does well is communicate his ideas in a coherent and comprehensible manner so this one hundred and forty page paperback is an easy but valuable read. Whilst it was first published in 2007, this is a more recent paperback edition and despite its age (in book years) its contents and message are indubitably timeless.

Dentists' confidence up but contract reform uncertainty remains

Dentists remain the most optimistic profession when compared to GPs and pharmacists, despite continued concern about the long-term funding of the NHS dental contract.

Published by Lloyds Bank Commercial Banking, the Healthcare Confidence Index shows a combined confidence amongst dentists surveyed has increased from a net balance of -8 to -5, an increase of 13 points over the past two years, representing the biggest rise across the three professions.

Long-term confidence amongst dentists has slightly improved since the last survey, up from -57 to -54.

The rise in confidence could be reflective of a profession that benefits from more non-NHS income. More than 37% of those surveyed want to increase their private work, up from 29% in last year's index. Indeed, 56% expect that a 'foot in each camp' of a mixture of NHS and private services will be the most valuable business model in the coming years.

Dental contract to shape future plans

Despite an increase in confidence overall, dentists are unsure about the outcome of the reformed NHS dental contract; a majority (81%) continue to express doubts that it will be adequately funded.

Another concern raised is the longer term profitability of NHS practices, with only seven per cent feeling that this will be the most profitable option over the next five years. This compares to 27% who think private practices will fare better.

In total 82% of dentists feel that the financial pressure on their practice will increase over the next five years, but that said, 74% are looking to grow their business.

Despite ongoing reforms, dentists remain happy to encourage their friends or family to follow them into the profession, with 63% saying they would recommend it up one per cent from last year's survey.

Ian Crompton, Head of Healthcare, SME Banking, Lloyds Bank Commercial Banking, said: 'The latest Index shows there is still optimism amongst dentists, with three quarters planning to expand, whether at their current site, or by branching out into more locations.

'It's good to see the profession is confident about plans to grow and, looking ahead, as younger dentists enter the industry, we may see an even greater appetite amongst professionals to control their own destiny, and cultivate their own practices.

'We continue to work closely with dentists in what is an evolving sector, and provide tailored funding and support to those seeking growth opportunities.'

Mixed and NHS Practice values continue to soar

There has been talk about a bubble, but it certainly shows no sign of bursting at present as reported in the latest NASDAL (The National Association of Specialist Dental Accountants and Lawyers) goodwill survey. Practice sales as a percentage of goodwill continue to increase – particularly in the NHS and Mixed sectors.

The average goodwill value for practices being sold with an NHS contract is 153% of turnover; up from 140% in the previous quarter. Mixed practices have seen the average goodwill rise from 104% to 123% in only nine months.

Alan Suggett, specialist dental accountant and partner in UNW LLP, commented: 'The market as a whole remains buoyant – it seems determined to ignore the uncertainty around the NHS in particular and is carrying on regardless.'

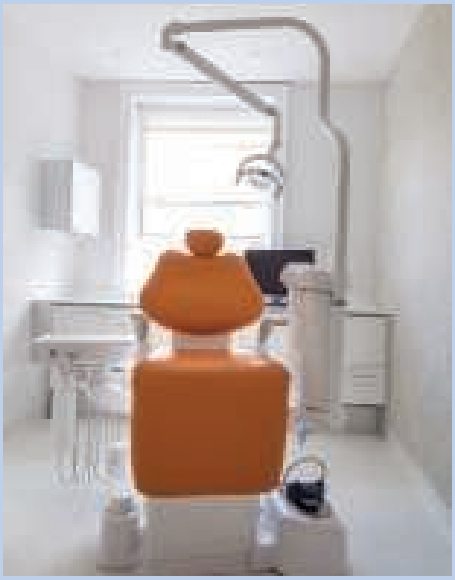
Indeed, one NHS practice sold for 294% of turnover and one mixed practice for 202% of turnover. Private practices have remained reasonably steady seeing an average goodwill figure of 84% - up from 76% at the end of October 2015.

NASDAL reminds all that as with any averages, these statistics should be treated as a guideline only.

NASDAL
National Association of Specialist Dental Accountants & Lawyers

Luxury and functionality combined

Dawood & Tanner… providing caring dentistry in a beautiful environment



Dawood & Tanner has long been a brand synonymous with the highest standards of patient care. Located, since 1992, in an impressive Georgian house in Marylebone's Wimpole Street, this 17-surgery practice is right in the heart of one of the best-known medical districts in the world. With the ethos of delivering 'caring dentistry in a beautiful environment', the practice has built up a reputation amongst patients and referring dentists for innovative dental implants and restorative dental treatments.

Leading this forward-thinking private practice are directors Dr Andrew Dawood, Specialist in Periodontics and Prostho-dontics, and Dr Susan Tanner, Specialist in Prosthodontics. Together they have developed Dawood & Tanner Dental Practice from its inception in 1992 into the thriving Specialist practice it is today, employing a team of 40 employees.

With unique in-house CBCT and 3D Scanning facilities together with operating theatres, on-site laboratories, sterilisation unit and state-of-the-art facilities the team are able to perform the most advanced and convenient treatments possible. To ensure the infrastructure keeps pace with the demands of their discerning clients, the practice is continually evolving. Most recently a new website has been launched to reflect in imagery and media the wealth of experience within the team and the advanced range of treatments available.

Investment in the building and facilities is also crucial. This year they renovated and invested in the addition of five new contemporary surgeries. The new surgeries and consulting rooms were designed to accommodate additional services. Each room has been fitted with the same leading edge technology and equipment but has its own individual style and décor, all in-keeping with the 'look and feel' of the distinctive Dawood & Tanner brand.

To assist with the selection and supply of the new dental chairs, the team turned to Ian Gocking at SPS Dental. After careful consideration the Belmont Cleo II folding legrest chair was chosen for all rooms. Andrew Dawood explains, "The chair's compact footprint was perfect for the spaces available whilst the upright position facilitates communication between the dentist and patient and is less intimidating for anxious and nervous patients. The visual impact of the chair was also important to us so the leather upholstery is stylish, soft and supremely luxurious to the touch whilst being hardwearing and resistant to bacteria. Finally, build quality and reliability are of paramount importance. In such a busy practice we cannot afford downtime from breakdowns so we felt confident in Belmont's excellent reputation in the market, knowing our chairs would be easy to maintain and give us years of trouble-free use."

Implementing this type of project requires skilful management to ensure day-to-day operations are not compromised in any way. Andrew recalls, "The biggest challenge of the whole project was the location of one of the surgeries on the very top floor. This meant all pipework and electrics had to be channelled through the building which is certainly not straightforward in a Georgian house. Also all the equipment including the weighty dental chairs had to be transported through the main stairwell making every aspect of the refurbishment a slow and laborious process."

With all five surgeries now successfully commissioned Andrew and Susan have now focused their attention on developing the Dawood & Tanner Academy. Education and training has always been an integral part of their practice. The broadening of the GDC scope of practice, changes in regulations, and the many new educational opportunities in dentistry, have motivated them to provide a single teaching centre offering accredited training and education. Course programmes are available on the website; please visit www.dawoodandtanneracademy.co.uk

Belmont

Please make enquiries to ~ 020 7515 0333 or One St Andrew's Way, London E3 3PA. Visit www.belmontdental.co.uk

10 years of the dental contract – so where are we now?

by David Westgarth,
Editor, *BDJ In Practice*

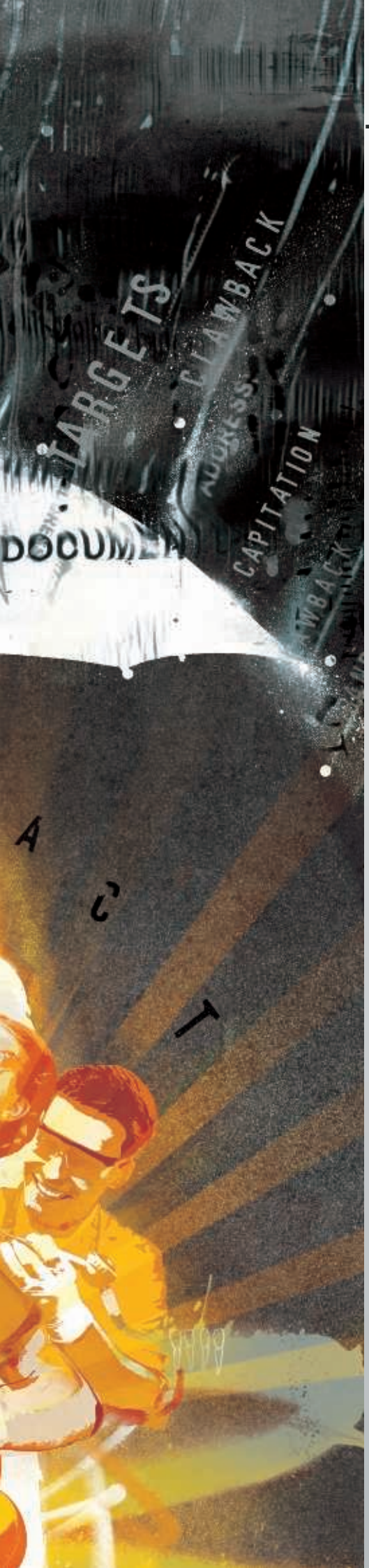
Hindsight. The *'understanding of a situation or event only after it has happened or developed'*, according to the Oxford English Dictionary.

Only *after* it has happened. The event in question is the introduction and imposition of the NHS Dental Contract in April 2006, yet even *before* it had happened, the warning signs were there. Not hindsight, but a foresight into what would prove to be an accurate prediction of the future of NHS dentistry.

> 'And what they are waking up to is chaos. The BDA has described the current situation as a shambles, for both patients and dentists.'

Some commentators have highlighted an uncanny resemblance between the imposition of dental contract and Jeremy Hunt's attempts to impose the junior doctors' contract. On the surface you can see why – the imposition of both the defining feature, but perhaps more pertinently is the negative foresight both contracts have as foundations. You will struggle to find anyone who welcomed the dental contract with open arms, just as you will struggle to find any support for the junior doctors' contract.

On February 25, 2006, chair of the General Dental Practice Committee Lester Ellman wrote the following editorial for the *BDJ*[1] on the imposition of the contract:



'Television shots of patients queuing, a leader article in *The Times* and front page splashes in the tabloids – at last the world is waking up to the biggest shake-up in dentistry for over half a century. And what they are waking up to is chaos. The BDA has described the current situation as a shambles, for both patients and dentists. According to the *Daily Mail*, 'almost seven out of 10 dentists might quit the NHS' after 1 April. Meanwhile at the BDA, our seminars on how to convert to private practice are a roaring success.

Every day our expert advisers hear a new horror story about contract values, Units of Dental Activity (UDA) allocations and the impossibility of planning for the future. The anxiety levels are rising and practitioners are angry and frustrated. While many general dental service dentists have known their contract values and UDA requirement since December, many do not agree that they are an accurate reflection of their past activity, cannot see how they will be able to deliver them, or have been told by their Primary Care Trusts (PCTs) that there is no funding for services to which they are already committed, often entered into with the active encouragement of the PCT. The finances of the PCTs are so tightly drawn that to support those practices that are growing they are dependent on practitioners withdrawing from the NHS to 'free up' some money. Additionally if, as the Acting Chief Dental Officer has said, PCTs will not be able to know whether they have growth funding until 1 April 2006, then significant numbers of practices are being de-stabilised just at a time when they need to be managing this massive change. Patient care is bound to be affected.

