BDJ InPractice

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# How dry is the well?

★ Associate special

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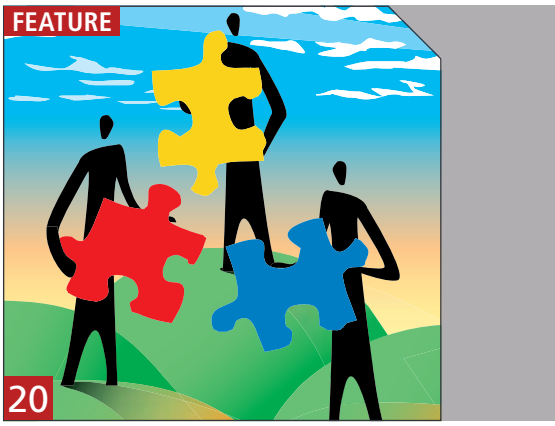



BDA
British Dental Association

# Same but different

**David Westgarth**
Editor, *BDJ in Practice*

Social groups define themselves by their rules. Whether the group is a golf club, a street gang or society at large, there are rules. Even if these rules aren't down in writing – and let's be honest, most are un-written, etiquette rules – they clearly exist because they exist.

Those on the outside are useful as members as they can point at them and say 'that person is not one of us because...'. If you are different, your 'not-like-me' characteristics contrast with the 'like-me' cloned identity within the group. People who are different act as out-group anti-exemplars, illustrating what is not allowed in the group, helping members to define who they are.

One of the rules of stable groups is not rocking the boat by trying to change things. Innovation is feared and outlawed, as similarity and stability are prized most. Yet this creates a dilemma when change is required in order to survive. Groups do not exist independently from their environment, and when that context changes, the group must adapt or die. Companies have competitors and changing customer demands. Families have changing incomes and social pressures. Hobby clubs are affected by fashion and technology.

That necessity for change is seen in our profession. Gone are the days where you had a pre-determined-verging-on-arranged career. There is no more rite of passage. But, in the same breath, things haven't changed. The patient base remains. The treatments remain. So we're in this constant spiral of things remaining the same but forever being different.

And that is the very challenge many associates tell us they face. Familiar stories of recruitment problems, low UDA rates, unfavourable working arrangements, all because things are different. We have often asked the question whether associates are one, homogenous group with the same aspirations, the same problems, the same career. Whatever your view on that particular question, in order to survive, the social rules have to be set aside.

The idea of building a brand of self-identity may necessitate the rocking of the boat, but what little choice is there? How do you get ahead of the next person without feeling like you're stampeding? How do you say that even after five years of dental school and the very same training posts that you're different to the numerous others applying for the same job as you? How do you build a 'brand you'? What does that phrase mean to you? And how does one stay humble throughout the process?

Of course, the answer to these albeit rhetorical questions will be very different in London, Belfast, Cardiff and Edinburgh compared to Cornwall, Cork, Caerphilly and Shetland. The old adage that it's better to be a big fish in a small pool rather than a small fish in a big pond rings true, but is predicated on having a pool to swim in.

Vast swathes of the UK report a crisis in recruitment. Dentistry is not alone. Practice owners cry there aren't sufficiently qualified associates to fill positions. Associates tell us they're getting paid what monkeys would – peanuts. Whichever side of the boat you're rocking, dentistry is suffering, and there are no signs of improvement.

So to our very first themed edition of *BDJ In Practice* looking at the value of associates, the challenges faced and the opportunities they present. The BDA fights in your corner. The not-fit-for-purpose dental contract is at the heart of what you do and what we want to change. And we will continue to do that, because together, we are stronger.

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## Employment status of associates

There has been an outbreak of discussion again in recent weeks in regard to the employment status of dental associates. This is nothing new and indeed there have been many instances where this subject has been debated stretching back over the last fifteen years or so, and according to NASDAL, the tax status of associates in the eyes of HM Revenue & Customs remains very clear.

As things currently stand (June 2017), HMRC guidance contained in *Employment Status Manual ESM4030 Particular occupations: dentists states:*

'It should be noted that there are standard forms of agreement for 'associate' dentists which have been approved by the British Dental Association (BDA) and the Dental Practitioners Association (DPA) (sic). These agreements relate to dentists practicing as associates in premises run by another dentist. Where these agreements are used and the terms are followed, the income of the associate dentist is assessable under trading income rules and not as employment income. In these circumstances the dentist is liable for Class 2/4 NICs and not Class 1 NICs.

'The NHS General Dental Services Contract, which came into force from 1 April 2006, provides for less fluctuation in associate dentists' income. However, providing the associate dentist continues to be responsible for paying their share of laboratory fees etc. for work relating to their patients and other terms of the standard agreement are followed, the above guidance will still apply.'

NASDAL Chairman Nick Ledingham added: 'It does seem that HMRC remain content that as long as dentists follow the rules and use a BDA approved contract, the vast majority of associates continue to be regarded as self-employed. This makes perfect sense as one of the key defining points of self-employment is an element of risk which of course all associates take on board as they are responsible for all the treatment that they have provided.' ◆

## Government attempt to fix NHS dentistry risks failure in face of slashed budgets

The British Dental Association has called on ministers to be honest that its stated goals to maintain access and embed prevention in NHS dentistry cannot be achieved on a slashed NHS dental primary care budget.

This follows the Government's announcement of a major expansion of the number of practices prototyping a reformed model for the widely discredited NHS dental contract. However, official evaluation reports show plans could further undermine the financial sustainability of NHS practice, with potentially fatal flaws in the proposed business model.

Dentist leaders have been clear that funds need to be made available to enable practices to widen access and spend more time with patients. Recent parliamentary questions have confirmed that Government spend on NHS dentistry per head has actually fallen from £41 to £36 per person in just 5 years.

One in four of the current hand-picked prototype practices have been unable to hit the access and activity targets, with the average practice reporting the need to work up to 10 extra hours a month to deliver on their new contract.

The current contract, in operation since 2006, has fuelled patient access and staff recruitment and retention issues in a growing number of areas. Over half of young NHS dentists have indicated they plan to turn away from NHS dentistry in the next five years, with 42% stating intentions to move into private practice.

The Government has pledged to reform the system in successive manifestos since 2010. Dentist leaders have called for the current reform package to be refocused away from activity targets and towards improving health outcomes, for significant expansion in the number of practices testing a new contract model, and for funding to be appropriately weighted towards high-needs patients in areas of high deprivation, who routinely require more time-consuming treatment.

The BDA's Chair of General Dental Practice Henrik Overgaard-Nielsen said: 'The current NHS dental system is fundamentally broken, with patients now travelling further or waiting longer for care. Yes, it's good to see wider testing of the prototypes, but when the one variable ministers won't change is funding cuts, we are unlikely to see progress.

'Key objectives for maintaining access, spending more time with patients and improving their oral health will not be delivered against the clock or on the cheap. We are already seeing practices having to donate time to make this new model work. In its 70th year we cannot expect goodwill or charity to be the foundation of any part of our NHS.' ◆

# FGDP(UK) endorses new advice on antibiotic prophylaxis

The Faculty of General Dental Practice UK (FGDP(UK)) has endorsed new advice for dentists on the prophylactic use of antibiotics against infective endocarditis (IE).

Following the revision in 2016 of the National Institute for Health and Care Excellence's Clinical Guideline 64 (NICE CG64), the Scottish Dental Clinical Effectiveness Programme (SDCEP) has published implementation advice, the crux of which is that:

'The vast majority of patients at increased risk of infective endocarditis should not be offered prophylaxis. However, for a very small number of patients ['Patients Requiring Special Consideration'], it may be prudent to consider antibiotic prophylaxis in consultation with the patient and their cardiologist or cardiac surgeon.'

Earlier this year, the Faculty raised some concerns when the advice was in development. However, a number of improvements have been made as a result of feedback from FGDP(UK) and other organisations, and the Faculty now supports the finalised guidance – which has also been endorsed by NICE – and says dentists throughout the UK will find it useful.

NICE CG64 states that antibiotic prophylaxis is not recommended 'routinely' for invasive dental procedures, and the new SDCEP advice aims to clarify the non-routine circumstances in which antibiotic prophylaxis to prevent IE from such procedures might be justified. It is accompanied by a patient management flowchart, a discussion points document for use with patients, and a patient advice leaflet, and also includes a template letter for use when contacting a patient's cardiology consultant or cardiac surgeon.

Dr Nick Palmer, Editor of the FGDP(UK)'s Antimicrobial Prescribing For General Dental Practitioners – which reflects NICE CG64 and provides evidence-based guidance for appropriate antimicrobial prescribing and stewardship – commented: 'For over ten years the recommendations in NICE CG64, which apply to all healthcare professionals including cardiologists, have remained the same. These are that patients at increased risk of IE should be advised of the risks and benefits of prophylaxis, and that antibiotic prophylaxis is not routinely required for invasive dental procedures. The patient should also be advised of the symptoms of IE, of the importance of maintaining good oral health to reduce their risk of IE, and when to seek expert advice.

'SDCEP's implementation advice re-emphasises the NICE CG64 recommendations, but notes that there are a very small number of dental patients that may require 'special consideration' for antibiotic prophylaxis. Importantly, SDCEP's implementation advice shifts the balance of responsibility for the decision on antibiotic prophylaxis for these patients from the dentist to the patient's cardiologist and to the patient under Montgomery consent. Dentists should ensure they record in the clinical notes any advice from the patient's cardiologist, and the patient's consent when a decision is made.

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# Dental Schools Council needs to do more to stem brain drain in research

The British Dental Association (BDA) has responded to workforce figures published by the Dental Schools Council (DSC) which show a marked decline in professorial roles and research.

The DSC reports that the number of clinical academics employed at professorial level in UK dental schools has declined by 8.3% since 2015, which the BDA believes undermines the UK's global reputation as a leader in dental innovation.

Although the DSC highlights a 2.2% increase in the number of full time clinical academic staff employed since 2016, the BDA notes that dental schools are increasingly relying on part-time staff with a concentration in teaching posts over research. The workforce figures reveal a steady increase in employing part-time staff in the last five years, from 57% of the workforce in 2013 to 59% in 2017. The picture since 2004 is even more stark, when the less-than-full-time figure was 44%.

The BDA believes that the decline in research posts is a direct threat to the profession being able to find and explore new treatments, and could lead to an unhealthy period of stagnation, particularly if work is being done in other countries which would eclipse the UK's reputation in research.

This overall shift from research to teaching contracts means that UK dental academia is in danger of becoming little more than a degree mill: this has grim repercussions for both practitioners and patients.

The report also warns that more than two-thirds of the dental schools – 13 out of 18 – have experienced difficulties in recruiting to one or more specialities.

Giles McCracken, the Chair of the Central Committee for Dental Academic Staff, said: 'The latest figures on the workforce in dental schools show a worrying trend towards employing part time staff to teach at the expense of research. This is incredibly short-sighted and mechanistic and undermines the global reputation that dental schools in the UK have enjoyed till now.

'Without the capacity for research, UK dental schools will have ongoing problems attracting top-class staff and this will impact upon the future of the profession.

'Advances in dentistry require ongoing investment in our research talent, not aspirational platitudes. The Dental Schools Council needs to do more to attract the top talent to deliver not just quality teaching but also world class dental research and thereby ensure the health of the profession in the long-term.'

# BDA announces restructure

In a restructure of its senior team BDA Chief Executive Peter Ward has now assumed the new role of Managing Director. Director of Member Services Martin Woodrow has stepped into the role of acting Chief Executive Officer and Finance Director Richard Shilling is now acting Chief Operating Officer.

# Future of the Ben Fund: Joint statement

Leaders from the British Dental Association and BDA Benevolent Fund have agreed common ground after differing opinions about proposals put forward for consideration at the BDA Benevolent Fund's AGM on 18 September.

In a joint statement Eddie Crouch, Vice Chair, British Dental Association, and Prof Ros Keeton Chair, BDA Ben Fund said: 'We are delighted to report there is a shared commitment to work together with common ground reached regarding the changes to the charity's membership, board size and administrative processes.

'In recent weeks, both organisations have been encouraged by the interest shown by members. It is clear the dental profession value the unique role the Fund plays, and all want to ensure it continues to help all dentists, dental students and their families in need.

'In that spirit, we have pledged to work closely to ensure practical proposals can instead be put forward at the Fund's AGM in 2019.

'We recognise this profession is under pressure as never before and the BDA Benevolent Fund are continuing in their commitment to ensure one off or ongoing financial assistance is given to those when they face hardship.'

The AGM takes place at 3.30pm on Tuesday 18 September 2018 at 64 Wimpole Street.

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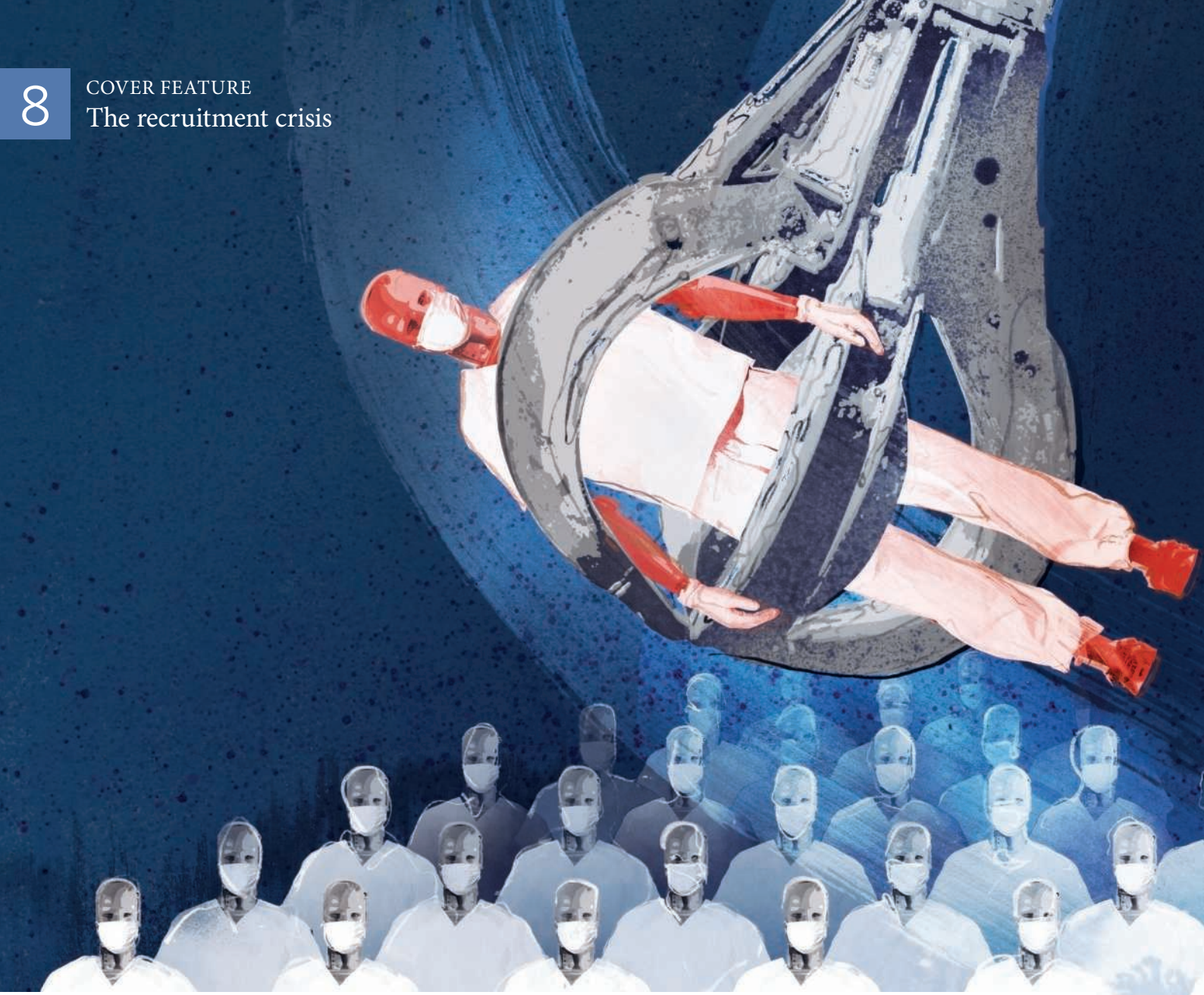


# The recruitment crisis: how dry is the well?

By David Westgarth,
Editor, *BDJ In Practice*

I am always tittivated in the supermarket when I see fellow shoppers rummaging through the various fruit and vegetable aisles trying to select their item of choice. It's like they're trying to get a competitive edge and buy a cucumber with one extra centimetre, a broccoli with two extra florets or heaven forbid a pack of mushrooms with three more than the pack adjacent to it. After all, they are all the same price. They're all the same weight. They're almost identical.

Yet on the rare occasion I'm feeling brave enough to quiz my fellow shopper on their disdain for an apple almost identical to the one they've previously disregarded, they tell me one thing; you have to get the most for your money, even if they all look the same.

The same attitude and approach could be labelled at practice owners and corporates looking to recruit associates. Fresh out of university and looking for a position, they're essentially the same blank canvas – five years of dental school, and let's face it, perio is perio and decay is decay – there are only so many ways you can treat them.

Yet there are whispers and indeed whimpers from all areas of the country telling us far from having their pick, the section is empty; there is no choice. And with grumble after grumble about a 'recruitment crisis', how dry is the recruitment well? Are associates drying up? Are practice owners knee-deep in choice? Or is the reality somewhere in between?

## The scale of the problem

There is no doubt the landscape in the UK has changed since 26 June 2016 and on the surface recruitment appears to be the least of the Government's problems. Yet the recruitment crisis runs deeper than dentistry. Half of British employers think they will struggle to find the permanent staff they need, the biggest proportion since early 2017, according to a survey from the Recruitment and Employment Confederation (REC).

Technology sectors. Teachers. Even the Armed Forces – specifically and bizarrely their chefs – have reported chronic shortages of available applicants to fill vital positions.

The Royal College of Nursing has called for a national recruitment campaign as the latest figures show a fall in applicants for student places. There have been 43,700 UCAS undergraduate applications for nursing courses, a fall of 10% compared with last year. It is estimated that the NHS in England is short of about 40,000 nurses. Overall UCAS reported a fall of 11,000 in the number of people applying for higher education courses. It said this was due to there being 18,000 fewer 18 year-olds in the UK and a decrease in applications for mature student places. However, applications from the EU were up 2% to 46,040, while those from other overseas countries reached a record high of 65,440.

The picture in dentistry is no better, according to data from the BDA.

Be it Brexit related or not, there is a shortcoming of dentists with an active Performer Number, which could, in part, be attributed to Brexit. Right across the NHS there has been a drop in the amount of EU candidates coming to the UK to obtain work in the sector, and one can only assume this is due to the uncertainty of the future.

Where foreign applicants are looking for employment in the UK, they have to overcome the barrier of passing the Overseas Registration Exam before they can register with the GDC and apply for their Performer Number. This process can take up to two years and as such this has had a knock-on effect on recruiting associates in NHS practices. It is still not clear in Chequers or any of the Brexit papers whether the country will have access to EU applicants as it has done so in recent years. Capita's shortcomings in processing Performer Numbers quickly has also taken its toll on recruiting EU candidates as employers simply can't wait that long.

Away from Brexit, evidence suggests over two thirds (68%) of NHS practices in England who attempted to recruit in the last year struggled to fill vacancies. Half (50%) of the NHS practices who attempted recruitment reported issues in the previous year.

> 'Right across the NHS there has been a drop in the amount of EU candidates coming to the UK to obtain work in the sector, and one can only assume this is due to the uncertainty of the future'

Figures reflect widespread disillusionment with England's unreformed NHS dental system, with levels of NHS commitment now a leading driver of low morale and motivation. Those with the highest levels of NHS work (over 75% NHS work as opposed to private) appeared more than twice as likely (39%) to report job dissatisfaction than those with lighter commitments (16%).

In the latest sign of emerging crisis Plymouth's Director of Public Health, was instructed by councillors to write to NHS England requesting 'urgent local action to improve access to NHS Dentists amid 9,000 long waiting lists fuelled by staff shortages and patients facing a 70 mile journey for treatment. Recent reports for both the *Times* and BBC have highlighted access problems across England, with half of practices across England unable to take new NHS patients.

The BDA has previously reported that 58% of NHS dentists say they are now planning to leave the service in the next five years. Failure to reform the target-driven system in England and Wales, and the 35% real-terms fall in practitioner incomes continue to threaten retention, recruitment and the long-term sustainability of the service. The BDA has called for the re-introduction of NHS commitment payments in all four countries to help NHS associates, who generally have a higher NHS commitment and form the vast majority of

the workforce, and NHS support towards indemnity payments.

## Here's one I made earlier

While the Government has pledged to reform the system in successive manifestos since 2010, the constant narrative of dragging feet has created an NHS workforce lacking in motivation to such an extent it's on the verge of collapse.

Understandably for young dentists looking to launch their career alongside quality of life, urban areas have tended to be more popular. Perhaps alongside London devolving – take the BBC for example – more and more practices outside of the city are offering better remuneration and attractive golden hellos – some worth up to £20,000 – which means more and more candidates are considering a move from the capital. But, in places of former strength, alarm bells are ringing.

In last month's *BDJ In Practice*, figures from MyDentist's annual report to shareholders highlighted how practices in the South East are now struggling. Their rapid sale of practices suggests that motivation is lacking in barrels.

Perhaps this is driven by – or as a result of – the very nature of today's workforce. Full time isn't a given. The need to juggle work and social life, allied to choosing a 'portfolio career' means an increase in part-timers in the workforce.

The difficulty in filling positions in certain geographical locations allied with more and more permanent dentists looking outside of NHS dentistry, this presents a unique problem. More associates than ever will remain working as dental associates for their whole career. Does this mean associates are unlikely to extend their skill set or use expertise for running a business and managing and leading teams, which again will drive them outside the NHS? Only time will tell. Everything on the surface suggests we're in a fully-blown crisis.

Or are we?

I asked several recruiters whether the use of the word 'crisis' was an accurate reflection of the recruitment situation in dentistry or not.

Kelly Saxby, Managing Director at Green Apple Dental, commented: 'I think using the word crisis is over-blown.

'Yes, the market is quieter than normal, but there are plenty of dentists looking for work. We believe some dentists do feel some uncertainty around Brexit so that is slowing movement around – understandably so.

'What we are finding is that a large part of what has changed over last few years is more dentists are wanting to work part-time and have more work/life balance, which in effect means practices need two people for every one full-time contract. This is a significant influence on the market. Likewise more dentists now want to work as a locum to give them more flexibility in their personal lives.

'Financially, minimal increases in UDA values and private income over the past few years have also impacted the market. It is difficult to identify one principle cause.'

Malcolm Barker, Managing Director at MBR Group agreed with Kelly's assessment of the slow market and highlighted a different set of issues.

> 'Does this mean associates are unlikely to extend their skill set or use expertise for running a business and managing and leading teams, which again will drive them outside the NHS?'

'Recruitment certainly has become more challenging and problematic for dental practices in the UK over the last two years and I believe most dental practices would agree', he said. 'Some geographical areas in the UK are more affected than others. We speak with practice owners over the UK who have not met their NHS targets because they have struggled to recruit dentists for their practice after a member of staff has moved on.

'Like Kelly mentioned, we find it difficult to pin point an exact reason for the recruitment deficit. Many practice owners look at Brexit, however we have dentists from the EU contacting us on a weekly basis looking for opportunities in the UK. We appreciate some dentists may have decided to leave the UK, however this is being replenished by dentists who want to work in the UK. Dentistry is a growing industry with more investors than ever before purchasing practices, salaries are on the up and we are finding a lot of dentists seem to be choosing the locum lifestyle rather than choosing to work as an associate. I've spoken to multiple agencies this year and they all seem to be busy, so it's difficult to say that we have reached a crisis point when dentists are still reaching out to find positions.'

CEO of AJs Dental Fairies, Anisha Jane, was far more certain in her assessment of the current climate.

'Yes I do feel as though there is a recruitment crisis', she said. 'We find a lot of people have become self-employed or have set up their own locum services as it is easier to advertise on social media for free these days than use recruitment agencies. This means there is more emphasis placed on the candidates coming through recruitment agencies, perhaps unfairly.'

Rob Fryers, Managing Director, Dental HR Ltd, agreed with Anisha's comments.

'Crisis is not over-blowing the situation', he suggested. 'We are seeing a major recruitment crisis within dental nursing and dentistry with greater problems on the NHS side of dentistry. Retention seems to be a problem in the dental industry, even though unemployment rates generally are at an all-time low, according to Government figures.'

## Quality, quantity or both

If there are more people than ever – according to Government figures – in work, is the word crisis appropriate? Is the problem not so much a lack of quantity for practice owners, but a lack of quality? Opinion was split.

'Practice owners' say candidates aren't generally of the right calibre', Rob suggested. 'We have heard stories of a real lack of committed dental nurses with the right ethos. They do not appear career minded and sometimes see this as a stop-gap to dental hygiene, for example.

'Clients say the kudos doesn't seem to be there any more, new training courses are not up to standard. Some prefer the old system with dental hospitals training dental nurses with proper nursing qualifications. 'Dumbed down' and 'flawed' a client recently commented. Rising indemnity costs have an effect on the wages practices are able to offer.

'We have a practice client on its sixth candidate for a replacement dental nurse in less than twelve months, after a long serving dental nurse retired. Another practice owner recently found a new dentist more of a liability than an asset. A previous NHS dentist, who may have picked up bad habits, caused more harm than good and was dismissed after six weeks as a damage limitation exercise. The dentist in question received nothing but complaints and treated private clients like NHS clients with time.