Of course, you could argue that we only hear the bad news on the 'phones at the BDA and as we travel across the country giving dentists our perspective on what is happening and advice on what to do. But listen to Health Minister Rosie Winterton and you will hear another story, that 'early indications' show that the vast majority of dentists are signing up to the new NHS contract. You will discover that instead of the current complicated treadmill system, dentists will soon have extra time to advise patients about better oral health. Indeed, we are looking at a bright new future for NHS dentistry, according to the Minister.

So, whose spin do you believe? Readers will make their own decisions but I suspect that the picture on 1 April 2009 when the ring-fence is removed from the PCT money for dentistry will not be quite how the Government envisages. Yet, when I met the Minister earlier this month, there was a real confidence across her team that all was well. The BDA had called for an urgent meeting to ask for the contractual requirement to deliver UDAs to be suspended until the system had been properly tested. The Minister wasn't having any of it.

'Every day our expert advisers hear a new horror story about contract values, Units of Dental Activity (UDA) allocations and the impossibility of planning for the future. The anxiety levels are rising and practitioners are angry and frustrated.'

My view, and it is one shared by the BDA's Representative Body, is that the new contract is not only being introduced with extraordinary ineptitude but that it is fundamentally flawed. It fails to achieve what it was meant to. It will not secure patient access, improve oral health or raise the quality of care. If you are a BDA member in England and Wales, we will be writing to you personally to explain our position and make sure you are getting all the support and advice you need. Not surprisingly, we have seen a significant increase in visits to our website (www.bda.org) which is proving a vital source of up-to-date and authoritative information for many of you.

Our priority now is to make sure dentists have all the materials and advice they need to survive this transitional period, and we will continue to keep the reality of what is happening in practices across England and Wales in the headlines.' ◆

1. Ellman L. Extraordinary ineptitude. *Br Dent J* 2006; **200**: 181.

Fast forward 10 years to 2016, and it appears NHS chiefs haven't learned their lesson. Another contract imposition wholly unwelcomed by the very profession at the sharp end of delivery. The prototypes – an admission that the 2006 contract simply did not provide the necessary room to deliver patient-orientated dentistry – have been evolving to the 'Blend A' and 'Blend B' currently being put to the test. So have the government and NHS chiefs learned their lesson with our contract? Current chair of the GDPC, Henrik Overgard-Nielsen, has his say.

Reading Lester's editorial from 2006 brings back bad memories for all of us who experienced the 'extraordinary ineptitude' at the time around 1 April, 2006.

What Lester describes is the chaos which was the order of the day when PCT staff had almost no knowledge of the rules, had not been trained in what they were supposed to do and what they were not allowed to do.

At the time I was chairman of the London Federation of LDCs. We had a practice on my patch where the PCT owned premises had burnt down in the qualifying period so the practice's entitlement under the new UDA system was less than £10,000 a year. This was a two dentist, one hygienist practice and despite the manifest unfairness of this and even though the CDO was informed about the problem the offer was not improved.

We managed to arrange a meeting with London MPs at the House of Commons where we were to discuss the problems with the new contract and we were obviously going to mention the problem for this particular practice, but the evening before the meeting the CDO managed to find a couple of hundreds of thousand pounds behind the sofa, so he called the PCT and asked them to offer this money to the practice in question – just before the meeting the following day.

The stress for everybody involved was enormous and I'm sure my grey hair started at that time.

One of our associates decided to go on holiday for eight weeks in January 2007, and when I suggested that I felt he should instead do some dentistry at the practice, he told me that he was running out of UDAs, and unless I could get the PCT to give him more UDAs he would have to stop work anyway. The CDO was unperturbed when informed that this dentist's only option was to offer private treatment to his NHS patients.

These are just two small examples of how chaotic the imposition of the contract was.

The biggest change was that PCTs suddenly had absolute power over which dentists and where dentists were able to work on the NHS, so instead of dentists being able to set up a practice where there was a need, we now had civil servants deciding where they thought a dentist should be allowed to work. If they were correct (and their criteria were often palpably ridiculous) and many people attend the practice then the dentist might well not be able to see all the patients due to limited UDAs. On the other hand if they were wrong and nobody attended the practice then the dentist would go bankrupt. To me it looked like no upside and a lot of downside.

A lot of the misery of 2006 has been forgotten and we have got better at dealing with the volatility and inequity of the UDA system but when Lester reminds us that the purpose of the contract was to provide more prevention and remove dentists from the treadmill then I think that by anybody's standard the contract has been an unmitigated failure.

I don't think anybody is in any doubt that the dental profession thinks that the present contract is and always has been, totally unfit for purpose, all you have to do is look at the results of our latest survey (http://www.bda.org/contractreform). But will whatever comes out of the contract reform process be any better?

I am still hopeful that the result of the pilots and prototypes will be an improvement on the present contract, you could say it cannot get much worse! But some of us are used to the existing contract and I recognise that some people are not comfortable with change but that doesn't mean we should not try to improve our working lives and the outcomes for our patients. There are however some things that need to be in the reformed contract if it is to be a success.

It needs to be focused on prevention and my opinion is that this cannot happen if the payment is dependent on doing fillings and dentures. At the moment the Department of Health (DH) seems unwilling to recognise that activity should also include the necessary time that needs to be given to discuss and implement preventative measures.

DH is also adamant that payments have to be based on a national figure, probably adjusted for age, sex and deprivation, but this will mean that some practices will have to see more patients than now where others will be able to see fewer.

If this is going to work, DH need to make sure they don't de-stabilise practices, so they have to find some money for an Income Guarantee, as they did for the GPs.

The reformed contract should also remove the cap on how much NHS dentistry each dentist is allowed to do, taking us back to the pre-2006 position.

If that happens then young dentists can start up on their own if they believe there is a demand, and existing practices will be allowed to expand, and with a new system where payments are based mainly on capitation it shouldn't cost the taxpayer any more money.

We are dentists providing NHS treatment, we should be allowed to do this to the best of our ability, for as many patients as want to be treated by us. ◆


Dentists sent on holiday by hard-up NHS

'Hasty and ill-judged'

Frustrated: Henrik Overgaard-Nielsen

©Daily Mail, March 29, 2007

Member stories

To further highlight our foresight into the catastrophe that would ensue, I asked three BDA members – one who worked only pre-2006, one who worked pre and post 2006 and one who only worked post 2006 – for their views on their respective contracts and beyond.

Pre 2006 – Stuart Robson

What was it like working pre 2006?

The question is going back into the 1960s when general practice was unhindered by a myriad of regulation – it was enjoyable! You had freedom of clinical opportunities, a reputation for high ethical standards and professional respect within the local community. The GDP was a 'jack' of all aspects of dentistry, practising a very wide range of skills. All undergraduates then had more 'hands on' education and clinical training in all aspects of clinical dentistry than modern day undergraduates which made dentists more aware of their limitations and therefore when to refer patients to a consultant. As a result there were many fewer patient complaints and fewer referrals to the first tier of enquiries, the Service Committees organised by the then local Family Heath Service Authorities.

There were patient charges but the fee was per item of treatment undertaken with a maximum fee for a course of treatment which generally rose per annum in line with inflation. This was fairer to both parties – the practitioner receiving remuneration for work done, and a ceiling for the patient.

What concerns – if any – did you have?

Compared to modern day the concerns were minimal. Occasional random checks (about twice per annum) a patient would be checked post treatment by a Regional Dental Officer (RDO) shortly after the course of treatment was completed, and often took place at the dentist's practice premises. In principle this was to prevent fraud, and for 99% of dentists it was a welcome distraction from day to day activity, and usually ended with a gossip with the RDO and a convivial coffee!

The main concern was the amount of treatment that was necessary as dental health was considerably poorer than more recently, possibly due to lack of understanding of preventative treatment and large numbers of patients requiring dentures, a relic of post war UK. This created huge demand, to the extent that my, and many other, practices had an extensive waiting lists of patients wanting NHS treatment creating the so called 'treadmill syndrome' amongst dental surgeons. Private practice was relatively uncommon in the provinces.

> 'I am not convinced the current NHS contract is beneficial for patients, for while providing routine treatment it is not geared for providing more advanced treatment and the patient charges are certainly a disincentive'

What would you have liked to see changed about the contract you worked under?

The 1990 NHS contract, of which I was a lead negotiator for the BDA, was a huge improvement in the terms of service for GDPs. The main changes that we secured, while maintaining the self-employed status of the practitioner, were:

- Help with practice expenses from DH that funded business rates at the practice
- For the first time Maternity pay and leave were introduced
- Funding for postgraduate education which had become a term of service. Previously GDPs had to fund their own CPD
- Formal registration of patients, for which a fee, paid monthly, without a patient charge was paid by the NHS giving some financial stability to the practice
- Improved NHS Pensions
- Children's annual capitation fee, paid monthly, again stabilising the practice funding
- Production of practice leaflets giving patient and public information
- The abolition of having to seek prior approval for advanced treatment such as complex orthodontics, chrome cobalt prostheses, multiple crown and bridges etc., giving the GDP more clinical freedom and trusting their professional judgment
- Provision of treatment plans for patients if the course of treatment required a second appointment
- Long term sickness financial benefits to assist GDPs who had serious health problem rendering them unable to practice for up to 6 months to fund the ongoing practice expenses.

From what you know do you feel patients are better off in the new system compared to the pre-2006 version?

I am convinced that patients and dentists are no better off. In fact wearing an advisory 'hat' I am finding many cases where dentists are worse of in the long run because, for instance, they do not, and will not, benefit from the still excellent NHS pension scheme (a factor which many have not factored into the financial conversion to private dentistry as the NHS pays a generous contribution into the dentist's pension pot over and above the amount the GDP contributes – which in turn is tax exempt), a state of affairs that many GDPs are not realising until they are in the latter days of their career when it will be too late to rectify the problem.

Some aspects of dental treatment are undeniably better, but this in spite of 'any system' not because of a 'system'. Improvements have resulted from patients being more dentally aware and becoming more self-conscious about their appearance, a very real possibility due to never ending TV adverts!

What benefits does the current contract have for patients?

I am not convinced the current NHS contract is beneficial for patients, for while providing routine treatment it is not geared for providing more advanced treatment and the patient charges are certainly a disincentive. Ask most lay persons, and they blanch at the maximum costs payable for dentures, crowns, and bridges within the NHS.

If you could choose one element of the pre 2006 contract to add to the prototypes, what would it be and why?

I feel that the profession should be given more professional credibility in providing` necessary treatment where it is appropriate, and not have to think about a financial balance sheet. Furthermore, a general dental practitioner should be precisely that – a generalist. Many new graduates are limited in the treatment they can provide compared to yesteryear, so I feel that more hands on clinical training should be provided, and the fast track shortened courses are insufficient to provide a sound clinical platform.

Pre and post 2006 – Anon

Was there a tangible difference among associates when the next contract started on 1 April?

The only difference among associates was a general feeling of uncertainty. The general consensus was that our income was going to be capped. If we reached the target, we would receive the designated income. If we exceeded it, we wouldn't be paid any more, yet if we fell short we would be penalised financially. We didn't know how easy it would be to reach the target.

How did it affect your day-to-day work?

The main feeling in the day-to-day work was pressure, particularly to reach the target. As the computer showed me what the UDA count was, I would feel very anxious if I did not achieve many UDAs that day, especially if I had had a really busy day.

What concerns – if any – did you have?