'All the new dentist's clients were checked by the practice principal and some work

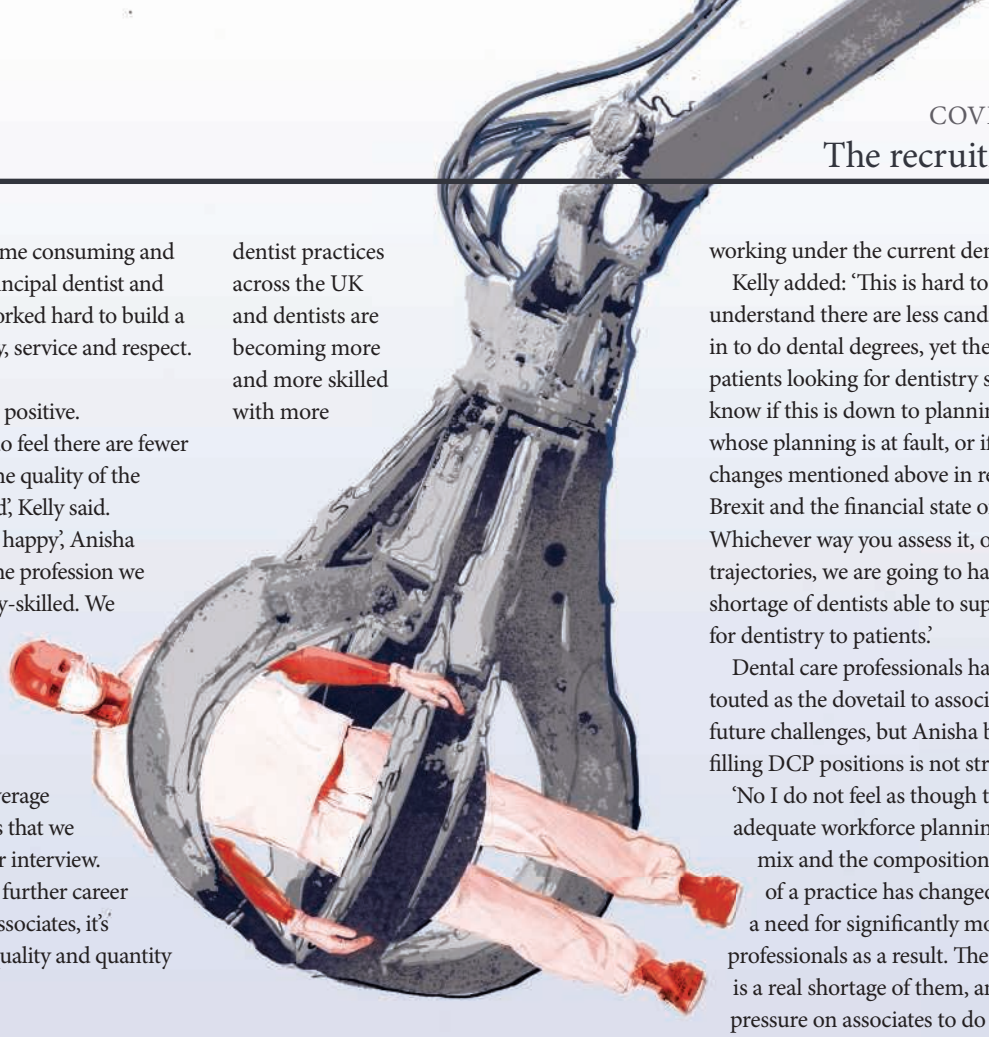
rectified. This was costly, time consuming and demoralising for a busy principal dentist and practice owner who has worked hard to build a reputation based on quality, service and respect. It is not easy.'

Others felt slightly more positive.

'Some practice owners do feel there are fewer choices for each role, but the quality of the candidates has not declined', Kelly said.

'No, practice owners are happy', Anisha added. 'It's a reflection of the profession we work in. Dentists are highly-skilled. We mustn't forget that.'

Malcolm added: 'I would say that most practice owners are happy with the candidates that we put forward. On average two out of three candidates that we put forward are selected for interview. With the opportunities for further career development available to associates, it's perhaps little wonder the quality and quantity is there.'



## Suitably prepared or chronically under-prepared

Any workforce discussion cannot take place without thinking of those currently in the system. The future is undoubtedly going to be shaped by the number of dental graduates coming through the system. The total number of dental students in 2015/16 was down 2.2% to 5,655 but up 17.4% on 2005/06, although continuing to fall from its peak of 5,918 in 2013/14. This is was a trend reflected in the student intake, down 4.5% to 1,005, a continued fall from its peak of 1,278 in 2010/11.

Dental graduates continued the rising trend, although this is expected to come to an end following the peak in student intake in 2010/11 and interrupted in 2012/13, up 0.2% to 1,215.

With fewer choosing a career in dentistry, yet more students are sticking the course out, will the profession have adequate numbers to deliver the care necessary? If the answer is yes, associates are in a prime position to deliver the care the next generation of patients require. If the answer is no, the BDA's research on the number of people leaving the profession may be significantly under-valuing the exodus that could take place.

Malcolm believes regardless of workforce planning, associates will always be hot commodities.

'The demand for dentistry is forever growing', he said. 'There are nearly 14,000 dentist practices across the UK and dentists are becoming more and more skilled with more technologies becoming available. There is a massive demand for NHS dentistry with more and more demand for private dentistry year on year. Dental practices are open longer hours and some are working 7 days per week.

> 'Whichever way you assess it, on current trajectories, we are going to have a chronic shortage of dentists able to supply the demand for dentistry to patients.'

'The demand I believe will always be there. The issue is the skill shortage (lack of dentists) that are available to meet the demand. This has to be looked at and how that can be addressed.'

According to Rob, workforce planning isn't one specific to the profession.

'There is often a lack of workforce planning, leading to problems', he said. 'There do not seem to be enough candidates to supply demand. We have prepared many practice owners for the reality, which is dentists, retiring or leaving the industry.

'Part of the issue – and associates will be able to relate to this, particularly those working across multiple practices, is the increase in red tape and compliance. It is so stringent, and it shows no sign of abating. Negotiating through that takes time and experience, time and experience associates simply do not have working under the current dental contract.'

Kelly added: 'This is hard to say. We understand there are less candidates going in to do dental degrees, yet there are more patients looking for dentistry services. I don't know if this is down to planning and if so whose planning is at fault, or if its more the changes mentioned above in regard to lifestyle, Brexit and the financial state of the market. Whichever way you assess it, on current trajectories, we are going to have a chronic shortage of dentists able to supply the demand for dentistry to patients.'

Dental care professionals have long been touted as the dovetail to associates for meeting future challenges, but Anisha believes even filling DCP positions is not straight forward.

'No I do not feel as though there has been adequate workforce planning', she said. 'Skill mix and the composition and make-up of a practice has changed, and there is a need for significantly more dental care professionals as a result. The problem is there is a real shortage of them, and it is putting pressure on associates to do more with their time.'

## Pushed to breaking point

The stress of being an associate is an area fraught with multi-level problems. Some point to the NHS contract, some point to money, some point to time. It's like an onion – the more you peel away one layer, another lies beneath. And for some, there are going to be tears involved.

Any newly-qualified associate may be encountering these problems for the first time, so are they qualified to deal with the issues in front of them?

'We do work with a lot of associates going into a GDP role for the first time that are able to cope', Kelly suggested. 'By agreeing to contracts that are achievable as well as looking for practices that can offer good levels of support/mentoring, we have found they are equipped to meet the challenges of being a dental professional.'

Malcolm believes the difference lies in the experience.

'With any profession, the longer you have been in a position, the more efficient, skilled and experienced you become and it's the same for any dentist. They can cope with demands, however moving into practice from their foundation year as an associate dentist, its important the dentist has the right support in practice from more senior dentists which can help assist with their personal development and build confidence further.

## British Dental Association research suggests...

- General dental practices are suffering with less than one applicant per post (outside London) for advertised positions and 63% of practices that attempted to recruit associates experienced difficulties in doing so in England, huge sums of money are clawed back from practices unable to meet their NHS commitment for various reasons including failure to recruit associates.
- In the community dental services morale and motivation have got worse since last year and there are recruitment problems, particularly to specialist posts.
  - The role of the service is changing in all four countries to concentrate on complex specialist work with patients who can, in theory, be cared for in general dental practice being discharged back. This increases recruitment problems and does not aid retention.
- In dental academia there is a permanent 10% vacancy level amongst Senior Clinical Lecturers, the backbone of clinical undergraduate, teaching.

'Kelly's point about having suitable NHS targets and not putting junior dentists under any unnecessary pressure is an excellent one. Allowing them to become more efficient with time served and then potentially looking at larger NHS targets is a great way to ensure you know you can cope with the demands and establish foundations for you to develop and improve.'

According to Rob, associates lack one crucial element preventing them from taking the next step in their careers.

'Young associates are not as commercially aware as they have less experience', he said. 'That does and will come with time. Contract-checking, knowing potentially problematic terms to look out for, understanding GDPR regulations; these sorts of things associates do need to be more aware of before getting into practice.'

> 'Finding an associate with a passion for dentistry and for looking after people after years of red tape and bureaucracy can be a challenge.'

But what about associates at the other end of their career? The corporate market means former principal dentists or practice owners become associates and file back into the ranks in what was their own practice. How difficult is that?

'It can prove difficult', Rob said. 'It is dependent upon their experience and how well a potential associate matches the business/culture of a practice. Finding an associate with a passion for dentistry and for looking after people after years of red tape and bureaucracy can be a challenge.'

'We work with a large number of principals who have sold their practice', Kelly added. 'In our experience, they are just happy to get back to enjoying dentistry rather than running a business, which is a challenging role in the current climate.

'Former principal dentists are in a unique position. They are knowledgeable, experienced and can be a great asset to many practices. As long as the individual can accept that they are no longer the final decision maker, and that working for someone else means just that, then it doesn't appear to be too difficult.'

Malcolm agreed.

'We never struggle to place dentists that have just sold their practice', he said. 'Most practice owners are quite happy to just work as a clinician without the added responsibility of running a business. Their skills and experience are always welcome in practice, and in fact they can be a large asset.'

And that is the very point. You, as an associate, regardless of where you are in your career, are a valuable asset to the practice you eventually join. Whether a practice owner has a rummage around to find the best one or whether you're applying for a job and are the only candidate, you will always be the chosen one. ◆

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* Introducing safety syringes into a UK dental school - a controlled study by JM Zakrzewska, I Greenwood and J Jackson Published in BDJ Volume 190

# A decade of stagnation through an associate's eyes

**Zoe Connelly** on the never-ending NHS dental contract

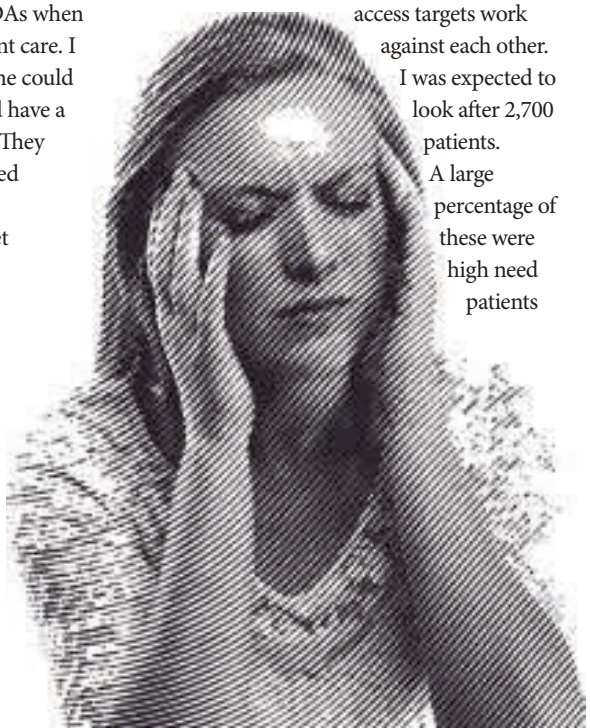
For me, 4 August 2018 marked 10 years since I became an associate. I entered the doors of the practice full of excitement and great hope that I could make a difference to the lives of my patients. Since then the landscape of NHS dentistry seems to have changed rapidly and drastically. Unfortunately, I don't feel these changes have been for the better.

My role in a busy NHS practice as a new associate building up a new patient list presented me with a range of challenges and stresses. How do you do the right thing by the patient while trying to achieve the overbearing UDA target which has been set for you? Dental school certainly does not prepare you for UDAs! I have always strived to do the right thing by every one of my patients and provide good treatment appropriate to their needs. Unfortunately, this was not easy and what ensued was about four years of heavy workload, anxiety and monetary clawbacks. Every day was about counting the UDAs when really the focus should be about patient care. I spoke to friends and family and no-one could understand about how a dentist could have a target for how many teeth they filled. They thought we just treated what we needed to and that was it! I came through it and finally managed to meet my target and in turn developed a fairly stable patient list.

When my practice had the opportunity to become part of the Pilot NHS Contract in 2013, I jumped at the chance to be free of the shackles of the UDA system I had grown to hate over the previous five years. It was certainly a leap of faith but with the late Jimmy Steele's vision we were promised, we would have more time with our patients and that we would be acknowledged for the hard work we were putting into everyday preventative care.

The starting point certainly took some organisation and delays in the start date of the pilot took an initial toll but once we got up and running the first couple of years were not all bad. The pathway approach with the RAG score reinforced those all-important messages about periodontal disease and caries which we had always provided but this time patients were sitting up and noticing on being presented with that all important red-amber-green score. The preventative ICM appointments ensured the patient was seeing the right dental care professional at the right time and the correct care was given which got positive feedback from both dentists and patients. Unfortunately, there was still a target – the patient number or Capitation Target.

Then April 2015 arrived and the introduction of the supposed 'new and improved' Prototype programme. Here we felt the brunt of not only the patient number target but the re-introduction of the UDA. We quickly came to the hard realisation that a Capitation Target and a UDA target do not mix; if you can see more patients then you probably can't reach the UDA target and vice-versa. Activity and access targets work against each other. I was expected to look after 2,700 patients. A large percentage of these were high need patients and therefore I was in the position of having a long treatment waiting list; I went home worrying every night about my patients and came to work worrying about the next complaint to come through the door. The appointment books were squeezed to breaking point and we were working at a pace we had never had to before; a coffee or comfort break was unheard of and a lunch 'hour' was optimistic! Too many patients and the ever increasing administrative demands stretched every member of the team to their limit.



There was much talk about the blends of the Prototype and which works best. The answer is neither. Blend A counts band 2 and band 3 treatments and therefore ensures the patients get all of the treatment they need, but there is then the higher activity target. Blend B focuses on band 3 treatments which therefore leads the practitioner to prioritise band 3 treatments, but what happens to those patients who just need a filling? There needs to be a realistic capitation target. Maybe there should be different pathways for patients wanting different types of care; in other words a pathway for those wanting to accept and comply with a full preventative oral health regime and a pathway for those wanting a tooth removed when they have toothache every five years. The UDAs need to be banished and a different measure of activity needs to be established. We cannot continue to do the same thing and expect a different outcome. Surely with all this manpower and 'expertise' the powers that be have there is someone out there with the imagination to create something better than the UDA?!

The associates where I work are all long-standing members of the practice like myself but we each have become more disheartened and demoralised. Like many members of our profession both in Prototypes and UDAs our thoughts were occupied with leaving the NHS and moving to private practice or even leaving dentistry completely.

On 31 March 2018, the decision was made by my practice to leave the contract reform process. We could no longer continue in

a process which did not take into account the needs of the patients which required treatment and also a system which did not care about the practices which were supporting the 'learning process'. We did not choose to return to UDAs because we think they are better; they are definitely not. We lost the Access Target from our contract because it was unattainable and unsustainable. Currently, the Prototype is no different from the UDA contract. It is target driven with no consideration of the oral health needs of the patient it is supposed to help and no thought to the future sustainability of the profession.

I have now been back in the UDA system for four months. Am I happy? Unfortunately, I am still constrained by the legacy of the Prototype; my waiting times remain long so not only do I have to worry about this but I now have to worry about ensuring I meet my UDA target.

Is this really what the future holds? I have heard newly qualified dentists don't want to work a full-time week and certainly don't want to do the six to seven thousand UDAs a year that has previously been expected of associates. I don't blame them. Why become ingrained in the treadmill that you simply cannot get off once you are on it? NHS dentistry certainly doesn't seem very sexy; why would you want to place an MO amalgam when you can go on a smile design course and place six veneers?

It also doesn't provide the income it once used to. Associate income is down 35% in real terms but yet the demands of the job have risen. This does not bode well for future practice ownership. I left dental school with £35,000 of debt which after 10 years of full-time work in NHS practice I still have not paid off. Graduates now leave with double that. Working in the NHS will not provide the income so they can one day buy their own practice; how is it possible with that amount of debt and then the buying power of the corporates?

Are there any good aspects of NHS dentistry? I initially thought the answer is yes – it is the refinement of skills and gaining the experience to provide good quality work. This is the foundation to a solid dental career. However, I am also aware of the practice of 'defensive dentistry' which is not necessarily in the best interests of the patient. Dentists should be allowed to learn and develop from those treatments that have not gone to plan without the threat of the GDC and the dental negligence solicitors. The beauty of the NHS is that you maintain that list of patients and monitor the treatments you have provided and learn and improve over time.

As dental associates we are self-employed and therefore should have the freedom to develop our career how we choose. I think our experiences are shaped by the practice environment within which we work. We rely on the nurturing of the practice to grow and develop into the practitioner we want to be. This is where a good principal is key and should be greatly valued in the world of the dental corporates where associates don't have a face to communicate with. Without this can the new associates fully develop and grow into well-rounded practitioners?

The resounding problem for Dentistry in the NHS is TIME. Dentists want more time with their patients. They want to have more time to provide good preventative advice and provide good quality treatments which will help to ensure a lifetime of good oral health. However, the NHS sees this from a different angle; they want dentists to spend more time seeing more patients and more time doing more treatments. The allure of private practice where the factor of time does not put the practitioner at a disadvantage is very appealing. For me, I am starting to think my time in NHS dentistry is running out but maybe that's true for all of us and really the clock is counting down for the end of NHS dentistry. ◆

# When **choice** isn't a **true choice**

Life is all about making decisions. Some are easier to make than others. Some are freewill. Some aren't. Apparently, we make close to 35,000 decisions a day. There's one important professional decision that might appear to be freewill on the surface, but could just as easily be shaped by the options available. **Richard Leck**, former associate dentist and current BDA Branch Treasurer delivers his assessment on whether being an associate is truly a choice or one forced upon the profession by a lack of it

## Richard Leck

*Richard graduated as a Dental Surgeon from Newcastle University in 2010. After completing Foundation Training, he gained further experience in the Community Dental Services, and Oral & Maxillofacial Surgery before settling into an associate position in a busy mixed practice. Here, as well as developing clinical skills, he provided part-time Undergraduate Teaching in Restorative Dentistry, and was an Educational Supervisor for Dental Foundation Training, and is currently Treasurer for his local BDA Branch. Richard recently made the decision to leave General Practice and return to Hospital Dentistry full time - where he has plans to pursue Speciality Training.*

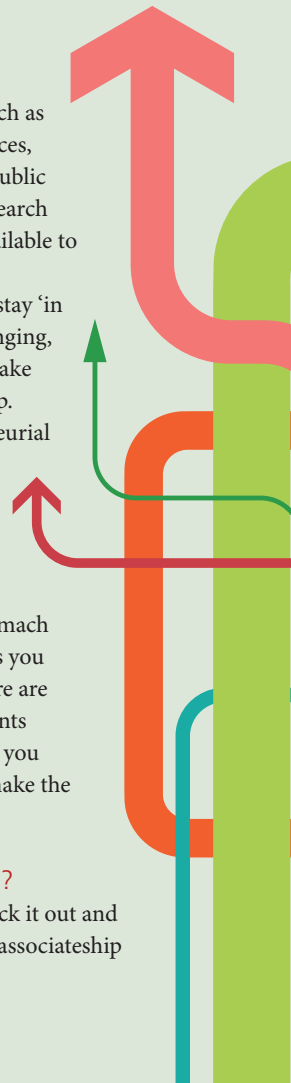
The story goes that historically, 'career associates' were a minority and would choose this over practice ownership because it offered them the flexibility needed when starting a family, or the time to enjoy other work commitments or hobbies. They may have even been viewed with contempt by principals, as they were able to enjoy rewarding employment, without the stress and expense of ownership.

Those days are gone, and associate dentists now make up the majority of the workforce. For most it will be their full-time occupation, and their only source of income. The shift was no doubt initiated by the ring-fencing of dental contracts, meaning the natural progression with which an associate can make the move into ownership is a thing of the past.

When I explain the current situation to patients, I liken it to the housing market. Current practice owners, often *baby-boomers,* or more recently corporate groups, have their feet squarely under the table, and in a closed market the associates face a future of forever renting surgery space from them.

So what choice do you have? Well, firstly there is nothing forcing you to work in primary care. The same dental career opportunities exist as they did 30 years ago. Secondary care posts such as community dental services, dental hospital, dental public health and teaching, research and academia are all available to dental graduates.

For those wanting to stay 'in practice' – whilst challenging, it is not impossible to make the break into ownership. Although the entrepreneurial aspect of NHS dentistry has been curtailed, you can still set up a private practice. Should you have enough capital - not to mention the stomach for it - is a risk, as unless you are well established, there are no guarantees that patients will want to pay the fees you may have to charge to make the model work.



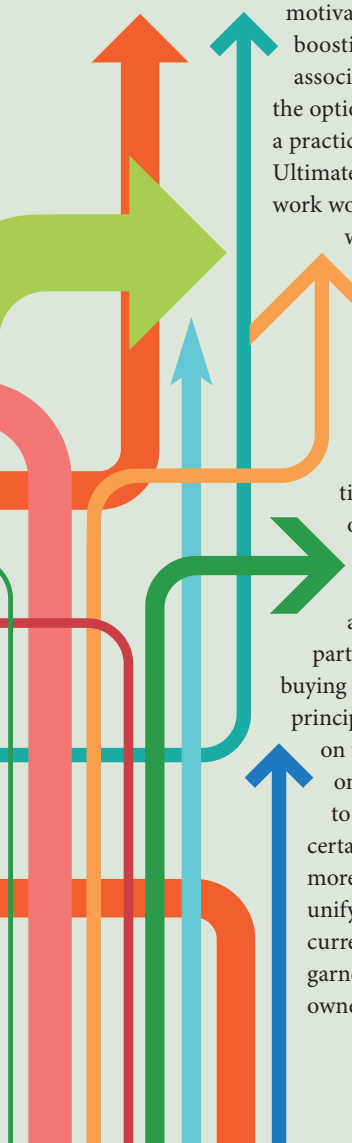
## Career development?

Should you decide to stick it out and make a career out of an associateship

in primary care, you do still have options – you can work solely for the NHS, or entirely privately or mix. You can work across several practices, or provide locum services. Whilst working, you can 'bolt on' Foundation Dental Training and even take on managerial roles within corporate structures.

The flexibility of the job lends itself particularly well to those who want to undergo further training or develop clinical skills whilst continuing working. A part-time or online MSc, which allows the dentist to provide advanced care or join the specialist register can add interesting and rewarding 'strings to your bow'. There are plenty of courses available to help you do this, but whether they are financially worthwhile depends largely on the demographics of the patients in your area, and the details of the contract you are working. In my mind there is definitely scope to move 'sideways' and develop a niche in practice, yet ultimately the option to 'climb the ladder' into practice ownership remains extremely limited.

And that is a point I cannot emphasise enough. I can think of nothing more motivating or morale boosting for an associate than having the option to 'buy in' to a practice at some point. Ultimately your hard work would seem more worthwhile if you knew that instead of building somebody else's business, you were investing your time into your own.



The old model of associate, partnership and buying out, with principals passing on the keys from one generation to another certainly sounds more symbiotic and unifying than the current relationship garnered between owners and workers.

However, the opportunity for increased responsibility still wouldn't be for everyone.

> 'BDA research shows 58% of NHS dentists are planning on turning away from NHS dentistry in the next five years.'

## Forcing your hand

Working the same number of hours whilst enduring increasing stress, rising expenses and decreasing earnings means that for many, more than a few years of 'head-down hard-work' as an associate is unsustainable. None of my associate peers can see themselves carrying on the way they are now for the next 20 years.

Little wonder then BDA research shows 58% of NHS dentists are planning on turning away from NHS dentistry in the next five years. In that survey, 53% of young NHS dentists (aged under 35) said they intended on leaving the NHS, and almost 10% said they will leave the profession entirely in the same period.

For many, after achieving those early graduate goals, of buying a house, a car, and getting married, the subsequent mood is 'I would like to work as little as possible'.

Without the promise of something to show for all your hard work along the way, there isn't the drive or ambition to keep going at such a pace. Many are considering dropping hours, going part-time, or undertaking further training in order to have more options outside of the surgery.

Those associates who are motivated to take command of their careers, engage with social media and undertake masses of CPD are likely to benefit from the current situation by understanding the need for diversification. The profession lacks specialists – paediatric dentistry, for example – has a chronic shortage. As long as you continue to enjoy the work and have the motivation to learn, I believe there is a tremendous potential to thrive.

Speciality training can be a good option for those with ambition and drive. Perhaps those who would have otherwise gone on to be practice owners but find that avenue has now closed. Even this route is not always an easy one and there are a lot of associates who may have already missed the boat. A recent graduate who has completed only minimal CPD, and has done no advanced courses is unlikely to secure anything other than the basic (and often undesirable) NHS associateship. They may then be exposed to a downward spiral, as the motivation to develop new skills is lost.

Those trying to make a move back into hospital dentistry will struggle if they haven't undertaken academic exams, or engaged with audit, research, publications. The grim reality is that it is entirely possible for a 10-year graduate to be out-competed in an application to a basic SHO post by a Foundation dentist who has a portfolio of evidence and an up-to-date reflective log, for example. Is that the best thing for the profession? Is that the best thing for patients?

## The right reasons

Undoubtedly the entire profession has seen costs rise and earnings fall. Reports suggest a 30% drop in real term pay over a decade. New graduates face an unprecedented burden of debt, and having slogged through five years of student living, will understandably be keen to focus on 'starting life'; buying a home, settling with partners, and paying off some of that debt. Putting themselves through more training, taking on the liability of buying a practice, or the loss of potential earnings whilst undergoing speciality training may simply not be an option for some.

A full-time associate position in a busy practice is without doubt the quickest route to earning a good living and it would be unfair to label a dentist who works in this way, as doing it 'just for the money'. Expecting to see that income rise year-on-year is however, unrealistic.

An associate who does the work because they love it may not, initially, see the current situation as a problem. In time however, they may come to realise the difficulty of maintaining a work-life balance and should therefore plan ahead to ensure they have options available, and a change in working arrangements can be achieved if required.

For the 'comfortable' associate, a step in any direction is likely to be a scary one. But just as the old saying goes, sometimes to move forward, you must first take a step back. Whether it means dropping lucrative surgery hours to gain experience in a hospital setting, hitting the books and undergoing further training to expand your horizons, or investing financially into a practice to take more control of your future. One thing is certain, the treadmill is only going to keep turning, and at some point you will need to decide how you are going to step off. ◆

# To **associate** or **dissociate**

**Asif Syed** on the importance of the associate

## Asif Syed

Asif qualified as a dentist and is now a committed full time dental business strategist based in London. Asif runs three well respected business courses for dentists: 'The Young Dentist Course FFQ', 'The Associate Course PYP,' and 'The Principal Course KYN.' In addition, he manages a select group of dental practice clients.

The worst business advice I received as an associate must be 'Asif, you have to look after No.1!' This was advice dispensed freely by an older associate who enjoyed holding court. His tactic was to monopolise practice resources by hoarding stock, controlling nurses, bribing receptionists and befriending the practice manager – even if this meant contradicting his friendly principal. As you might imagine, their relationship was frosty. The associate saw himself as an indispensable individual, and the principal saw the associate as an irreplaceable irritant.

Fast forward a few years and the dental profession is shivering as the associate/principal relationship falls further into a freeze. Attempts by principals to engage their associates in the struggle against rising practice pressures are met by well-rehearsed replies such as:

- **I don't see any reason why I should**. No other associates are spending their time assisting their principals so I am not sure why this request is being made of me
- **I don't think the principal deserves it.** I haven't been given everything I requested at the practice so you get out what you put in
- **I don't get paid for it.** My time and effort has a monetary value so I don't work for free
- **It's not my job.** It's the principal's job. I pay a large percentage for this not to be my job.