I had many concerns. The first concern was that my UDA fee was quite low. This was because there was a test year, which in theory meant that if we carried on in the same pattern of working, we would not experience a drop in income. Anecdotally, we heard of dentists who changed their working practice in that test year to maximise their UDA fee. However we, as a practice, did not change how we worked. We had a well-maintained and stable patient base, and the result was that our UDA rate was low. In fact, my UDA fee was a little higher than the principal's rate, which they were not happy about, but accepted. Generally, we all felt it was unfair that dentists were paid at different amounts for the same restoration, for example.

I also had concerns about reaching my target. I reached it for the first year, but not the second year. I was able to carry over the small shortfall. By the third year, without any significant change in my working practice, I fell rather short. I decided to take on some new patients to try to reach my target but quickly discovered nearly all of them were high needs patients, so it took several visits to get them dentally fit. I was working harder than ever but I still didn't reach the target. When the PCT visited they were very unsympathetic, and clawed back their 'overpayment', joking that I hadn't done the work so I would have to pay it back. The stress it put me under was considerable.

> 'I feel my long standing patients have suffered as they pay large fees for one restoration – for example – but new patients with high needs have really benefited. I found that some patients tried to play the system.'

If you had concerns, who did you raise them with?

I discussed my concerns about the difficulties I was experiencing with the principals, but they felt they were even worse off because overheads were rising, so I just had to get on with it.

Thinking about before and after the introduction of the contract, what do you feel was the biggest change to your working life?

The biggest change to my working life was the amount of pressure put on me over the years, and I felt totally demoralised and de-valued. There have been numerous conflicts too. One time I recall being influenced to split necessary treatment over two courses, when I felt it was not necessary and one course would suffice. As a result of one such incident I received a disciplinary letter. There was so much conflict between me trying to do the best for the patient but also not annoying the principal by carrying out treatment which was not financially beneficial for the practice. On many occasions I was restricted in the work I could carry out for this very reason, even if patients were in desperate need. I had to ask permission to do this and on occasions would be forced to get a second opinion to ensure the work was absolutely necessary. You can imagine how demoralising that was.

The restrictions weren't limited to my work. Pay rises were scant and UDA rate reductions were frequent. I know it must have been a difficult time for practices across the country, but this was horrendous for me.

Do you feel patients are better off in the new system compared to the pre-2006 version?

I feel my long standing patients have suffered as they pay large fees for one restoration – for example – but new patients with high needs have really benefitted. I found that some patients tried to play the system. I recall one time when I recommended a crown and they declined. However when they needed another band 3 treatment they jumped at the chance. It was all financially motivated, which isn't in the patient's best interests.

What one thing would you like to see in the new contract and why?

The one thing I would like is a uniform UDA rate, and a fair capitation system, so that we are all paid fairly.

Post 2006 – Sheena Patel

Why do you feel the current contract has remained in place for so long given the nature of the problems it has faced?

There seems to have been a 10 year spell of procrastination around implementing a new reformed contract.

Understandably, it's a huge responsibility to overhaul the NHS dental contract but it seems the changing government don't want to embrace that responsibility. Perhaps dental health doesn't top their agenda but nevertheless it seems clear and simple that a new NHS contract needs to be prevention focused; not only to aid patients wellbeing but also dentists'.

I believe the DOH's initial intentions to implement a pilot scheme in 2010 has encountered challenges, complexities and has needed continual refinement which has delayed the transition of a new contract.

However, it seems 10 years on since the introduction of the contract, we as dentists on the front line are just sailing on a sinking ship.

What benefits does the current contract have for patients?

The banding system benefits the patient on the NHS. If they require 4 or 14 fillings, they are only charged the one fee.

A patient will only ever be asked to pay one charge for each complete course of treatment regardless of the number of visits.

However patients are disadvantaged when the contract is juxtaposed with the ability for dentists to abuse the system and commissioners setting out targets and limiting the number of patients we can see.

Would you have liked to work under the pre-2006 contract? If so why – and if not then why!

As I understand, the pre 2006 contract still failed to prioritise prevention. The 'fee per item' strategy still had issues with dentists providing unnecessary treatment and undervaluing prevention.

Perhaps it suited the demographic at the time but with oral health trends changing we should continue to shift towards a prevention focused contract that supports this trend.

Conversely, with sole experience in the current UDA based contract, I can see how dentists feel nostalgic about the old system, regardless of its faults, and felt better off when they were financially rewarded for the work they felt was clinically necessary.

What do you think of the prototypes?

I'm pleased to see the prototypes are structured on capitation and aim to reward high quality dental care with the DQOF approach. It also puts the patient first. This is where the current contract fails as it doesn't directly address:

> 'Conversely, with sole experience in the current UDA based contract, I can see how dentists feel nostalgic about the old system, regardless of its faults, and felt better off when they were financially rewarded for the work they felt was clinically necessary.'

- → Patient safety
- → Clinical effectiveness
- → Patient experience
- → Data quality.

However I hope it prevents the potential to carry out unnecessary treatment. Also, I'm not entirely convinced that patient experience is a true reflection on quality.

What one thing would you like to see in the new contract and why

The current NHS dental contract forces general dental practitioners to focus on hitting targets, and is not in the slightest based on patient care. It seems illogical to encourage a dentist to carry out heavy restorative work, on a generation that's increasingly caring for their own teeth, for their own remuneration. In other words turning their back on prevention and education in order to make a living.

I chose to become a dentist to primarily care for my patients and spend time with them, and shouldn't have to be financially penalised as a consequence. The majority of my patients are seen on a private basis to allow me to focus on prevention, not box ticking and clock watching. The drive for our profession should be prevention and quality. However it'd be naive to think a constrained NHS budget would allow this.

Essentially, the fundamental change I'd like to see is a new contract focusing on prevention and incentive for quality.

If you could change one thing about the current contract what would it be and why?

If we could change one specific thing about the current contract, it'd be to subcategorise Band 2.

Perhaps a band '2a' that encompasses extractions and '2b' for root fillings. This would hopefully encourage dentists to put down the healing forceps and to carry out quality RT's.

At present the contract doesn't take into account the cost of equipment and time needed to complete a RT. It's difficult to evaluate spending, on occasion, a few sessions to root fill a tooth with individual costly files compared to just swiftly extracting it. The patient loses out.

The NHS wasn't born to behave like this. ◆

Digging beneath the skin of aesthetic procedures

The boom in cosmetic procedures makes it more important than ever to know exactly what the rules and regulations are surrounding the practice. Here we cover those regulations and their practical implications

The value of the UK cosmetic procedures market is growing – figures from the Department of Health in England estimate it grew from £2.3 billion in 2010 to £3.6 billion last year[1]. Non-surgical cosmetic procedures account for nine out of ten of these and three-quarters of the market value. With this growth in mind it is not surprising that patient demand has led to a number of dentists offering, or considering to offer these treatments. Also, a 2009 research paper published in the *British Dental Journal*[2] by confirmed that Botox® injection is safe, providing correct procedures are followed.

We spoke to Dr Harry Singh, CEO of Botox Training Club, about some of the practical aspects of offering Botox® – and other aesthetic treatments – in practice.

'I would divide the practicalities into three distinct areas. Pre setup, during procedure and post-procedure. Firstly pre setup, of which there are three things to consider:

Indemnity – You will need to arrange indemnity either as an add-on to your dental indemnity (certain restrictions and terms may apply) or separate specialist indemnity from insurance providers.

Pharmacy – BTX-A is a prescription only medicine therefore can only be prescribed by a medical professional holding a prescriber's licence (dentist, doctor, medical nurse) and is normally ordered via a prescription

Clinical workshop – Attend and complete a workshop. I'm speaking at the British Dental Conference & Exhibition in Manchester where you can find out more about what we offer. Team training is crucial to get the team singing from the same hymn sheet. If the team experiences the treatment, it will help this process.

'During the procedure you should already have the necessary paperwork, such as, consent forms for the procedure and photos, assessment template and post-operative instructions for the patient. These are no different to things you would do during a routine dental assessment.

'The same principle applies to the delivery and disposal of clinical waste and sharps. It is also prudent to have a medical emergency kit on hand.

'Post procedure it's vital to have a retention system and referral programme in place. Patients re-visiting and recommending you to their family and friends is a cornerstone of any good business. In practice keep up with training and CPD, and consider what – if any – other services your facial aesthetic patients are requesting.'

A lack of regulation

A 2010 scandal, however, led to a review of the regulation of cosmetic interventions. Many readers may remember the Poly Implant Prothèse (PIP) breast implant scandal. Approximately 47,000 British women were affected by this, having had PIP implants fitted that were deliberately manufactured with industrial grade silicone and so prone to rupture. Following this the Department of Health in England commissioned a review. The report by the review group, led by Sir Bruce Keogh, (published in April 2013) drew attention to widespread unsafe practices right across the sector.

Not surprisingly, the report noted that non-surgical cosmetic interventions are almost entirely unregulated, with dermal fillers identified as a particular cause for concern – anyone can set themselves up as a practitioner with no requirement for knowledge, training or previous experience. As claimed in the report, *'dermal fillers have no more controls than a bottle of floor cleaner.'*

Adequate training – new guidance

With the aim of improving and standardising the training available

The UK's healthcare regulators

In England, the Care Quality Commission only licence and regulate cosmetic treatments that involve surgical procedures. They do not regulate muscle relaxing injections (e.g. Botox®), remodelling techniques using cells, tissue or synthetic products (dermal fillers), chemical peels, non-surgical laser and intense light treatments (such as hair removal), or tooth whitening only services.

In Scotland, the regulation of private clinics (including dental) carrying out non-surgical cosmetic interventions began in April 2016. Like England, the healthcare regulators in Wales and Northern Ireland do not oversee the provision of these treatments.

to practitioners, the government also commissioned Health Education England (HEE) to develop qualification requirements for the delivery of a range of non-surgical cosmetic interventions.

All dentists involved in non-surgical treatments should be aware of these publications since the recommendations will now be taken forward by the Department of Health.

The HEE framework foresees the future accreditation of all practitioners for the work they undertake in this area, including doctors and dentists. Dentists who are involved in providing Botox® and dermal fillers are therefore advised to keep a portfolio containing proof of their qualifications and the CPD they have undertaken, as well as any other information on their ongoing experience, so that they can demonstrate how they meet the new standards.

> 'During the procedure you should already have the necessary paperwork, such as, consent forms for the procedure and photos, assessment template and post-operative instructions for the patient.'

In a show of support, the HEE documents were co-signed by the Chief Executives of most of the UK's professional regulators, including the General Dental Council (GDC). Welcoming the recommendations, the GDC added *'we are clear that dental professionals carrying out non-surgical cosmetic treatments as an additional skill should be suitably trained, competent and indemnified to do so.'*

And it seems the training and guidance is helpful for patients too. Dr Singh added: 'The only myth or hindrance that I have experienced when offering facial aesthetic treatments in a dental practice was the anxiety or phobia many patients have about their dental experience.

'When I first started offering these services within my dental practice, I was carrying out these procedures in between my normal dental patients and in my dental chair. From the outset, I could see the worry and panic take over certain patients as they sat in the dental chair. They were not relaxed, even though they know they were not in for a dental procedure. They could not wait to get out of the dental chair and as soon as I completed the procedure, they would stand up and listen to my post op instructions.

'Therefore, space permitting, I would strongly advise you carry out your facial aesthetic treatments in another room. I would also dress this room like a spa and so not make it too clinical. I would have soft colours, music, aromatherapy, candles, etc. Also have a beauty couch instead of a dental chair. If you are going to use a dental chair, then dress it up with towels and cushions so it does not look like a dental chair.'