Invariably this conversation leaves principals scratching their heads and associates crossing their arms. As the points above are contractually correct, the views have become entrenched; but here's the interesting thing – the textbook definition of associate is something quite different: *'associate: a partner or companion in business or at work.'*

Oxford and Cambridge dictionaries provide near identical search returns meaning all of us in the dental profession have misunderstood the term 'associate' as someone who does not associate, but does the exact opposite, and dissociates. As this dissociation deepens, the strained associate/principal relationship may decay through the stages below:

- **Indifference** – working together in the same practice, but having no working relationship
- **Non-compliance** – practice systems agreed on Monday are violated by Friday
- **Resentment** – both think that the other one has it better
- **Moaning** – the associate doesn't perform and the principal doesn't invest

| | | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 | |
|---|---|---|---|---|---|---|---|---|---|---|---|---|
| 1. Attitude to work | I want to escape work | | | | | | | | | | | I want to get excited about work |
| 2. Payment terms | I want a stable income | | | | | | | | | | | I want to earn a share of results |
| 3. Income | My work is paid money now | | | | | | | | | | | My efforts earn money later |
| 4. Work challenges | I should not put in effort | | | | | | | | | | | I know effort is mandatory |
| 5. Staff support | I deserve the best support | | | | | | | | | | | I create the best support |
| 6. Work motivation | I prize security | | | | | | | | | | | I prize ambition |
| 7. Work focus | I concentrate on increasing skills | | | | | | | | | | | I concentrate on increasing value |
| 8. Work skills | I only need to work clinically | | | | | | | | | | | I need to acquire non clinical work skills |
| 9. The future | I wont more comfort | | | | | | | | | | | I want more progress |
| 10. Work life balace | I want a life | | | | | | | | | | | I want a career |
| | | DISSOCIATE | | | | | ASSOCIATE | | | | | |
| | | SALARY | | | | | | | | SELF-EMPLOYED | | |

- **Ridicule** – satirising character traits in each other
- **Hostility** – overreaction to the smallest triggers
- **Resignation** – agreeing to disagree resulting in a stalemate.

Of course, many practices can congratulate their dentists on avoiding the troubling toxicity outlined above but it would be prudent to remain vigilant. Increasing business pressures mean it is ever more likely that this relationship is placed under strain so dental practices should avoid sleepwalking into this scenario. Especially as the damaging ramifications are well understood by both parties as lack of practice progression, team fracture and noxious culture. When the clinicians tolerate poor interpersonal relationships, it forms a mistaken mandate for team members to follow suit. This forms a workplace where no one performs at their best.

As such, dentists who disengage may unwittingly decimate the very organisation they desire. Without doubt, there is much principals can do, but the question for contemporary associates is whether to associate or dissociate with the challenges ahead. The answer lies in the fundamental nature of associate employment; dental associates are self-employed, meaning they are incentivised with a percentage split in return for creating value for the practice, with resources available to both parties.

They are not salaried, meaning they are not compensated with a regular income for concentrating specifically on clinical skills with professional support provided only by the practice. This concept is so simple that many associates and principals have difficulty in understanding how powerful it is. The vital role distinction is typically lost in a cloud of contracts, clauses, rates, percentages and hours.

However, the most successful dental associates have identified the need to associate by an empirically observed intuitive insight: My principal is permanently overwhelmed by business pressures. Therefore, to create the dental work environment I need to succeed I must develop non-clinical skills.

I have clarified the term 'non-dental skills'. By the defining the top ten dimensions in a table you may test yourself against.

It is my contention that by scoring above 50 on this framework you will certainly experience a more fulfilling and rewarding associate role. I hope this levels the playing field so all associates may enjoy self-employed success in the modern dental workplace. To assist you further I have outlined three guidelines with real life examples.

Start where you are. Kate Moss started as a sales assistant and David Beckham cleaned Bryan Robson's boots. I am personally aware of an associate who came close to quitting dentistry after being demoralised by her job in a corporate. Instead of dissociating, she spent just a few months documenting how she met a high UDA burden whilst contending with her challenges, e.g. because my practice does not provide material x, I purchased material x myself. At job interviews, she presented her documentation, complete with dental material purchase orders, so easily convincing any interviewer of her excellent attitude and commitment. Within six months she landed her dream job in London.

It's your career. Build work skills for which you will be rewarded in the future, and don't become distracted by whether your current principal deserves your effort. In a real-life example, an associate was asked to provide induction training for a new nurse by an overworked and absent principal. His first instinct was to lead an associate revolt against this contractual unfairness. Instead of dissociating, he decided to engage with this new learning opportunity. He is now so proficient at nurse training that he can count on first-class support whenever he turns up for work giving him greater confidence to complete the clinical work he most enjoys. Ironically, lack of nurse support was previously his biggest grievance.

Be proud. To arrive as a GDP, you will have demonstrated many abilities, e.g. resilience and resourcefulness, thus putting associates in the top 5% of UK earners and the top 1% globally. Repurpose your ambition for your current challenges. I have seen a situation where a super-skilled specialist was frustrated by gaps in her day. Instead of dissociating, by placing demands on the principal, she decided to learn how to increase her own referrals. This consumed much her own time and expense but, within 18 months, her new non-clinical referral skill was so successful she could start her own specialist referral clinic.

With dental business pressures set to increase, the scene is set for a new breed of associate to succeed; associates that avoid career gridlock by creating value, associates that side-step conflict in favour of engaging opportunity. Associates that update obsolete operating systems for a fast-evolving dental industry. For the modern associate it is imperative to choose wisely when faced with the inevitable question: to associate or dissociate? In short, if you think you're better off looking after No.1, then don't be surprised if your situation turns into a bit of a No.2. ◆

# Three ages of an associate

**Alun Rees** on how you progress through your career as an associate

Dr Alun Rees
Dental Business Coach

> All the dental world's a stage
> And all the associates merely players
> They have their exits and their entrances
> And one associate in their time plays many parts.'

With apologies to William Shakespeare who said there were seven ages, I have limited myself to the three important parts or ages of an associate's development. Within each age come highs and lows. The highs come from successful procedures, building good relationships with patients and finally earning a reward for your hard work and dedication. The lows arrive from falsehoods, distractions, and dead ends.

The important thing for the associate to know is that it's not necessarily the destination but the journey that matters. It's a journey where each will travel at their own pace; for some it is a sprint, for others a marathon, learning their own lessons along the way and they will know when they have reached their destination.

This ageing process is not necessarily linear - for many it comes with quantum leaps from one stage to the next and the changes enjoyed are often philosophical and come from the results of experiences, both good and bad.

Some dentists never reach their growth potential and that's fine as long as they accept it.

## 1. Fledgling

This starts for everyone at the end of the Foundation Year, that halfway house between university and the 'real world'. If you have been lucky you will have had a mostly positive experience with a supportive trainer, good nurses and sympathetic patients in a well-run, ethical practice. For whatever reason, if you have been less fortunate, a few degrees of cynicism may have entered your outlook.

Whatever the past, you are now on your own: wide-eyed, largely optimistic, excited and understandably slightly nervous. You might have a slightly higher estimation of your skills, whether those be diagnostic, mechanical and with people, than you ought, but hopefully will also have a certain amount of caution to prevent you getting into too much trouble.

One of the first challenges is to understand how the practice works; as a FD you were probably the latest in a long line who were never over booked, had good nursing support and were, quite rightly, sheltered from storms. You will have to get on with a whole new set of people, a new set of shorthand sayings and acronyms and probably a different way of defining and booking emergency appointments. What you have gotten used to over the past 12 months is at once alien in the new place.

You will find yourself working with a nurse who may appear to either know more than you or could also be a new recruit (I have never understood the logic of pairing two newbies, but it still happens). Your equipment might not always function as it

should (learn to diagnose and fix equipment problems quickly). Expect the challenges, deal with them, leave your ego at the door and learn to muck in, to pull your weight and above all to ensure you are earning what you should be.

The pace and pressure of life will increase, accept that is the way it will be and don't get too precious until you understand how things work. Targets, whether from UDAs or the need to earn enough to pay the bills, can be tiresome when imposed by someone else. Do your best to understand them; try to get to grips with the rules of this system where you are a small, but important, cog.

It's unlikely that you will stay where you are, after a while small irritants can become larger and you realise that you're not enjoying the surroundings and your work. The grass will always appear greener; promises will be made of better terms, of nicer or wealthier patients and more opportunities to test yourself.

## 2. Flight

A year, two or three soon pass. You realise that your skills are adequate to do no harm and competent enough to make a living. Your chair-side manner is good enough to get along with most people and your confidence is high. You tick the minimum boxes and do the basic courses the GDC says you must but the journals still seem dull and not relevant. You are able to deal with most clinical situations with a good manner and an acceptable level of skill.

At last your income is reasonable, compared with the past anyway, so you think about spending some money on a nicer car and perhaps somewhere to live that you can call your own. A holiday or two are possible as well – but make sure that you're not spending the money you should have put away to pay your tax bill.

A warning, if you have ambitions to travel, to Australia or New Zealand for instance, now is the time. Once regular repayments of house and car loans kick in it's tough to get away.

As if the scales have fallen from your eyes you become aware of the vast amount of work that people say they are doing privately. At a university reunion someone tells you how they placed 20 implants last month, another is doing 'loads' of short term ortho and a third is going off on a facial aesthetics course. You become aware of the braggadocio world of social media and start to think you're the only dentist in the world who isn't after the 'low hanging fruit' that leads to a big income.

You despair of bashing the nash and chasing UDAs plus the occasional private white filling and hand in your notice before looking for another job.

In slight desperation you move to a 'private' practice with promises, but then discover that the owner sees all the new patients and you are recycling the ex-NHS ones most of whom seem to resent paying for anything and have a 'if ain't broke don't fix it' approach.

> 'This ageing process is not necessarily linear - for many it comes with quantum leaps from one stage to the next and the changes enjoyed are often philosophical and come from the results of experiences, both good and bad.'

It soon turns out that your principal is a great fan of glass ionomer but less keen on treating basic perio. The fee scale is set to compete with NHS practices. Time to move again.

A year later after promises of great things from the regional clinical director, you have worked in three different branches of the same chain where, as the only dentist, you are expected to generate twice as many UDAs as is reasonable. Your income is falling and you are considering joining Aldi as a management trainee, it sounds attractive.

Many associates never escape from this cycle, the result is that they lose their ambition, lower their sights and become time servers that do as little as possible. They are comfortable, they will never own or have a share in a practice and will always work at the whim of the practice owner. They don't rock the boat and their gross earnings contribute to the value of the practice when it is sold. They are able to take career breaks if they wish so it can be a win/win. This model worked reasonably well for many years when the 'fee-per-item' NHS dominated dentistry. Since the new contract of 2006 closely followed by the financial crisis and the subsequent decade of austerity, the comfort has gone from the system. Incomes have fallen significantly and now the insularity afforded by the self-employed status is threatened.

## 3. Set to soar

Despair had started to set in, but a chance meeting with an old friend from university got you interested in his visits to the Pankey Institute. On his suggestion you join a couple of study clubs where you meet people from different areas who start to enthuse you and realise that although it takes 10,000 hours to become truly expert at anything many dentists do the same hour 10,000 times.

It gradually dawns that there is more to life than chasing targets set by someone else. Cometh the hour, cometh the teacher and inspiration. At last you understand that dentistry is about helping your patients to aspire to high quality and that once they understand the processes of disease control they will have a trust in you.

A weekend course on occlusion helps you see why so much of your work had been failing. The speaker's words, 'if you don't want to learn about occlusion, move practice every two years' strike home. A mountain appears in front of you that you had never seen before, a mountain of possibility.

You learn to value some of the 'Ps of dentistry' that seemed 'unsexy' for years – 'Paeds, Perio and Prevention'.

This new injection of energy brings its own challenges. Your principals don't understand why you want to start using articulators for some of your restorative work as it increases laboratory bills. They say that your 'check-ups' are taking too long as you're now using your new camera a lot and that the time taken doesn't fit into the patient membership scheme pricing.

You accept that you are rapidly growing out of this stage of your life and start searching 'practices for sale' or perhaps look for a site to start a cold squat dedicated to the excellence you want to achieve. You know that the next stage will be hard and costly but having seen what is possible you are able to map out the next twenty or even thirty years of your life where you will not compromise on what you believe in for your patients, or yourself. ◆

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# Associates: a regional picture

Four specialist dental accountants from NASDAL (National Association of Specialist Dental Accountants and Lawyers) discuss the nuances of being an associate across England, Scotland, Wales and Northern Ireland...

## England

*Alan Suggett is a specialist dental accountant, partner in UNW LLP and NASDAL media officer.*

The situation that associates find themselves in England is very regional. If you are an associate in one of the major conurbations such as London, Birmingham or Manchester, then to a certain degree, life is currently pretty decent. Yes, real earnings have stagnated somewhat over the last decade or so but there is no shortage of posts available to you and remuneration is still at a comparatively decent level.

Away from the smoke there are major fluctuations in associate earnings. These can be difficult to interpret but they seem to come down to three major factors:

1. The rate of pay (e.g. NHS 50% of what agreed UDA rate?), or 45% of private earnings
2. The availability of work – are earnings restricted by lack of patients? Can the associate put in extra hours and therefore earn more?
3. NHS or Private?

Brexit has had a huge impact – particularly away from the cities. Since the referendum result, there seems to have been a number of dentists deciding to return home to EU states – uncertainty over their future status may have fuelled this. Fewer available foreign dentists has made it very difficult for some practices to attract associates.