Support for BDA members

Further information on the standards and expectations relating to non-surgical cosmetics is available in the BDA publication Botox® and non-surgical cosmetics available at www.bda.org/advice.

You can also read the HEE recommendations at www.hee.nhs.uk and the GDC's Focus on Standards here www.standards.gdc-uk.org.

If you are an Extra or Expert member get in touch by emailing compliance@bda.org or telephoning 020 7563 4572.

Royal College of Surgeons guidance

- The common standards all practitioners are expected to follow:
- Make your professional qualifications clear to patients
- Inform patients about the full financial implications of the procedure that they are requesting before signing a consent form
- Ensure marketing is honest and responsible and adheres to standards laid out by the relevant professional regulator
- Have in place procedures for handling patient complaints
- Have in place indemnity insurance that is adequate for the procedures that are undertaken
- Have completed life skills training in compliance with the Resuscitation Council (UK) guidelines and ensure patients have access to help at all times

The GDC view

The GDC's *Scope of Practice* document lists the provision of non-surgical cosmetic injectables as an additional skill which a dentist could develop. It is worth noting that the GDC does not list this as an additional skill that could be developed by other GDC registrants, though this does not mean they are legally prevented from doing so.

However, currently dentists are the only GDC registrants who can prescribe Botox®, though they must not prescribe remotely (for example via telephone, email, or a website). Unlike Botox®, injectable dermal fillers are not prescription only medicines – they are classed as medical devices and therefore do not require a prescription. The GDC expanded its view on the provision of non-surgical cosmetic procedures on its dedicated *Focus on standards* website. ◆

1. 'Review of the Regulation of Cosmetic Interventions, Final Report'. Department of Health – April 2013. Available online at https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/192028/Review_of_the_Regulation_of_Cosmetic_Interventions.pdf (accessed April 2016).

2. Gadhia K, Walmsley A D. Facial aesthetics: is botulinum toxin treatment effective and safe? A systematic review of randomised controlled trials. *Br Dent J* 2009; **12:** 207.

SWOT analysis – moving with the times

Even if you have done it many times before, a SWOT analysis – strengths, weaknesses, opportunities and threats for your business – is worthwhile, enabling you to take stock and pay heed to the current business environment

Business success often comes down to a businesses ability to adapt to external factors. Changing technology or customer demands can mean that survival without adaptation is unlikely, especially when the world around us is changing at a tremendous pace never seen before. You will know this because you are not treating patients in the same way and with the same equipment as a decade ago.

New technologies have created a whole new world – consumers no longer have to settle for products and services. The internet has opened up access to so much more. As a result, consumers have products and services almost at their complete demand, there will always be someone else able to offer what you cannot.

Health care service providers are in danger if they think that this does not apply to them. Regardless of the product or service, consumers will shop around until they find something that meets their needs (or even neglect their health and look for, say, beauty products and services instead). They will seek out the terms that suit them. They will seek out times that fit in with their lifestyle. It is no longer all about you being the best but about you providing a service that suits your patients. Dr Kit Yarrow, a Consumer Psychologist at San Francisco's Golden Gate University, has termed the growing consumer mentality as IWWIWWIWI which stands for 'I want what I want when it want it'. In her book 'Decoding the New Consumer Mind: How and Why We Shop and Buy,' published, 2014, Dr Kit Yarrow focuses on how the younger generation are completely revolutionising how we buy products and services. Booking in for a dental appointment is no different to buying any product or service. You may not have an appointment this afternoon, but, the internet will probably bring up a whole list of other dentists for the patient to try. Loyalty used to be king, but times are changing extremely quickly.

For a business to succeed it should consider how the world around it is changing. A SWOT analysis is the perfect tool for moving with the times. What makes a SWOT analysis such a perfect and relevant business tool is its ability to pick an area and look at how the business is positioned from different perspectives. You may have done this before but the world moves on. Companies like Starbucks, Samsung and Apple already have their SWOT analysis in place for 2016. It is an on-going process for them and one of the reasons they remain competitive and successful. If we bear in mind Dr Kit Yarrow's view of consumerism

'What makes a SWOT analysis such a perfect and relevant business tool is its ability to pick an area and look at how the business is positioned from different perspectives'

SWOT analysis – key points to consider

Strengths	Weaknesses
→ What do your patients see as your strengths? → What advantages does your practice have? → What do you do better than anyone else? → What are your practice's unique selling points/ propositions?	→ What do patients perceive as your main weaknesses? → Which areas could you improve? → What should you avoid? → What factors are weak in your business management?
Opportunities	**Threats**
→ What opportunities can you identify? → What trends are you aware of and can respond to? → What technological developments can you take advantage of? → Are you responding to changes in the economy, the local area and competitors' weaknesses?	→ What are your competitors doing? → Is changing technology threatening your position? → Do you have bad-debt or cash-flow problems? → Could any of your weaknesses seriously threaten your business?

Here is an example of a basic SWOT analysis for a practice in a large, inner city location

Strengths	Weaknesses
→ Established customer base → BDA Good Practice member → Significant clinical experience → Good reputation and links with university → Strong presence within community → Good social media presence → Low rent	→ Small premises → Low number of UDAs available → High wages → Location means vulnerable to vandalism
Opportunities	**Threats**
→ Develop marketing strategy to target non-customers → Work with local schools to attract new business → Use clinical experience to forge reputation as local spokesperson → BDA member gives access to changes in regulation before competitors	→ Competitor within area with more UDAs available → Suseptible to losing customers with no interest in retaining good oral health → Rent increase

today, we know right away that patient expectations are likely to have changed. Paula Slinger talked to *BDJ In Practice* about the process behind a SWOT analysis.

'First think about the strengths that you have. These may concern location, the services you offer, practice facilities or the reputation of a well-known and established practice. These are things you want to shout about, maintain and build upon in the IWWIWWIWI culture.

'Considering weaknesses takes brutal honesty, setting aside your pride to consider where you have room for improvement. You may want to look at patient retention, patient access and what your competitors have been doing. Look at whether you have kept up with the latest developments in treatments, technology or your practice website.

'You can use your identified weaknesses to create your opportunities. For instance if your practice website does not view very well on a mobile phone device, bear in mind a third of internet users see their smartphone as the most important device for going online[1] then there is an opportunity to redesign and relaunch your site.

'When looking at the threats to your business, think about future challenges that may arise. These are not just your weaknesses that you have already identified but external factors. Threats may be posed by the economic outlook, regulatory changes, negative press stories on dentistry, a new practice opening nearby or a whole range of other factors. It may not be the same things that were foreseeable last time you thought about it. The notion of IWWIWWIWI culture could be a threat in itself if patient demand for dental services comes to be governed by wanting a service when they want it and not when you can provide it.'

Luke Pickering, Head of Marketing at the BDA, said: 'I've used SWOT analysis' throughout my career and I think the key to a good SWOT is to relate them to your core business. Just because you have identified various strengths of your practice it doesn't mean there should be back slapping all round. If that strength isn't vital to your core business then you could actually be over delivering in certain aspects of your work at the expense of others. For example, a local low cost barber may have a fantastic website but if most of his trade comes from people passing then he's actually over delivering in this area. *Vice versa*, a weakness doesn't necessarily mean panic stations if it's not a core part of your business. As such I'd recommend putting all 4 areas of the SWOT into order of impact on your core business and tackling them in this order. Weaknesses don't necessarily need to be tackled first despite the temptation, maintaining strengths can be just as valuable.

It's also worth scheduling an annual SWOT analysis rather than just expecting a one off to be sufficient. As the practice and external factors transform due to staff changes, technology or government regulation then your SWOT will change. You need to regularly carry out a SWOT to ensure you're not working on action points from a SWOT that is no longer applicable.'

The general points listed here are just signposts. Your SWOT analysis will be distinct to you and your business. It will give you ideas that you can turn to your advantage – to analyse, to plan, to improve. Dentistry has always been about oral healthcare but the business environment and patient expectations move on, you should constantly rethink your objectives and how to develop your business in the current environment. SWOT breaks this down into a useful framework for you. ◆

1. OFCOM. The Communications Market Report 2015. Available online at http://stakeholders.ofcom.org.uk/binaries/research/cmr/cmr15/CMR_UK_2015.pdf (Accessed April 2016).

Check www.bda.org/advice for BDA advice on Business Planning and Managing Change.

Think patient safety: buy the genuine article

The recent GDC public hearing resulting in a dentist receiving sanctions on his registration highlights 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

BDIA CSIDI
COUNTERFEIT AND SUBSTANDARD
INSTRUMENTS AND DEVICES INITIATIVE

British Dental Industry Association, Mineral Lane, Chesham, Bucks HP5 1NL
T: 01494 782873 **E:** admin@bdia.org.uk **W:** www.bdia.org.uk

Image of counterfeit products confiscated by the MHRA.

Generating goodwill during National Smile Month

BDJ In Practice editor David Westgarth takes a look at why taking part in a national campaign is good for goodwill

Public relations – or PR as it is usually known – is exactly that, how you handle relations and interaction with the public. It can be used to shape public perceptions of your business, so when people think of you and your practice, they think warmly of it. If people are aware of and feel positive about your practice they are more likely to switch to you if they want a new dentist, or come to you if they develop a problem; particularly if they have heard good things about you from their neighbours, friends or work colleagues.

Patients are the lifeblood of any dental practice, and for most dental practices those patients will overwhelmingly come from their local area. Word of mouth remains the cornerstone of many practices recruitment efforts through good PR, but during May and June there's another way to raise your profile.

National Smile Month is an opportunity to engage with a national campaign, promote good oral health practices and in turn raise the profile of your business. The campaign, organised by the Oral Health Foundation, is synonymous with excellent PR at a local level. Previous campaigns have seen everything from fancy dress days, open days and displays to school visits, toothbrush amnesties and healthy food checks. Here are some of the ways getting involved in the campaign can reap dividends for your practice long after it has finished.

Press release

Local newspapers love knowing what is going on in their local area. Almost all locals have websites now too, which means any press release they use will have a wider reach than the printed version alone. David Arnold, Director of Communications at the Oral Health Foundation, explained how a press release can go a long way.

'In any given town there can be three or four dental practices competing for patients, and getting involved in National Smile Month could certainly have the benefit of making you stand out from the crowd.

'Every year we put together a press release template for practices to download and complete. It contains everything a press release should. I would recommend basing the release around the 5 W's – who, what, where, when and why. By covering these Ws you can send your local news desk something they can read and use quickly and easily.' According to John Ling, Marketing Executive at the BDA, working with local newspapers is still the best way to generate goodwill and attract new patients.

'Local newspapers remain a very potent channel to reach your local community. A good press release can gain you lots of free, positive coverage. The template for National Smile Month is a very good example of that. It also has an advantage over advertising in that, rightly or wrongly, stories in the media are thought more credible and trustworthy than the organisation's own adverts.

'If you establish a good footing with your local community through positive, outgoing media work, there's more chance of further opportunities arising. It might start out with the National Smile Month press release, then there's a photo opportunity and a meet and greet and before you know it you're the local dental expert providing useful information on a regular basis and you may even be approached to comment on future news stories or articles, perhaps when a national story, like the sugar tax, comes up. Being noted in this way will help enhance your reputation amongst your local community.

'News deadlines are by their very nature short term, so a good relationship with the paper is crucial. And it works both ways too. If you know there's an event coming up or you are looking to take on new patients, contact the newspaper to ask what features they are planning to run or discuss whether they would be interested in a feature on oral health, a 'perfect' smile. Or maybe they are planning a feature on the particular locality where your practice is.'