When foreign dentist numbers reduce, the impact is first seen in the more remote parts of the UK – there seems to be a retraction back into London, Birmingham, Manchester etc. Therefore, Cumbria, the North East and the like are harder hit.

The consequences of this can be clearly seen by the recent 'fire sale' of MyDentist practices, where NHS underperformance issues have arisen due to lack of associates.

## Scotland

*Heidi Marshall is a specialist dental accountant, heads up the dental team at Dodd & Co and is secretary of NASDAL*

There are many benefits to working in Scotland, being surrounded by stunning scenery being just one of them. However, with just seven cities in the country, if dentists prefer a metropolitan lifestyle, they may be disappointed with the more rural aspect of Scotland. There are other differences to be aware of too.

Compared to the rest of Great Britain (and therefore excluding Northern Ireland), associates in Scotland earn the lowest average fees. This is primarily due to more associates in Scotland being on a fixed contract of less than 50% (44% of dentists compared to a national average of 21%).

This is compounded by differences in the way a dentist's net pensionable earnings (NPE) are calculated, thus potentially affecting the pension pot of Scottish dentists. In England, an associate's NPE is based on the net amount they receive. So if their contract earnings percentage is 55%, then 55% of their NHS income (less any relevant deductions) is pensionable. In Scotland, associate NPE is still calculated using 43.9% of earnings,

> 'As with the general picture, associates in Wales have seen their earning potential and UDA values either decrease or stay static in real terms over recent years.'

regardless of the rate at which the associate is paid. Therefore, depending on their contract earnings percentage, this may be a benefit or a shortcoming.

There are several specific financial perks of working in Scotland. NHS associates and principals both benefit from receiving a remote area allowance of up to £9,000, providing they work in an area where population is less than 0.5 persons per hectare. For current and prospective practice principals looking to establish a new or improve or an existing practice or acquire an existing practice, they may be eligible for assistance from the Scottish Government, in the form of a Scottish Dental Access Initiative (SDAI) grant. This grant provides up to £100,000 towards the cost of setting up a new practice or acquiring an existing practice within specific areas in Scotland. Additional grant funding can be obtained if additional surgeries are added to the current number of surgeries within the practice.

In respect of associates working in private practices, the difference between Scotland and the rest of the UK are minimal, other than the aforementioned reduction in average earnings and pay rates. From an administrative point of view, there are differences for associates carrying out NHS work. In England and Wales, the practice holds the NHS contract(s) and associates are added as a performer on these. In Scotland, each dentist has their own list number, on which patients are added. For associates in Scotland who have just joined a practice, this can cause the growth of their patient list (and therefore their fee income) to be inhibited in the initial few months, depending on if they are building a list from scratch or have had patients transferred from another dentist's list.

## Wales

*Anthony Mayled is a specialist dental accountant at Staffer Mayled & Co Ltd.*

As with the general picture, associates in Wales have seen their earning potential and UDA values either decrease or stay static in real terms over recent years. They have also seen an increase in the complexity of doing dentistry – linked to HIW (Health Inspectorate Wales) and other further regulation. When you add this to an increased risk of litigation from patients and the (sometimes aggressive) GDC stance on many issues it is not hard to see why many Welsh associates are considering their future options.

Some of the recent articles in the dental press have been unnerving for associates as they suggest that their self-employed status could be at risk. Although currently time HMRC has not signalled it will change its position, this does add to a sense of unease.

For those associates who are looking to strike out on their own and buy a practice, times can be tough. Corporate acquisitions have pretty much priced associates out of the practice purchase market. It could be said that some of the practice valuations that we have seen in recent times are particularly high. Certain practices that are larger and located in the right place seem to be gaining from competition between the larger corporate groups as they compete for the sale. As we have noted previously, geographical factors seem to be becoming increasingly important, and this links with a similar pattern in associate availability.

## Northern Ireland

*Paddy Miscampbell is a specialist dental accountant at Belfast based NASDAL accountants, Miscampbell & Co.*

Northern Ireland (NI) has seen a big increase in corporates entering the market place in recent years and they will typically pay 40% of gross fees. The corporates seem to be snapping up a lot of newly qualified dentists and many of them have introduced a sliding scale to encourage their associates to increase their gross monthly fees. The upper end of the scale can be as high as 50% but typically the level of gross fees is very difficult to obtain. Independent principals with long standing associates are still paying up to 50% on gross fees. This seems to be above the current norm but it seems these principals are happy to pay a premium as they don't want to risk losing associates that have shown loyalty to their practice and patients.

A big challenge facing the NI dental market continues to be the political uncertainty in NI. The NI assembly collapsed in January 2017 and with the absence of a devolved government things have been progressing very slowly. To exemplify this, the 1% increase for NHS treatments scheduled for April 2017 was only paid in July 2017, and the percentage increase for April 2018 was not applied for as there was no health minister in place to request it from Westminster. ◆

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# Is being an associate a lonely place?

Gemma McGarry,
Associate, High Green Dental Practice

Being a dentist can be a lonely profession, even if you're surrounded by patients and colleagues throughout the day. But is that a myth or a solid theory grounded in reality? Associate dentist **Gemma McGarry** candidly discusses her experience and initial fears of working in a family-run practice that was recently acquired by a dental corporate, and how those fears did not materialise

### As a practising associate, do you consider dentistry to be a lonely place to work?

It may well be for some people, but in my experience, I can honestly say that has not been the case. However, I do believe that people, including myself, can easily get stuck in their ways and continue to keep working within their comfort zones, going through the motions on a day-to-day basis without thinking about the bigger picture.

High Green Dental Practice – the practice I work in – has helped push a lot more opportunity our way and encouraged the wider team to think about how we wish to develop our careers. I'd put that down to the ownership structure and the freedom we're encouraged to find. There is now an expectation that the whole team – dentists, nurses, hygienists and therapists alike – takes up some of the fantastic opportunities for professional development. For example, I have expressed an interest in introducing anterior composite work, which is an area I've always been attracted to, and have been encouraged to pursue this.

The level of communication and interaction required in order to pursue successful career development, means that there is no reason for dentistry to be a lonely place and I would never consider myself or my team as 'working in silo'.

### Does being an associate – and potentially working in multiple locations – mean you might not have a connection with the teams and patients you work with?

Perhaps surprisingly, it doesn't. My previous understanding had been that dental corporates manage their practices from afar, where people you've never met issue directives on all the important issues, with little or no input from the dental teams on the ground. My practice is owned by Dental Partners, and the CEO, Neil Lloyd, took the time and trouble to visit and talk to us, which wasn't an approach I'd previously encountered.

Now I have access to a wider network and it has been possible for me to extend my outreach teaching, which is absolutely the favourite part of my job. On top of my existing outreach work, I am travelling to another partner practice in Barnsley to look after their students.

We have also been encouraged to start offering private work, which was something that previously just wasn't done. The new approach has challenged my previous assumption that patients weren't interested in private options and we have been shown how to start the conversation with our patients.

### Why do you think some corporates have a reputation that isn't as great as an independent?

I must admit I was shocked when we heard we were being taken over by a dental corporate. Many of my friends who had taken jobs with corporates had become quickly disillusioned and I imagined a future of constant clock-watching to meet performance targets and using inferior materials and the loss of all clinical freedom.

Dental corporates are also often criticised for restricting clinical freedom, but we have

found the opposite. All the clinical decisions are left to the dental professionals and this includes giving us the freedom to choose our equipment and materials. For instance, I have an opportunity to do some work in another practice which doesn't use rotary equipment. On my recommendation, they are now investing in rotary, so they are able to provide better, faster treatment.

### What do you place greater importance on – clinical or professional development?

Both are just as important to me and the opportunities provided here are enabling me to broaden my horizons and develop both personally and professionally. I feel valued and supported at work and it's a source of great satisfaction to me that my employers are investing the time and resources to expand my career. I have the opportunity to give back and help other dental students who are the future of the profession and I am loving every minute of it.

### How would you describe your level of autonomy in the practice?

Amongst one of the many reasons, I'm pleased to have been given the title of Clinical Lead in recognition of the extra responsibility I have taken on since joining High Green Dental Practice. I now handle any complaints we receive and have set myself the challenge of learning how to deal with these effectively and minimise any future complaints.

### Finally, what would you say to anyone who may be wary of working for a corporate?

I too had been extremely wary, almost to the point of looking for a new job. But in my opinion, the reality is that our association has been a fantastically positive move and the opposite to what I was expecting.

When the idea first came about I attended a presentation about Dental Partners' attitude to corporate dentistry. Neil Lloyd encouraged an open discussion and gave us his email address in case we had any further questions. His insistence on getting to know every practice and being approachable and accessible impressed me and I decided to give the new management a chance.

I have since found that they have exactly the right priorities, which puts excellent dental care first. The ethos is to create 'pleasant, diverse and respectful workplaces with a social conscience' which means our practice is a great place to work. While I understand and appreciate not everyone will share my positive experiences, it's important I share mine. Associates are an important part of the workforce, to the point where they are integral. For me, this is a model that could work.

For any associates on the fence about working for a corporate, I'm in a position to say just how surprisingly refreshing it has been to work within a practice recently taken over by a corporate. When the CEO has made it his business to be proactive within the practice, encouraging charitable opportunities and developing staff skills, that for me is one of the key differences between the average corporate and the opportunities I have been presented. ◆

Gemma qualified from Sheffield in 2009. She has a particular passion for cosmetic and paediatric dentistry and is an honorary clinical tutor for the outreach students in association for The University of Sheffield and a FD trainer.

Find out more at www.dentalpartners.co.uk, or email contact@dentalpartners.co.uk.



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## BIOGRAPHY: Dr. Diyari Abdah DDS DDS MSc ImpDent

Dr Diyari Abdah is a cosmetic and Implant expert in private practice in Cambridge, UK.
He is passionate about research and innovations, especially in the fields of Implantology and 3D imaging. He deals with all aspects of Implantology and grafting techniques, and has been actively promoting and teaching Implantology to GDPs worldwide for over 15 years through lecturing, clinical research, workshops, articles and mentoring programmes, and as a visiting academic at the University of Warwick Medical School (UK). He also runs a successful mentoring programme on avoiding and solving problems in Implantology.
Currently, Dr Abdah is on the editorial board of several dental publications. He is a two times best-selling author and an Emmy Award nominee for his humanitarian documentary.

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# Mediation

By Neeta Udhian

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

Disputes in any type of work or business can be common, and dental practices are no different. Due to the nature of dentistry, disputes generally fall into two categories: interpersonal and/or commercial disputes.

Interpersonal disputes often arise in dental practices due to the close-knit working environment and because long-standing members of staff have become accustomed to a certain way of working together. Sometimes it can take the arrival of a new member of staff to rock the boat or a change in management to cause conflict between staff or between staff and management.

Conflicts can also arise between business partners who may disagree on how best to run the practice and as a result of this, they're no longer able to communicate effectively – to the detriment of the practice.

The problem with interpersonal disputes are that they can cause a considerable amount of stress, especially in a small practice. The team may become divided, the atmosphere tense and matters can escalate rapidly resulting in outbursts or upset amongst staff. It can also lead to increased sick leave due to members of staff feeling bullied or isolated.

Due to the personal nature of these types of disputes, they can be difficult to resolve. Commonly practices will try to get staff together to talk about their problems or a member of staff may raise a grievance or be disciplined for their behaviour. These approaches can often make matters worse because the root cause of the issue is not addressed and resolved.

Partners who are in dispute may try to get staff onside which can divide the practice and cause friction between loyal members of staff and management.

Commercial disputes on the other hand generally arise when there's a disagreement about money. The most common type of commercial disputes in dental practices are between partners or between practice owners and associates.

It may be that one partner is not performing well so the other partner wants them to sell their share of the practice or it could be that an associate is leaving, and the practice owner wants to withhold money for various reasons. Any contractual dispute between an associate and practice owner would be considered a commercial dispute.

Commercial disputes usually result in one party taking legal action against the other which means they can be very costly and time consuming to resolve, as well as very stressful.

An alternative and lesser known form of dispute resolution for both interpersonal and commercial disputes is mediation.

Mediation is considered a win/win solution for both parties because both parties work together to resolve their issues (even if they're unwilling to sit in the same room together!). With other forms of dispute resolution such as arbitration and litigation, an independent party assesses the facts and makes a final decision for each party. With mediation, an agreement reached is based on both parties working together.

Mediation is also a voluntary process, so its success is dependent on both parties being willing to resolve their disputes (usually to avoid the alternative which is costly legal action). With mediation, there are no legal fees to be paid and no awarding of costs (you won't be liable to pay for the other sides legal fees and vice versa). All BDA members can access the BDA mediation service free of charge.

The mediation process itself is simple and only requires both parties to attend a one-day mediation meeting which is usually held at the BDA offices in Wimpole Street. Prior to the mediation, both parties exchange a 'position statement' outlining their issues and the resolution they are seeking.

During the mediation itself, two certified Mediators will meet with each party individually to gain a full understanding of their concerns and the resolution they are seeking. The mediators will then facilitate a discussion between parties to help each party achieve their desired outcome, by working together. The idea is to look ahead rather than focus on what has happened.

A joint facilitated meeting is encouraged for interpersonal disputes but both commercial and interpersonal disputes can be resolved via the 'shuttle' process. Where the mediators will shuttle between both parties until an agreement is reached.

The benefit of mediation is that any issues can be aired in a safe and controlled environment. The skilled Mediators ensure that both parties are not only able to express their views and concerns without fear but that they are also heard by the other party. For interpersonal disputes especially, this is crucial.

As mediation is a voluntary process, if at any point either party feels the process is not working for them, they are free to end the meeting without any repercussion. Likewise, if the Mediators feel that the parties are unwilling to move from their positions, they too can terminate the process.

If an agreement is reached, a mediation agreement is drafted on the day and signed by both parties.

The Practice Support Team has successfully mediated over dozens of disputes over the years saving members tens of thousands of pounds in legal fees. They have also saved many a partnership and relationships between staff. Contact the BDA at advice.enquiries@bda.org for more information about our mediation services.

# Updated BDA template associate agreements

By James Goldman

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

Associates can now work whenever they want. And they can charge whatever they want for private work. The BDA has recently issued the latest incarnation of its template Associate Agreement. In it, associates have more freedom. With that freedom, comes more commercial responsibility.

The BDA advice teams take calls every day from associates and practice owners who have questions or issues with associateships. For the most part, we have found that the BDA template associate agreement provides a solid and fair basis for associateships. But, as the way people work changes, and as the law changes, we have found some opportunities to make the agreement more helpful to both associates and practice owners.

## More freedom, more responsibility

We speak to practice owners asking about associates wanting more time off than they are allowed; or from associates complaining that practices won't give them time off even though they are ahead of target. Our view is that the amount of time an associate works is not as important as whether the associate does their UDAs or, in the case of private practice, brings in enough work.

Perhaps the most significant change in our model associate agreement is that associates are no longer required to work on the days available. The practice must make the facilities available to the associates, but the associates do not have to use them.

There are some important conditions which protect practice owners:

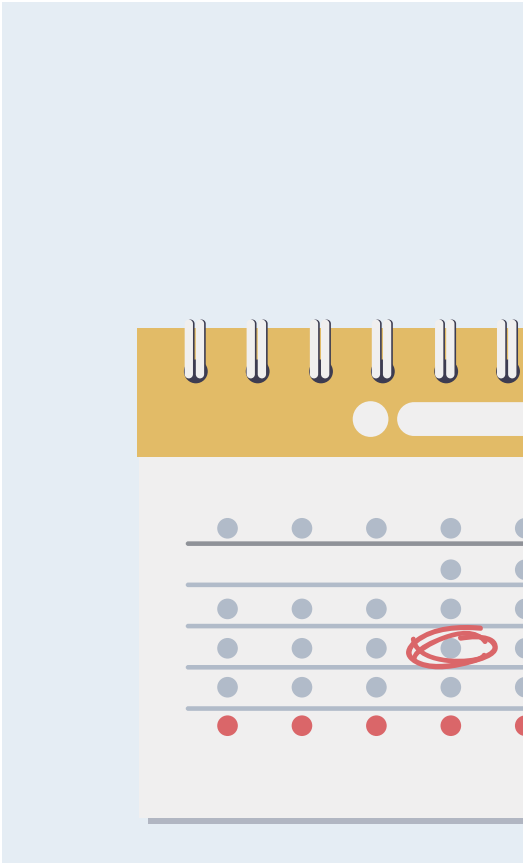
- Associates cannot simply decide not to turn up to work. They have to comply with practice procedures for notifying absence. After all, patients should not be inconvenienced, and the practice needs an opportunity to plan its staffing levels
- In England and Wales, associates are responsible for meeting their UDA target. If they choose not to work and they miss their UDA target, the associate, not the practice owner, should pay
- There is an option for a minimum private licence fee. An associate may well decide to take three weeks off for a motorbike trip round Europe, but the practice owner may still collect a licence fee to cover its costs for that month
- In England and Wales, if – without any agreement – an associate takes a day off and leaves a practice without any cover, the practice owner could end the associateship without notice. There is an exception for serious illness. But we believe that an associateship should be at risk if an associate puts the practice at risk of a breach notice.

We have amended the locum provisions to allow associates more freedom to engage a locum. The practice can, of course, deny access to a locum if it has good reason. But associates are self-employed. Self-employed people can choose who does the work, and they remain responsible for that work.

The practice has further protection in relation to UDA targets. If an associate is failing significantly, the practice has some rights to change the associate's UDA target. This allows it to assign those UDAs to another associate who is performing better.

## Charges to private patients

Another area where we have had a lot of queries is in relation to associates under charging patients for private work. This is another area where we believe associates should have more control provided that the practice owner doesn't lose out. We have therefore including a provision that allows



associates to charge patients less than the practice standard fees. Where the associate does charge less, then the associate should bare the cost of that discount. The new model agreement therefore says that the licence fee is based on the practice minimum charge.

Say the practice minimum fee for a filling is £100. Say the if associate gives the patient a £20 discount and charges only £80. And say the practice licence fee is 50%. The practice can charge a licence fee of £50 for that filling; leaving the associate with £30. That means the associate bares the full cost of that discount. Where the associate charges more than the practice charge, the licence fee is calculated in the normal way. If an associate charges more, it may well be because the procedure is more time consuming and the practice should therefore get its share to cover the increased costs of that procedure.

## Goodwill

Goodwill is vital for practice owners, who often invest substantial amounts of time and money building a list of loyal and regular patients.

Practice owners have a genuine commercial interest in protecting that goodwill. Like any business, the way practices protect goodwill is to put restrictions on associates stopping them seeing practice patients after they leave.

Whereas the previous model contract had restrictions that operated only after the associateship ended, the new model agreement has restrictions during the agreement as well.

This means that dental practices can prevent associates who work part-time from working at another practice and siphoning off patients.

We would urge members to be careful about the use of restrictions. There are blanks to fill in for the length of time the restrictions operate and the radius in which the associate cannot work.

These restrictions are only enforceable if they are no more than necessary to protect practice goodwill. Practices need to think carefully about them.

Practices should also think about the extent to which restrictions are necessary. Many dentists in England and Wales who provide NHS treatment are unlikely to cause much difficulty to a practice if they work at another local practice; especially in an area where there is a demand for NHS dentistry.

On the other hand, where a practice introduces a lot of private patients to an associate, protecting goodwill is vital and should be done carefully.

## GDPR

The Data Protection laws, known as GDPR, requires agreement between practice and associates to cover certain aspects of data protection.

For example, there are some clauses that say the associate must only use patient information for the treatment of the patient, that the associate must comply with the practice's data security measures, and that the associate must help the practice if there is any question or inquiry into patient information used by the associate.

With the new associate agreement, there is now no need for a separate Data Processing Agreement between practices owners and associates.

## Associate's own equipment

Some associates may wish to use their own dental equipment. We have given an option for the practice owner and associate to agree that the associate may bring in their own equipment. There are provisions in the agreement to protect the practice. The associate can only bring in equipment that is suitable and which has been properly maintained. The associate remains liable for their own equipment.

## Fair to both parties, protection for both parties

We have tried to make this model agreement fair to both parties. We always do. The BDA staff members who have made the changes to the contract are the advisers who have been answering member calls for many years. We understand the problems raised by practice owners and by associates. We have heard the frustrations of both parties. We have tried to address them in this contract.

The contract is only as fair as the way it is completed by our members. There are many blanks that need filling in. It is not difficult to fill in the contract in a way that is unfair to one party or another. We always advise members that they should read and understand any contract before signing it.

We have also worked hard to ensure that both parties have the protection they need, whether it is about failure to meet UDA targets or goodwill.

But, if both practice owner and associate are to use this model agreement (or, to be fair, any other agreement) for their own, commercial interests, both parties must communicate timely and effectively about problems. To that end, both parties need to listen to concerns raised by the other.

Like any relationship, associateships in a dental practice rely on ongoing communication.

The new BDA model contract is available on the BDA website now. ◆

# Associate agreements; key terms to watch out for

By Claire Bennett.

Claire is a practice management consultant in the BDA Practice Support Team, she qualified as a solicitor in 2008 and advises general dental practitioners on associate contracts and a wide range of employment and other law

You're ecstatic. You've just received a letter confirming an offer of your dream associate position. The contract is enclosed and you are asked to sign and return a copy, demonstrating your acceptance of the post, without delay. Keen to secure the position, you whip out your best fountain pen and prepare to sign on the dotted line – the contract will be back in the post before the day's out.

But wait! Are you sure the contract reflects what was discussed at interview? Does it confirm where you will be working? Are the financial terms accurate? How quickly will you be able to leave the practice if things don't work out? Will your dream practice try to restrict your professional activities or withhold your fees after you leave?

## Importance of a contract

The importance of having a written associate contract is difficult to overstate. A well-drafted agreement will provide all parties with clarity and certainty on key terms and conditions and very often will be a crucial document in the event of a dispute. By not entering into a written agreement, you leave yourself open to claims that you have agreed to terms you may not have, for example, to provide an unrealistic number of UDAs or to deliver your services below market rate. It's also possible that, in the event of a dispute, a court will impose a more onerous set of terms and conditions upon you.

As important as obtaining a written agreement is taking the time to read and understand the terms and conditions you have been presented with. Some contracts use complex language and legalese, which can be confusing and difficult to understand. If you don't understand the terms of a contract, you should resist any urge to sign it and seek advice. BDA members can have their contracts checked by an experienced member of the Advisory Services before they accept a position; to help them fully appreciate the terms and conditions they will work under and assess whether a particular practice will be right for them.

## Terms to watch out for

There are a number of key terms that you should look for in any prospective associate contract. You should look for these terms even if the practice owner provides you with an agreement which it says is based on the BDA template associate agreement or some other 'standard' contract – the implication being that its terms are reasonable and fair and you should agree to them without full consideration. It's possible that the practice owner may have made amendments to the BDA template agreement, which place you in a less favourable position or may quite simply be wrong. It may be that, driven by its own set of commercial objectives, the practice owner's standard agreement is one that takes advantage of dentists seeking associateships in difficult circumstances, for example, VTE dentists, focussed on achieving qualification, who are asked to sign contracts that tie them in for lengthy periods of time. You should always take the time read any contract carefully and in full.

Terms to watch out for include:

**Financial arrangements** The financial arrangements underpinning an associateship are often complex. Typically, they involve an associate agreeing to pay a practice owner a licence fee for use of their premises and facilities. This fee is deducted from the associate's gross earnings, together with other deductions, for example, laboratory costs, bad

debts and/or hygienist fees. It's imperative to check the mathematical correctness of the payment provisions in any contract. The financial terms should be clear, certain and reasonable. Associates often find it useful to apply illustrative figures to a payment schedule, which sets out things like how much they will be paid per UDA performed (gross and net), how laboratory costs will be apportioned and the value of any licence fee.

**Increased risk** It would not be unusual for you to be given a contract, containing performance targets; either a UDA target, a private income target or both. Where this is the case, the contract often contains clawback provisions or indemnities, which seek to protect the practice owner from sustaining any losses in the event that you fail to achieve your targets. Before agreeing to any performance targets, you should consider whether the target is realistic and fair, by reference to factors like the practice's patient base and local market conditions. You should also consider whether corresponding clawback provisions or indemnities are fair and reasonable. If the compensation the practice owner will receive should you underperform places it in a better position than if you had met your target, then it may be that the clawback provisions are too high. An indemnity that permits a practice owner to recover from you where you have failed to meet your targets, but through no fault of your own, may be drafted too widely.

You will be paying the practice owner to use its facilities, including its premises and equipment. You should look for clauses that set out what will happen should those premises become unavailable or equipment breaks down. Ideally, the contract will provide for you to be compensated in these circumstances. However, it may be that the contract makes no provision for compensation, which could mean you lose out financially. Where the contract does not provide for compensation, you should raise it with the practice owner. It may be that the practice owner can justify its position, but if not, you should try to negotiation the inclusion of a clause which compensates you in the event of breakdowns, etc.

**Notice** Generally, associate contracts will provide for three months' notice of termination from either party – this is the industry norm. Occasionally, a practice owner will ask for something more than this – four or six months' notice of termination from the associate – or even seek to tie the associate to the agreement for a lengthy fixed-term, perhaps as long as two years. You should think carefully before agreeing to notice periods that exceed the industry standard or entering into a fixed-term contract. You might ask the practice owner to explain why it is seeking a longer notice period than usual. It may be that you are willing to agree to a longer notice period where the practice owner has a good reason for requesting one – a shortage of associates in the area, making recruitment difficult, for example. Be cautious though, six or twelve months can feel like a long time when you have taken the decision to leave a practice and the relationship between you and the practice owner may not be what it once was.

**Post-termination restrictions** Most associate contracts will contain restrictive covenants; provisions that are intended to protect a practice owner's goodwill after an associate leaves the practice. It's tempting to glance over these provisions since they will only apply on termination, but any future associate positions may be hampered if they are too restrictive. Commonly, restrictive covenants in associate agreements prevent associates from working as a dentist within a particular radius of the practice for a particular period of time and from treating patients of the practice. You should consider whether such clauses are reasonable. In most cases, it will be difficult to justify a restricted period of more than 12 months. The reasonableness of the proposed radius will depend, amongst other things, on the location of the practice and local factors.