Engaging with the community

You could also look to engage in your community. Visits to schools, sports clubs or community groups, teaching them about good oral health and how to look after their teeth, can generate considerable goodwill and demonstrate a real commitment to your community. David believes these events often prove the most popular.

'Children are a fantastic audience to engage with. They are always keen to learn and have some fun in the process, which for us is what National Smile Month is all about. There's no getting away from the dreadful childhood tooth decay statistics we see banded around frequently, so working with schools and education centres can help to reverse some of these figures.

'In the past some of our most successful events have been at schools. Brushathons, Smileathons and the Two Minute Challenge really get the children excited about oral health. If your child goes home with a goody bag or some information about good oral health and the role your practice can have, you make their parent's jobs easier by choosing a dental practice for them.

'These great efforts haven't been confined to the classroom. The roadshows we have seen in the past have been spectacular and award-winning, as they really make a difference to oral health education in the community.

'It's an event which dental practices, dental community groups and oral health educators can all take part in, and involves heading out into your local area to deliver oral health education, whether it's in the form of group talks, one-to-one advice, or handing out good quality information.

'The roadshows we have had so far have taken place with teams hiring buses and mobile units for either a week during National Smile Month or over the whole campaign itself, and stationing them in areas where there are usually large crowds of people – town centres, landmarks, local events. They are also a real favourite with local media.'

> 'It is worth bearing in mind National Smile Month is a charitable campaign. Fundraising or sponsorship of local events or charities can be a great way to raise your profile and generate goodwill.'

It is also worth bearing in mind National Smile Month is a charitable campaign. Fundraising or sponsorship of local events or charities can be a great way to raise your profile and generate goodwill. John added: 'Look for fundraising events such as a fun run where you could enter a team. Perhaps you could you sponsor a local fete or have a stall at it. See whether you could partner with a local health club or gym to promote one another. Hold an open day so people can have a look around your practice and meet the team. All of these ideas get the name of your practice to the front of people's minds when they are looking to register. Everything is a business opportunity, even a charitable campaign.'

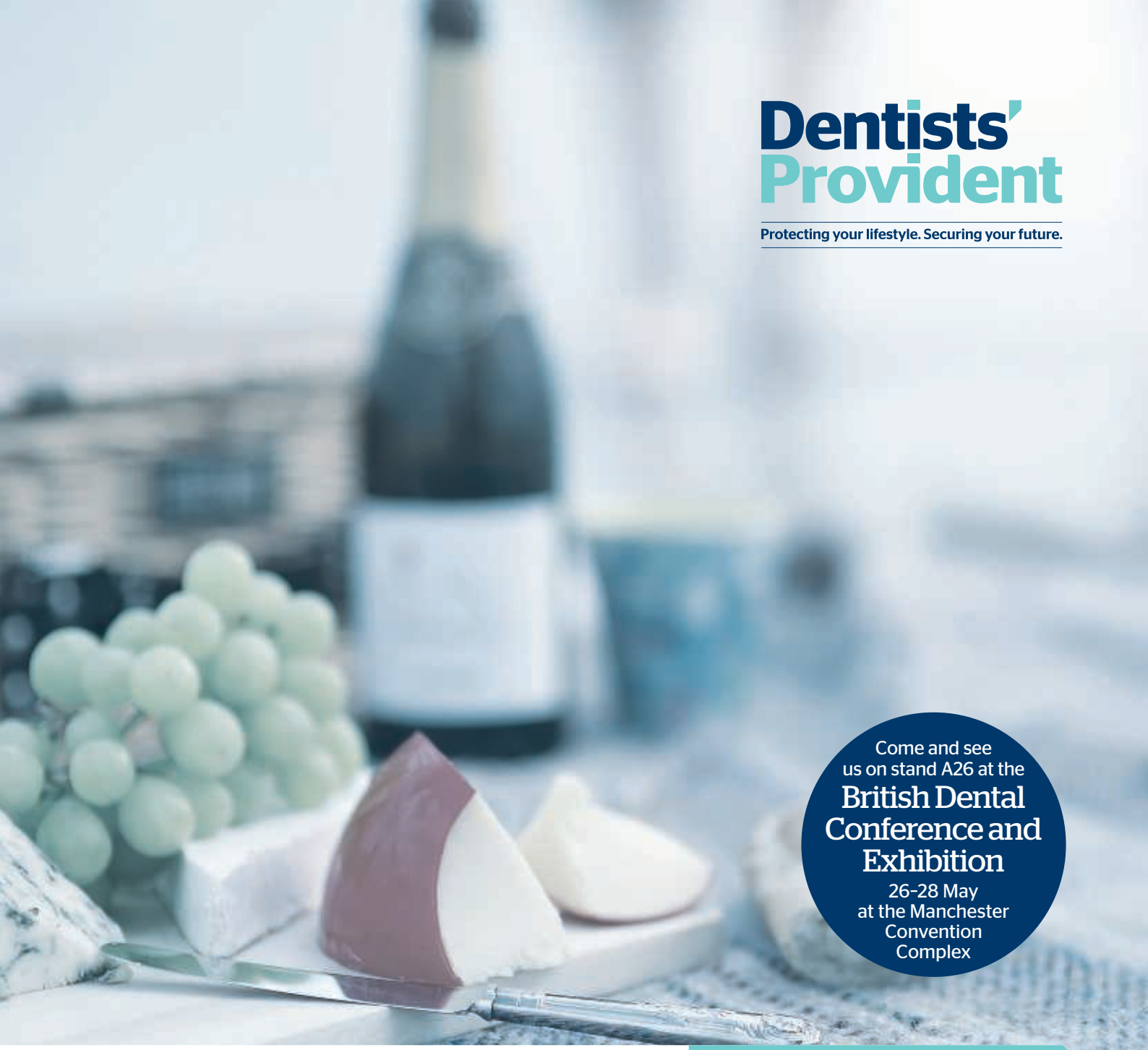
After the campaign

Community engagement is most effective when it is properly planned rather than *ad hoc*. Whilst one-off sponsorship or school visits can be fruitful in the immediate aftermath, they work far better when there is a long-term commitment from the practice. National Smile Month can be the springboard for this. You become well known in your local area. Also consider where your involvement would make sense to the public – health or fitness events or charities for instance rather than drama groups.

There are obvious links with allied healthcare professions, which can help to give more credibility. David said: 'We often find the campaign provides practices with the enthusiasm and the know-how to go on and engage with their local community. That's the beauty of it – there's a concentrated period of activity around the campaign, but a steady stream once it has ended. Good engagement means more patients. More patients means better oral health. It's a win for everyone.'

Done right, raising your profile in the community can generate much goodwill and see many new patients beat a path to your door. Making sure you and your practice are well known in your local community often requires time, a little money, and a willingness to get involved with local activities. These may be short term inconveniences, but they will bear dividends in the long term. ◆

National Smile Month takes place from 16 May to 16 June. To support the campaign and receive your free registration pack visit www.smilemonth.org/register.



Dentists' Provident

Protecting your lifestyle. Securing your future.

Come and see us on stand A26 at the British Dental Conference and Exhibition 26–28 May at the Manchester Convention Complex

Enjoy the moment, together we've got it covered.

Dentistry is a physically and mentally demanding profession and you could suffer from an illness or injury at any age. That's why it's important to have a plan.

With over a hundred years' experience of caring for dentists just like you, our members trust us to give them the peace of mind when they need it most.

Protecting your lifestyle. Securing your future.
To find out more visit our website at **www.dentistsprovident.co.uk** or call our member services consultants on **020 7400 5710**

A member of Dentists' Provident in their 40s suffered from work-related stress last year and we paid them nearly £20,000 for the eight months they were off work.

2015 claims statistics

WINNER Laboratory Awards 2014 2015

S4S

SEMINAR AND TRAINING PROGRAMME

SPLINT THERAPY & OCCLUSION SEMINARS

WITH DR BARRY GLASSMAN

Day 1: Myth Busting Occlusion for the General Dentist
Day 2: Hands On Practical Session

London - 27 October 2016
London - 28 October 2016

SMILELIGN ESSENTIALS

WITH DR MILAD SHADROOH

- *Case selection*
- *Orthodontic assessments*
- *Treatment planning service from impressions to retention*
- *Technical and clinical support*

London - 8 July 2016
London - 16 September 2016

PARAFUNCTIONAL CONTROL, MIGRAINES, CHRONIC PAIN & RESTORATIVE PROTOCOL

WITH DR PAV KHAIRA

- *Parafunction and Bruxism*
- *Pain management for Migraine and headaches with SCi (NTI-tts)*
- *Live fitting demonstration of SCi*

London - 6 June 2016

SNORING - A ROLE FOR THE GDP

WITH DR AMA JOHAL

- *The course is recognised by GDC, DDU and Dental Protection Limited as suitable training for any GDP wishing to provide snoring treatment.*

London - 20 May 2016
Cardiff - 24 June 2016

***£147.50** per seminar

**Book 6 weeks in advance @ £147.50 or £199 thereafter*

£20 discount for BDA members (quote ref: BDA20)

BOOK YOUR PLACE:

☎ 0114 250 0176 ✉ info@s4sdental.com

@s4sdental /s4sdental

Dentist meets dentist

Alison Murray

President of the British Orthodontic Society and Consultant Orthodontist at the Royal Derby Hospital. Alison is involved in teaching orthodontics at all levels, undertaking randomised clinical trials and she works as an expert witness.

Richard George

Director of External Relations for the British Orthodontic Society and editor of the BOS newsletter, *BOSNews*. Richard is a specialist orthodontist working in West Kent and a director of Total Orthodontics Ltd. He has a particular interest in lingual orthodontics and is a committee member of the British Lingual Orthodontic Society

If I asked what word was accepted into the *Oxford English Dictionary* in August 2013 that is pertinent to dentistry, without googling the answer, you would be hard pushed to know which word I am referring to.

The word in question is, of course, selfie. Gone are the days when you have to use quote marks around the word. It's in our vocabulary and it's here to stay.

By definition, the acceptance of selfie into the dictionary heralded the official beginning of the cosmetic dentistry era, although an argument can be made for its existence a long time prior to that. Now we use the word selfie in everyday language, the connotations reach further than just the selfie stick. Adults want to look good and by extension feel good for their selfie.

With greater demand for looking good comes greater demand for adult orthodontics. The rise in options available to patients is quite staggering, so David Westgarth spoke to Alison Murray (AM) and Richard George (RG) from the British Orthodontic Society about how the profession can brace themselves for the future.

Where has the demand for adult orthodontics come from?

RG There's definitely been a significant increase in both interest and demand over the last 10 years. Back then I had maybe a handful of adult orthodontic patients at best – now it's at least half of my caseload. I believe the increase has been driven by cultural changes and particularly the selfie culture. Patients want to have better teeth, and age no longer appears to be a barrier.

AM I think that's right, but I'd go further and say patients are far more conscious about their overall health than they ever have been. Dental health fits into that. As a generation we're more dentally fit than we ever have been. Older patients are keeping their natural teeth for longer, and at the other end of the age spectrum access for younger patients has improved dramatically.

What has been the driving factor?

RG There has been a distinct move away from what I would call 'destructive' cosmetic dentistry. Technology has advanced beyond recognition over the last decade to the point it's almost unrecognisable from when I first started. Orthodontics can be seamlessly created around the patient, instead of the other way around.

AM It's that technology that allows us to be far more thorough than we ever have been. In my hospital we often treat patients with severe malocclusion, which involves complex treatment and is far from straightforward. Technology allows us to deliver this service, which opens up the realm of orthodontics for adults.

When I was a child I had clunky metal braces top and bottom. Do you find adults who had braces in their childhood are more likely to return for adult orthodontics?

AM You could make a case for that. If you look at the volume of information out there, the advances in technology and the growing desire to look good, you get a situation like we find ourselves in today – patients wanting fast treatment now.

RG In many cases you find there has been relapse from orthodontic treatment in childhood. It's fair to say that retention in the past tended to be an afterthought and following up on treatment wasn't quite as thorough as it is today. Techniques have changed so much that it almost encourages adults to consider orthodontics, very often having previously missed out on it. Adults being re-treated certainly don't have to wear the headbraces they used to wear in the 70s and 80s!

> 'There are a number of different treatment options available, and patients do confuse elements of those.'

Is it easier to discuss orthodontics with adults than with parents?

AM The hospital setting is quite unique in that many patients present with significant problems that are not only oral health issues but may also be affecting self-esteem and their quality of life. It's not uncommon for a parent to have googled orthodontics ahead of the visit and expect it to work quickly, as it might with a patient with a simple problem. Of course they want the best treatment for their child, but they want it now. It takes time to explain the process and make both the parent and child aware of the compliance required for it to work. Adults are far easier.

RG Alison is absolutely correct. I find parents may be less informed about treatment initially, but will always want the best for their children and so are usually receptive to advice. Some adults seeking treatment, on the other hand, may come with a technique and treatment plan already in mind. Interestingly, an increasing trend I'm seeing is parents going on to become adult patients themselves once they've seen the results on their children!

Does generation Google help or hinder the process?

RG A little bit of both! We do have patients who are very well informed but confused. There are a number of different treatment options available, and patients do confuse elements of those. That's why our patient guide to adult orthodontics and the accompanying video is a major step forward. There's a void when it comes to patients seeking the right advice about the whole spectrum of orthodontics available. It's our aim to fill that and make adult patients of the future more discerning consumers.

AM We developed the guide to adult orthodontics to give patients the full picture.

There are a lot of treatments available, which adults discover when they go onto Google which can make it easier to deliver orthodontic treatment to those who need it. Conversely adults sometimes then make their mind up before they get to me about what treatment they want, which might not be in their best interests. The guide will explain what's available, giving an overall view of options rather than focusing on one particular brand of appliance.

What happens when treatment goes wrong?

RG Get a second opinion, ideally from a specialist. The BOS can give advice too; we want to be the leading voice when it comes to orthodontics and provide patients with accurate, impartial information.

AM I am seeing a growing number of adult patients that have had treatment go wrong. This goes back to what I said before about the right treatment. It's crucial not to take the patient's wishes at face value without discussing what the best option for them is.

What is the biggest change you have seen in adult orthodontics since you started in 2000?

RG Lingual braces and aligners. The development and capabilities of CAD/CAM and the ability to fully customise appliances for patients has been dramatic. Technology we were using only four or five years ago is now out of date. The sector is rapidly advancing and I fully expect this to continue.

AM I would agree with Richard. Lingual braces and aligners have really changed the face of adult orthodontics. The attention to retention is something I would add. Patients are prepared to invest a lot of time and money in orthodontics, so ensuring retention compliance is crucial to their success. It's an integral part of the process.

More recently the line between what can be considered aesthetic and what is necessary has become blurred. It is wrong that the patients I see with severe problems are even being considered as cosmetic patients. The NHS is trialling a 'prior approval' scheme for jaw surgery cases, and I fear patients who need it the most will not receive that approval. Their needs are currently graded by clinicians. Taking this away and rationing treatment is a massive difference and has the ability to ruin lives.

Does the advancement in technology mean patients are becoming increasingly impatient?

AM It definitely skews patient expectations. They often believe the brace is going to alter the speed of treatment. Teeth don't know if there's a star, square or triangular shaped appliance fixed to them. You have to respect biology.

RG That does happen from time to time. Intra-oral scans replacing impressions is of great benefit to both patient and orthodontist, but this does mean speed and delivery becomes paramount. It reflects the cultural changes I mentioned earlier – if someone wants news they don't have to wait to buy a paper, they can access it on a smartphone. But a quicker treatment is only a better treatment for the patient if they're getting everything they expect, limitations and all. Like Alison I'm frequently reminding patients to respect the biology and to remain patient and compliant. Keeping adult patients informed is crucial to the success of the treatment.

Is there a difference between younger associates who have grown up with new technology and older dentists?

AM When I qualified in orthodontics in 1985 specialising was something that wasn't a really popular choice. It is far more appropriate now, and there is definitely more knowledge coming from associates and younger dentists at referral stage than ever before.

RG I have noticed that too. Younger GDPs coming through the system are quite open to attending orthodontic courses to widen their clinical practice but will refer on cases they are not competent to treat. Older GDPs tend to refer adults routinely, knowing I am a specialist in the area. I like to work closely with my referring dentists throughout the entire process. It helps patients achieve their desired outcome, and that's ultimately what we're about. ◆

.X cellent adaptation and sculptability

Based on new SphereTEC™ Technology

ceram.X®

universal nano-ceramic restorative

Unique SphereTEC™ technology takes handling to the next level

- Fast and easy polishing for outstanding gloss
- Natural aesthetics
- Ingenious simple shading system: 5 shades to cover the full VITA®[1] range

Visit **dentsplyrewards.co.uk/ceramx** to request a FREE trial*

DENTSPLY REWARDS

Earn Rewards at dentsplyrewards.co.uk

DENTSPLY

Small things. Big difference

*While stocks last.

[1] VITA is not a registered trademark of DENTSPLY International Inc.

THE MAKERS OF

PROTAPER® | CAVITRON® | WAVEONE® | SDR® | CERAM·X® | NUPRO®

Who can be a companion?

by Abalene Odell
a practice management consultant in the BDA's Practice Support Team. Abalene advises general dental practitioners on associate contracts and a wide range of employment and other law

When you need to hold a formal meeting with an employee about a disciplinary matter or about a grievance they have raised they have the legal right to be accompanied at the meeting. Being accompanied is about fairness, so you should not worry about someone else being involved in your internal staff management affairs. Nevertheless, it is important that your employee brings an appropriate companion.

The legal right to bring a companion comes from the Employment Relations Act (ERA) 1999, section 10[1] – all employees are entitled to request the presence of a representative at formal disciplinary and grievance hearings. Though the law states that employees can insist on having certain people as their companion in the meeting, the right only applies to formal meetings held as part of disciplinary or grievance procedures. The right does not apply to informal chats with employees about workload or performance. Nor does it apply to investigatory meetings held to find out the facts in a disciplinary or grievance situation.

Employees have a legal right to be accompanied by:

- Trade union officials – a person employed by a trade union
- Trade union representatives – an elected trade union officer from inside or outside the workplace; or
- A colleague

Nevertheless, do not always be so rigid. The recent Stevens case[2] considered special circumstances concerning a clinical academic. Professor Stevens worked for both the University of Birmingham and Heart of England NHS Foundation Trust. Professor Stevens was invited to an investigation meeting by the university, which typically no employee has the right to bring a companion to; however the letter he received did state that he could bring a Union representative or a colleague to the investigation. Professor Stevens was not a member of a union but he was a member of a defence society, which had agreed to represent him in all cases. Professor Stevens requested to be accompanied by a member of his defence society, this was rejected by the university. Professor Stevens took the university to court and won. Since the university had offered him the chance to bring other companions it was found to be a breach of the implied duty of trust and confidence not to allow an employee to be accompanied by his chosen companion.

This decision builds on a landmark 2009 decision in the case of Kulkarni,[3] basing his claim upon principles of human rights. Dr Kulkarni asked to have legal representation supplied by his defence society, at a disciplinary hearing, rather than one of the three types of companion, outlined in law. He succeeded in being able to bring a legal representative with him. His basis for this was that it was a fundamental breach of his human rights to not be afforded legal representation because his whole livelihood as a registered professional could be put in jeopardy if the allegations against him were upheld. He might have been struck off the medical register as a result of the disciplinary. Not just his present post was in jeopardy, it could have been career ending.

The situations in both these cases were both high stakes, generally employers and employees will not find themselves in similar situations, even where dismissal for gross misconduct is a possibility.

Technically it is possible to refuse an employee's choice of companion if they are not a trade union official or a work colleague. You may consider this if you have the perception that the companion may prejudice the hearing. If they ask to bring a family member you could reasonably be concerned that they will make the meeting too emotional. If they ask to bring a solicitor you could reasonably be concerned that they will bog down the meeting in procedural quibbles. Where you are worried about the companion the employee intends to bring then think carefully and, generally, seek outside advice.

Nevertheless, being flexible should generally be in your best interests so consider any request to bring a companion who is not a trade union official or a work colleague. Their presence could make the meeting go better by giving your employee reassurance on how to address the matters that you raise. Also it shows that you wish to be fair and provides another witness to what went on in the meeting. And in light of the Stevens and Kulkarni cases do consider how serious or complex the matter is. In any case always ask for the employee to provide you with details of their companion beforehand. ◆

Extra and Expert members can contact practicesupport@bda.org or telephone 020 7563 4574 for further information.

References

1. Employment Relations Act 1999, c.26. London: The Stationery Office.
2. Stevens v University of Birmingham [2015] EWHC 2300 (QB).
3. Kulkarni v Milton Keynes Hospital NHS Foundation Trust (2009) 109 BMLR 133, 109 BMLR 133, [2009] EWCA Civ 789, [2009] IRLR 829, [2009] LS Law Medical 465, [2010] ICR 101.

Associate finances and retained money

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

Remedial treatment for an associate's former patients can often be a contentious issue when an associate leaves a practice because the practice owner may ask the associate to cover the cost and associates may be concerned about being asked for cash after they have left. But as long as both parties have a clear understanding of how these cases should be dealt with it does not have to cause problems.

Associates as the treating dentist are responsible for the treatment they carry out. So if a patient returns to the practice after the associate has left, the associate is still nevertheless strictly responsible for the treatment that patient had received. Though, generally speaking from the patient's point of view, they see themselves as a customer of the practice. So regardless of who carried out the treatment, if it fails, as far as most patients are concerned they will expect the practice to sort it out. And herein lies the difficulty for practice owners. They must balance the interests and rights of practice patients (and their reputation and goodwill of the practice) with the responsibilities of the former associate. This will often mean carrying out any necessary remedial work on the patient promptly but ensuring that the cost is covered by the former associate.

Theoretically the practice owner might ask the former associate to return to do the remedial work in person, but this is often impractical – the associate may not be available due to their new work commitments and the patient may resent having to wait for remedial care. Doing the work directly however incurs costs, which the practice owner may fear would take some time to recover from the former associate. To pre-empt this it is common for practice owners to seek to retain some money when an associate leaves to cover the costs of any failed work.

Need for agreement

Associates may, understandably, worry that the practice owner will retain too much money to cover the work necessary. They may also worry that treatments will be replaced inappropriately. For these reasons (though hopefully the latter is an unfounded worry) it is important for the practice owner and associate to discuss the situation.

If the practice does retain money, the associate must expressly agree to it. Though there is a good reason why associates should agree a reasonable retention; they would have to reimburse the practice owner for all genuine replacement work carried out and so it is generally less hassle to agree a realistic retention figure. An agreement should cover not only the amount, but the purposes for which it should be used and the information that will be provided to the former associate on how it is used and how long it will be retained. After an agreed period any surplus should be repaid to the former associate. As a rule of thumb you could consider average patient recall periods as being a suitable length of time – any patient requiring replacement work should have returned within that timeframe.

The parties should, at the latest, discuss this when the associate gives notice – by then both will have an idea of the associate's average monthly earnings and how much remedial work generally needs to be done. However, often retentions are covered in the associate contract signed at the start of the relationship.

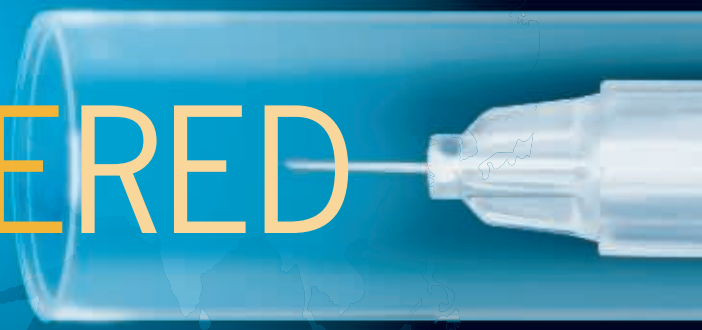
The amount retained is usually no more than 5% of the associate's total gross pay for the last six months. This idea is based on two assumptions: most patients needing remedial work will return within that time; and 5% of earnings or a twentieth is a reasonable proportion to retain on the basis that one in 20 patients is the most you would realistically expect to need replacement work.

Deductions from the retention should follow the practice's normal fee scale. The practice should not profit from doing the remedial work. For any costly repairs the former associate should be asked whether or not they agree that the remedial work is needed and the options should be discussed. The former associate should be given an itemised list of replacement work carried out and be able to cross-check this with patient records. ◆

To view a Model BDA associate agreement available and more, visit www.bda.org/associates.

NEW REGULATIONS ON NEEDLE INJURIES

GET COVERED



COMPLIANT WITH NEW REGULATIONS[1]!

ULTRA SAFETY PLUS
THE SAFE INJECTION SYSTEM.

As the world leader in dental pain control [2] , Septodont solves the increased need for safe simple solutions to meet new safety regulations.

Over the years Ultra Safety Plus has proven its efficacy and ease of use becoming the standard for needle stick protection on all dental local anesthetic procedures. In the United Kingdom , Ultra Safety Plus already represents over 45% of the injection systems used in the dental groups and hospitals.[3]

Ultra Safety Plus is offered in an assortment of needle lengths and you can choose the sterile single-use handle or an autoclavable handle.

Ultra Safety Plus. Get Covered.

septodont

[1] Council Directive 2010/32/EU of 10 May 2010

[2] Septodont is the only company producing 500 million dental cartridges per year

[3] Source SDM data, YTD Q3 2012

Tel: +44 (0)1622 695520
www.septodont.co.uk

Working for you

Specialising in working with dental clients to achieve their dream of dental practice ownership, employment or HR issues and support owners with the sale of their practice when the time comes, FTA Law has been founded to bring together a combination of legal skills and commercial understanding, knowledge and experience of the dental sector.

Following feedback from numerous disgruntled buyers and sellers and frustrating delays in the purchase/sale process, positive action was taken to create a new law firm that would specialise only in providing legal services to dentists and dental practice owners. This decision has resulted in a new venture between the directors at Frank Taylor & Associates, the UK's most successful sales broker for the dental profession, and established, respected and effective dental specialist lawyers, Thomas Coates and Sarah Buxton.

Lis Hughes, Managing Director at Frank Taylor & Associates, commented: 'The directors at Frank Taylor & Associates decided they need to bring their values of client focused service to the legal sector and the best way to achieve this was through the establishment of FTA Law. It has taken many months of careful planning to bring the right partners together and we were delighted when an agreement was reached with Thomas and Sarah who are both well established, respected and effective dental specialist lawyers.

We are all passionate about 'doing things differently' and with our many combined values we look forward to working together as a group to continue to deliver outstanding customer services within the dental market.' More details are available at www.fta-law.com.

The first purely ceramic-based restorative material

VOCO will present several innovations at the BDA's British Dental Conference and Exhibition, such as Admira Fusion, the world´s first purely ceramic-based universal restorative material. This is made possible by combining the proven nanohybrid technology with that of the ORMOCERs. Silicon oxide forms the chemical base for this nanohybrid ORMOCER restorative material, not only for the fillers but also for the resin matrix. This unique 'Pure Silicate Technology' offers several remarkable advantages in one: for example, the fact that Admira Fusion, in comparison with all restorative composites of market relevance, shows by far the lowest level of polymerisation shrinkage (1.25% by volume) and, coupled with that, extremely low shrinkage stress.

The ORMOCERs (Organically Modified Ceramics) used in the manufacture of Admira Fusion make it highly biocompatible, as there is no content of classic monomers. The light-curing, radiopaque nanohybrid ORMOCER has an 84% (by weight) content of inorganic fillers and covers a broad spectrum of indications. Admira Fusion's particularly high colour stability gives it an additional edge and allows its absolutely universal use – for highest demands in both the anterior and posterior regions. This very homogeneous material offers outstanding handling and is compatible with all conventional bonding materials. Admira Fusion is available in rotating syringes and also caps for direct application.

For further information visit www.voco.com, email info@voco.com or call 07500 769 613.

Quality solutions

With its excellent customer service and dedication to providing quality magnification products to dental practices, Nuview is the leading supplier of Carl Zeiss dental loupes and microscopes in the UK.

The EyeMag Pro loupes, which deliver pinpoint clarity and offer up to 5x magnification, are hugely popular. Another favourite is the OPMI® Pico microscope, which has a cutting-edge Varioskop 100 objective lens and boasts up to 5 step magnification, from 3x to 20x.

Nuview is also the exclusive distributor of the Yirro-plus self-clearing dental mirror – a unique autoclavable, ultra-reflective mirror that uses adjustable airflow for permanent clear vision. Available either as an automatic (PREMIUM) or manual system (COMFORT), the Yirro-plus has been designed to be conveniently mounted onto the delivery unit.

In addition to this, Nuview manufactures its own range of cleaning and disinfection products. The Continu range is both HTM01-05 compliant and alcohol-free and features Surface Cleaner and Disinfectant, Hand Sanitiser, Dental Instrument Cleaner, Disinfectant for Dental Water Lines and Impression Disinfectant.

To find out more, visit Nuview at the British Dental Conference and Exhibition 2016 on stand B32.

Completely dry environment for a variety of different procedures

Super Absorbents have reached a new level with the introduction of the new and unique Drydent Sublingual for optimal saliva control.

A unique new product which collects and controls the saliva produced by the sublingual glands as well as the submandibular glands. It is placed under the tongue for the optimal collection of unwanted moisture in the sublingual area. Its super absorbent qualities provide a super dry oral environment during a variety of procedures.

Patient comfort has been improved with its smooth soft material design that reduces uncomfortable swallowing reflexes.

Saliva ejectors can be placed over the DryDent Sublingual, minimising uncomfortable suctions of soft tissue. DryDent Sublingual's super absorbent capacity keeps moisture control even when it is fully saturated.

Support your denture patients

When patients hear the news that they need dentures, everything else you tell them is often unheard.[1] At least 32% of patients don't know what questions to ask their dentist when getting their new denture fitted.[2]*

The Poligrip range includes:

- Poligrip Overnight Whitening Daily Cleanser
- Poligrip 3 Minute Daily Cleanser
- Poligrip Ultra Fixative Cream
- Poligrip Flavour Free Fixative Cream

For additional support GSK have developed a distance learner module on the topic of 'Caring for Patients with Dentures'. The module has been designed to provide you with an insight into the patient experience of dentures as well as supporting you when providing practical advice.

For further information on the Poligrip range and to complete the distance learner module visit www.gsk-dentalprofessionals.co.uk.

1. Kessels R P C. *J R Soc Med* 2003; **96:** 219-222.
2. Data on file, GSK. RH02678, December 2014.

*Based on a survey of 1748 denture wearers in four countries.

Visit GSK at BDA!

This year the GSK Consumer Healthcare team will be visiting the British Dental Conference and Exhibition to showcase Sensodyne and Pronamel. New Sensodyne Repair & Protect – now with stronger repair+, offers sensitivity sufferers the benefit of both advanced NovaMin® technology with sodium fluoride in a single formulation. The immediate availability of sodium fluoride when brushing allows for greater fluoride uptake into the hydroxyapatite-like layer formed by NovaMin, over exposed dentine.[1]

Pronamel toothpaste has an optimised fluoride formulation to help minerals penetrate deep into the tooth surface, actively strengthening and re-hardening acid-weakened enamel.[2-5] Pronamel toothpaste delivers more fluoride deeper into enamel than other fluoride toothpaste[2] helping to protect patients enamel from the effects of erosive tooth wear.

Visit stand B03 to try Sensodyne Repair & Protect and Pronamel toothpaste for yourself.

1. GSK Data on File, 142234.
2. Edwards M I *et al.* Correlation of Enamel Surface Rehardening and Fluoride Uptake – DSIMS imaging. Presented at IADR, September 2006.
3. Fowler C *et al. In vitro* microhardness studies on a new anti-erosion desensitizing toothpaste. *J Clin Dent* 2006; **17:** 100-105.
4. Hara A T *et al.* Influence of fluoride availability of dentifrices on eroded enamel remineralisation *in situ. Caries Res* 2009; **43:** 57-63.
5. Barlow A P *et al.* Evaluation of different fluoride dentifrice formulations using an in situ erosion remineralization model. *J Clin Dent* 2009; **20:** 192-198.

Breakthrough toothpaste ingredient hardens your teeth while you sleep

A new toothpaste ingredient which puts back the lost minerals from tooth enamel and helps prevent decay and treat sensitivity while you sleep is available online and from specialist dental distributors now.

The new BioMInF toothpaste ingredient provides a new tooth repair technology which will bring relief to the millions of adults and children around the world who are prone to tooth decay and sensitivity.

Dental decay is the most prevalent disease worldwide and the majority of adults will also experience tooth sensitivity at some stage during their lives. Decay is the single biggest reason for children being admitted into hospital with between 60-90 percent of school children being affected.

Toothpastes containing BioMInF are able to slowly release calcium, phosphate and fluoride ions over an 8-12 hour timeframe to form fluorapatite mineral to rebuild, strengthen and protect tooth structure. The slow release of fluoride has been identified to be particularly beneficial in prevention of tooth decay.

MORE THAN DEFENCE

Dental Protection

MORE SUPPORT

Free CPD approved online education and workshops

MORE ADVICE

Expert, impartial specialist advice, dentist to dentist

MORE DEFENCE

Right to request comprehensive, flexible occurrence-based indemnity

TAKE AWAY MORE THAN EXPERT ADVICE WITH OUR PRIZE DRAW.

VISIT US AT STAND B42

Visit Dental Protection at stand B42 at this year's British Dental Conference & Exhibition, for your chance to win £100 of Amazon vouchers.

Don't miss your opportunity to talk face to face with our dedicated dentolegal advisers, and renew your membership – giving you advice, support and peace of mind throughout your career. Plus, if you are a Foundation Dentist be sure to ask about our earlybird renewal offer.

dentalprotection.org | Dentolegal Advice: 0800 561 1010
Membership Information: 0800 561 9000

2293: 04/16

Dentaid needs your help!

TEXT TEETH TO 70660 TO DONATE £5

PLUS YOUR STANDARD NETWORK RATE

Dentaid is trying to end world oral pain, but we can't do it without you!

From a space at the Great North Run, to a bake off, you can fundraise for us today.

Visit www.dentaid.org/get-involved/fundraise to choose your event and download your pack

Dentaid, Giles Ln, Landford, Salisbury SP5 2BG.

+44 (0) 1794 324249 info@dentaid.org www.dentaid.org

Dentist to Dentist

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

Scotland

BLACKHILLS SPECIALIST REFERRAL CLINIC
www.blackhillsclinic.com

5 Maidenplain Place, Aberuthven Perthshire PH3 1EL
Tel: 01764 664446
Email: info@blackhillsclinic.com
Cone beam CT scanning

Mr Paul Stone BDS (Hons) Lpool, FDS RCSed, FDS RCPS (Glasg)
Interests: Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts.
On Specialist List: Yes, Oral surgery (60534)

Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants
On Specialist List: Yes, Prosthodontics (66211)

Dr Marilou Ciantar BChD (Hons) Malta, MSc Lond, PhD Lond, MFDS RCS Eng, MFD RCS Irel, FFD RCS Irel
Interests: Oral surgery, implant surgery, tissue regeneration, periodontology, conscious sedation
On Specialist List: Yes, Oral Surgery and Periodontics (84070)

Mr Brian Stevenson BDS Glasg, PhD FSA (Rest.Dent.) RCSEd, MFDS RCSEd, FHEA
Interests: Fixed and removable prosthodontics, endodontics and dental implants
On Specialist List: Yes, Restorative Dentistry and Endodontics (77605)

Mr Graeme Lillywhite BDS Edin, MFDS, MSc, MRD, FDS RCSEd
Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics (68916)

Mrs Lorna Harley BDS Glasg, MFDS RCSEd, MRD (Endo) RCSEd
Interests: Endodontics
On Specialist List: Yes, Endodontics (79246)

Dr Donald Thomson BDS (Hons) Edin, FDS RCSEd, DDR RCR
Interests: Cone beam CT imaging
On Specialist List: Yes, Dental and Maxillofacial Radiology (70079)

266979

Midlands

THE PRIORS DENTAL PRACTICE LTD
www.thepriorsdentalpractice.co.uk

Pinfold Lane, Penkridge, Stafford, Staffordshire ST19 5AP
Tel: 01785 712388
Email: info@thepriorsdentalpractice.co.uk

Dr Mark Emms L.D.S.R.C.S (Edin) MSc (UCL)
Interests: Dental Implants, Fixed and Removable Prosthodontics, Bone Grafts, Sinus Lifts, Full Mouth Reconstructions, Periodontics, Occlusion, Restorative and Cosmetic Dentistry, Implant Mentoring

Mr John Scholey BDS, FDS, RCS (Edin), FDS (Orth) RCS (Edin) MOrth RCS (Eng), MDentSci
Interests: Specialist Orthodontics, Mini-Screw, Lingual Braces
On Specialist List: Yes

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

CT Scanner and dedicated implant suite on-site.

236739

PARK ROAD DENTAL PRACTICE
www.parkroaddentalpractice.co.uk

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

South East

TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

LONDON SMILE CLINIC
www.londonsmile.co.uk

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

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

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

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

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

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

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

263521

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

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

209440

DENTAL SPECIALISTS ST ALBANS

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

239826

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

266913

East Anglia

DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

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

Specialist Referral and Education Centre

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

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

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

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

Specialist Periodontists:
Trisha Whitehead and **Puneet Patel**

Specialist Orthodontist:
Dirk Bister

269120

GRANTA DENTAL LTD
www.grantadental.co.uk

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

237823

North

SPECIALIST DENTAL CARE
www.specialistdentalcare.com

Mr Martin F. W-Y. Chan
BDS, MDSc, FDS (Rest Dent) RCPS (Glasg), DRD, MRD, RCSEd.
29 The Grove, Ilkley, W. Yorks, LS29 9NQ
Tel: 01943 608090
Email: info@specialistdentalcare.com
Interests: Restorative and Implant Dentistry, Prosthodontics, Periodontics, Endodontics
On Specialist List: Yes, as above

261782

North West

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

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

261006

BRITISH DENTAL CONFERENCE & EXHIBITION 2016

26 - 28 May | Manchester

INNOVATE

LEARN

INSPIRE

OVER 130 SESSIONS OF QUALITY LEARNING CHOSEN BY DENTISTS

FREE THREE-DAY PASSES
for Extra and Expert Members

GAIN UP TO 15 HOURS
of verifiable CPD

REGISTER TODAY
Visit www.bda.org/conference
Or call 0844 3819 769

BDA
British Dental Association

Business skills CPD

Q1: The GDC's Scope of Practice refers to the provision of non-surgical injectables as:

A Core CPD

B Highly recommended

C An additional skill a dentist could develop

D A recommended skill

Q2: How often should you schedule a SWOT analysis?

A Monthly

B Quarterly

C Annually

D Bi-annually

Q3: Complete this sentence: 'If the practice does retain money, the associate must:

A Expressly agree to it

B Give verbal consent

C Continue as normal

D Re-negotiate terms

Q4: Where does the legal right to bring a companion come from?

A The Employment Relations Act (ERA) 1999, section 1

B The Employment Relations Act (ERA) 1999, section 10

C The Employment Relations Act (ERA) 1999, section 11

D The Employment Relations Act (ERA) 1999, section 101

Q5: Under what circumstances can you refuse an employee's companion?

A If they are not a trade union official or a work colleague

B If you feel they are too close to the situation

C If they used to work at the practice

D If they are not legally trained

WELCOME ONCE AGAIN to the *BDJ In Practice* continuing professional development (CPD) programme.

To complement the clinical CPD you can earn with our sister publication, the *British Dental Journal*, our CPD is designed to help dentists polish their business and practice-management skills.

All the questions relate to articles in this issue of *BDJ In Practice*. By completing the answers online, you can earn one hour's verifiable CPD. Do so in every issue of *BDJ In Practice* and you can earn 12 hours' verifiable CPD in a year.

This programme is free to members. A record of the CPD you have earned from *BDJ In Practice* CPD is available to view and print at our CPD Hub. Responses must be completed within six months of the publication date because we need to ensure our questions serve their purpose in helping you keep up to date with current issues.

Log onto **cpd.bda.org** now to earn one hour's CPD.

Need help?

To access *BDJ In Practice* CPD online:

Either visit **www.bda.org** and select 'CPD' from the main menu, or type **cpd.bda.org** directly in the long white box at the top of your web-browser screen. When prompted, log into the BDA CPD Hub using your BDA website login email and password details.

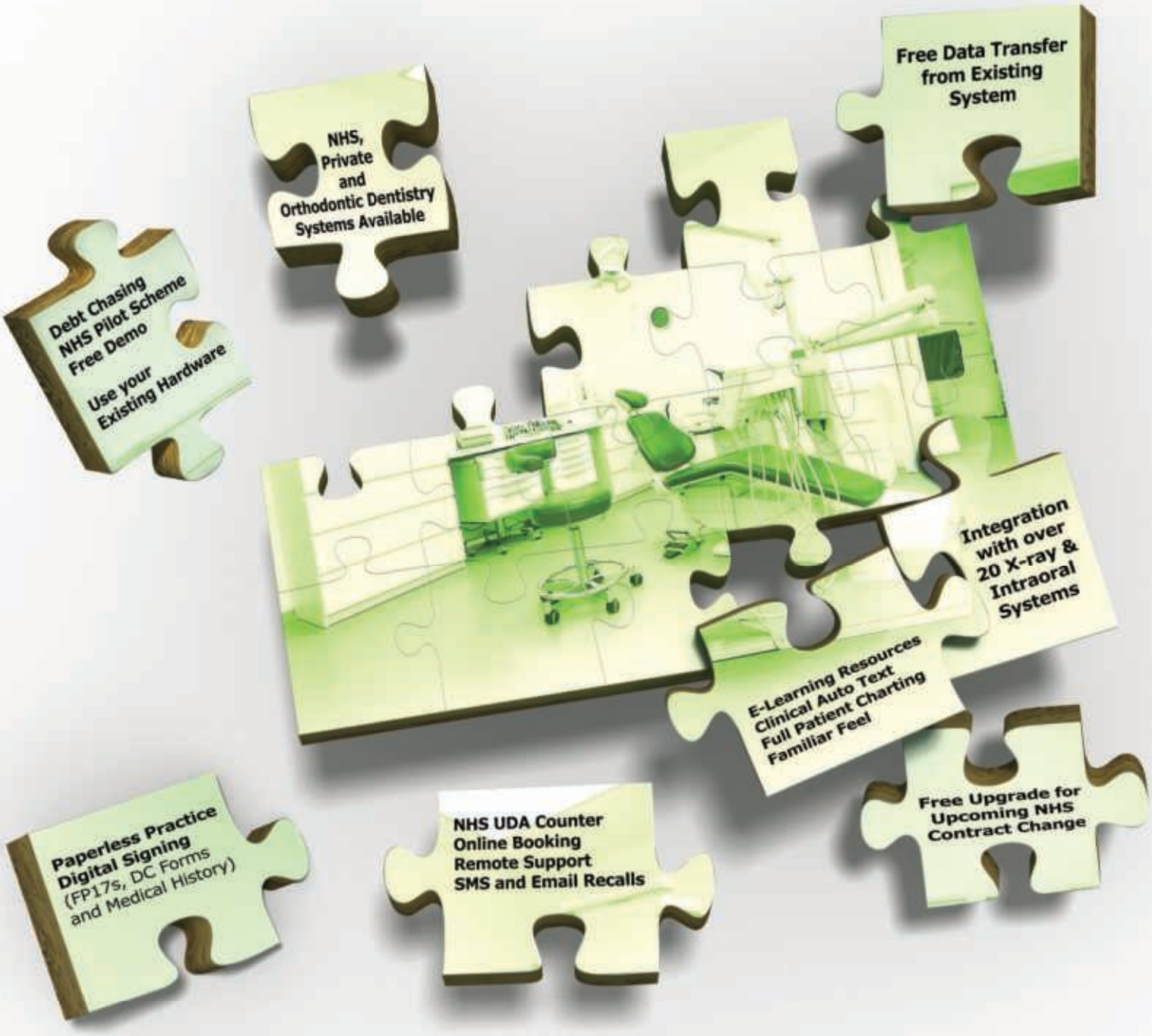
First-time user: select *BDJ In Practice* CPD on the front page of the CPD Hub and enrol for the service. You will automatically be taken to the *BDJ In Practice* CPD page.

Registered user: Log into the BDA CPD Hub and select *BDJ In Practice* CPD to see the available CPD opportunities.

Select an issue and answer the questions. When finished, you will be prompted to view your CPD Record where you can see your result.

For support use: cpd.hub@bda.org

Is your practice missing a **vital piece?**



Pearl Dental Software

The ***FASTEST*** growing dental software.

One Off £275 for installation + training, Monthly £44 add £22 for each additional surgery. (Prices Exclude VAT). Call us on **0116 275 9995** or **0800 086 8133** for more information, or email us at **info@bhasoftware.com**.

Find out more at www.pearldentalsoftware.com

BHA software

Income Protection has never been so easy

Lloyd & Whyte

Get an income protection quote online and receive 20% off your BDA membership renewal when you take the policy out.

We've been working with dentists long enough to know which income protection providers give you the best cover, so we put them all in one place.

What's more we're rewarding BDA members with 20% off their renewal membership when they take the policy out. Full terms and conditions are available on our website.

Get a quote today by visiting www.lloydwhyte.com/bdaincomeprotection

What matters to you, matters to us

www.lloydwhyte.com

In proud partnership with

BDA