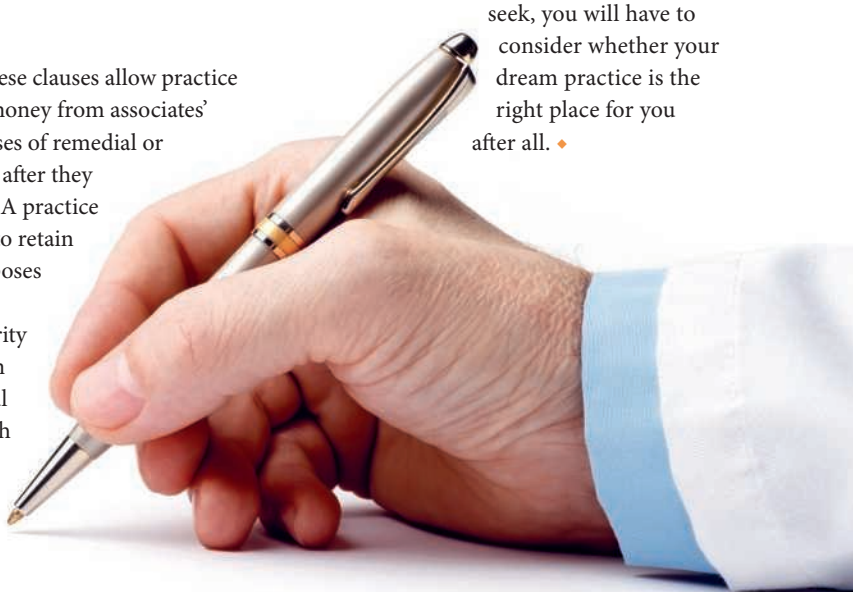
**Retention fees** These clauses allow practice owners to retain money from associates' fees for the purposes of remedial or replacement work after they leave the practice. A practice owner is not able to retain fees for these purposes without express contractual authority to do so. Retention fees can be a useful way of dealing with returning patients once you have left a practice. You must check, however, that the amount you agree to leave behind is reasonable and proportionate, taking into account your length of time at the practice, the type of list you have and the number of returning patients you may have had during the last 12-18 months. It's also important that the contract sets out when the retention fee can be used and how and when any balance will be returned to you.

## How to address key terms

An associateship is a commercial arrangement between two parties and coming to an agreement often requires some negotiation. If you are presented with a contract that seems skewed in the practice owner's favour, places you at increased risk or fails to reflect your needs, speak up.

Before approaching the practice owner, understand a little about the practice and the position you are negotiating from – how quickly does the practice need a dentist in post; is there a shortage of dental provision in the local area; how much are other associates being paid locally? The answers to these questions, may mean that you are in a stronger position to negotiate the removal or amendment of these terms.

During any negotiation, you should prioritise the clauses that are most important to you – don't become bogged down in discussions about clauses that are not 'deal breakers'. Try to support your position with evidence and explanation rather than simply stating that you feel a term is unfair. The aim of your negotiation should be to get to a point that you are comfortable with. However, if the practice owner is unwilling to make the changes you seek, you will have to consider whether your dream practice is the right place for you after all. ◆



# What associates need to know about GDPR

By Alan Pitcaithley

Alan is practice management consultant with special responsibility for Scotland and Northern Ireland. Based in the Scottish Office, Alan advises general dental practitioners on associate contracts, all aspects of employment law and GDS regulations in Scotland and Northern Ireland.

## What is GDPR about?

The General Data Protection Regulation (GDPR) is the name given to new European law on data protection. It seeks to ensure that you know who has your information, what information they have and what they are doing with it. GDPR goes further than the Data Protection Act 1998 by making sure that anyone holding personal information uses it correctly.

New requirements include:

- Auditing the types of information that you hold and what you do with it
- Having a valid reason for using and storing information in the way that you do
- Letting people know that you hold information about them and what you do with it.

## Are associates a Public Authority?

The GDPR requires that all Public Authorities appoint a Data Protection Officer (DPO). If you are a principal in Northern Ireland or a contractor in Scotland you will need to appoint a DPO. In other words, unless you treat all the patients on a wholly private basis, in Northern Ireland and Scotland both practice owner and associate need to appoint a DPO.

In practicable terms the practice owner can agree, as part of the associateship agreement, and also as part of the data processing agreement (see below) that they [the practice owner] will provide the associate with a DPO as part of the licence fee the associate pays the practice owner.

The role of a data protection officer is:

- To make sure the practice owner understands their responsibilities under GDPR
- To monitor practice compliance with GDPR, train staff, make sure everyone knows what they are supposed to do
- Where necessary, ensure that impact assessments are done – for example, with the introduction of new technology to deal with personal information
- Cooperate and liaise with the Information Commissioner's Office (ICO).

## Are associates data processors or data controllers?

Only data controllers pay a data protection fee to the Information Commissioners Office. Most associates (and other self-employed contractors at the practice) are not controllers, so will not need to pay a data protection fee. They may be controllers if:

- They have their own patient following
- They see their patients at other practices as well as at the practice in question
- They use patient information for their own ends, such as to promote their specialism
- They are a specialist at the practice and have their own pricing.

## Do associates need to issue privacy notices?

Personal information is any information that allows an individual to be identified. Where you hold personal information, you must give the individual a privacy notice that describes:

- What information you hold
- How long you hold it for
- What you do with it, and
- Who you might share it with – you must also let them know about their rights in relation to this information.

An associate will only need to issue privacy notices if they have registered with the ICO as a data controller.

Whoever is the data controller the important thing is to ensure that your patients have easy access to your privacy notice.

## Do associates need data processing agreements with practices?

GDPR requires that data controllers have a data processing agreement in place with any data processors. Therefore, most practice owners will need to have a data processor agreement in place with their associates. The agreement will state that the data processor will only use the information they have been given for the specific purpose it has been provide for and that they will keep it secure

## Referrals to and from other practices

Referral practices are usually controllers and will have their own privacy notices.

You should discuss any referral you wish to make with the patient and get their agreement to be referred and to passing relevant personal information to the specialist or referral practice (which should be identified). As you are passing on information for medical purposes and have the agreement of the patient to do so, you do not need further consent to satisfy GDPR requirements.

If a patient has been referred to you then you must give the patient your (practice) privacy notice within one month of accepting the referral. Acknowledging a referral, provides you with the opportunity to include your privacy notice or providing a link to your website.

## Can I still send appointment reminders and recalls?

You do not need the patient's consent to send appointment reminders and recalls but you should check that they are happy to receive them and their preferred method (email, text, letter, for example). If the patient objects, you should not send reminders or recalls. ◆

The BDA has a dedicated webpage on GDPR which contains advice, templates, FAQs, articles etc. This can be found at: www.bda.org/dataprotection

# BUY PRODUCTS AND SERVICES FROM SUPPLIERS YOU CAN TRUST

## BDIA Member companies
Suppliers you can trust

The British Dental Industry Association (BDIA) is the UK's dental industry trade body. Since 1923 its members have been working closely with the dental profession to provide the quality, innovative and dependable equipment and services that you need day in day out.

As BDIA members are bound by a comprehensive professional Code of Practice*, bespoke training and a common vision, choosing to do business with them means you can have confidence that everything you buy is of guaranteed quality and provenance - you are choosing a supplier that you can trust.

SO, WHEN YOU THINK SUPPLIER **THINK BDIA MEMBER**

To find BDIA member dental suppliers visit **www.bdia.org.uk/member-directory**

BDIA member companies range from SME's to large international businesses who manufacture and supply quality products, services and technologies to the dental profession - from aspirators to X-rays and everything in between.

*The BDIA Code of Practice and details of the BDIA Certificate, "Introduction to Dentistry" are all available on the BDIA website – www.bdia.org.uk.

**British Dental Industry Association,**
Mineral Lane, Chesham,
Buckinghamshire HP5 1NL.

A company registered in England & Wales with registration number 3488299.

BDIA BRITISH DENTAL INDUSTRY ASSOCIATION

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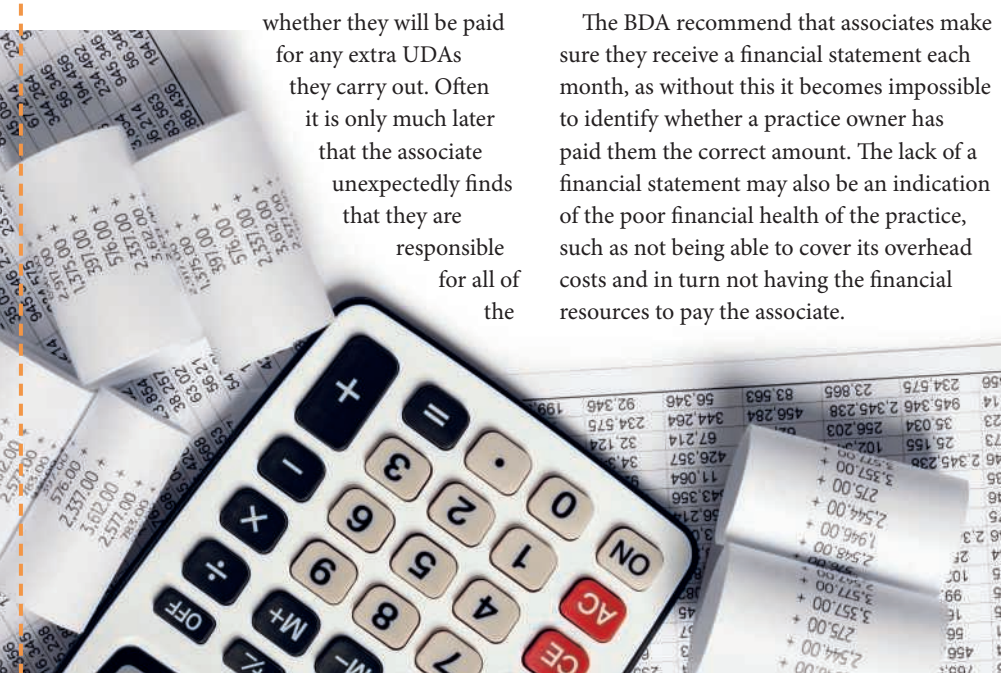
# Keeping on top of your finances

By Sabina Mirza

Sabina is a practice management consultant in the BDA's Practice Support team. Sabina advises general dental practitioners on associate contracts and all aspects of employment law.

Most dentists work as self-employed contractors by entering into an associate agreement with the dental practice owner. When it comes to payment terms it is important that you have a clear understanding what your earnings will be and how they will be calculated to avoid contractual disputes later. It is the responsibility of the practice owner to provide the associate with an unambiguous monthly financial schedule which sets out their gross earnings, any deductions made and the net take home pay. The deductions will be for use of the surgery, equipment and staff and for costs for lab fees, hygienist's fees etc. The financial schedule enables an associate to check if these deductions are accurate and that they have been paid correctly.

At the BDA we receive many calls from associates seeking advice about their payments terms due to finding they have been underpaid or do not understand how their pay has been calculated. In the majority of cases these concerns arise from having signed an associate agreement without fully understanding the financial terms, such as how the lab costs are to be deducted or whether they will be paid for any extra UDAs they carry out. Often it is only much later that the associate unexpectedly finds that they are responsible for all of the lab costs whilst they had been under the impression that the costs would be split between themselves and the practice owner. Or, they are not being paid for performing an extra UDA because their agreement did not clearly stipulate any additional pay for UDAs over and above the agreed number.



You need to deduct from your gross income the cost owed to the practice owner for lab and hygienist fees as well as for bad debts, such as those related to chasing unpaid fees from patients and fee apportionments. Some associates find that the practice owner deducts the license fees before their costs are deducted, whilst others deduct the licence fee afterwards.

An associate is usually financially better off if they agree to pay the practice owner their license fee after the costs owed have been deducted. There are various methods that can be used by an associate for calculating the net take home pay, with one of the most frequently used methods being to divide the gross earnings into a percentage. You should then factor in overheads like GDC/indemnity fees and superannuation contributions for your pension fund, as this will reduce net income even further.

The BDA recommend that associates make sure they receive a financial statement each month, as without this it becomes impossible to identify whether a practice owner has paid them the correct amount. The lack of a financial statement may also be an indication of the poor financial health of the practice, such as not being able to cover its overhead costs and in turn not having the financial resources to pay the associate.

Associates should review their financial statements each month and take care to spot any changes or errors so that these issues can be taken up promptly. Also, you should look for early warning signs of potential problems, such as payment delays, unpaid lab bills, unexplained cutbacks. Otherwise you could end up losing thousands of pounds.

If the financial statement is not clear, in the first instance seek clarification by speaking with the practice owner to resolve any issues informally, pointing to the financial clauses in the associate agreement if necessary. If the issue is still not resolved, set out the payment discrepancies in writing to the practice owner and seek a formal response. If it still isn't corrected then you may have to recover your losses by taking court action against the practice owner in the form of a money claim. To be able to do this you will need to evidence your losses by reference to the clauses of your associate agreement and financial schedules. Without written evidence it may not be possible to pursue a successful claim. Furthermore, associates can only pursue legal action for losses incurred within six years of the contract or payment being due.

We recommend that associates take time to fully understand their payment terms, make sure they receive a financial schedule each month and carefully review this to check the payment received is accurate on an ongoing basis. This will help ensure they are able to raise any concerns in a timely way and protect their right to take legal action to recover any underpayment as a last resort if necessary. ◆

The BDA has a dedicated webpage on GDPR which contains advice, templates, FAQs, articles etc. This can be found at: https://www.bda.org/dentists/advice/Pages/GDPR.aspx

## Not long now...

Dental Showcase takes place the first week of October and if you haven't already registered, now's the time to do so. If you went a couple of years ago and are concerned that not much will have changed, then think again. With no other UK event attracting such a wide range of dental suppliers under one roof, there will be plenty that's new. Whether you want to check you're taking advantage of the latest advances in technology or want marketing or financial advice, all the leading players will be at your service.

This year, for the first time, there will be a specific day dedicated to Foundation Dentists which is being sponsored by MyDentist. One of the keynote lecture theatres will be committed to the needs of trainee dentists. Topics will cover how to bridge the gap from DFT to associate, organising your CPD, risk management, effective treatment planning and complaint handling.

As well as formal lectures, there will be a specific Foundation Dentist Hub where you can get one-on-one career advice. The opportunities don't cease when the exhibition hall closes, for there will also be a Foundation Dentists' Ball on Thursday 4 October on the Sunborn super-yacht, which is conveniently moored alongside Excel London. Why not organise a reunion with your former students, where you can share your FD experiences?

To register, or for more information, visit dentalshowcase.com.

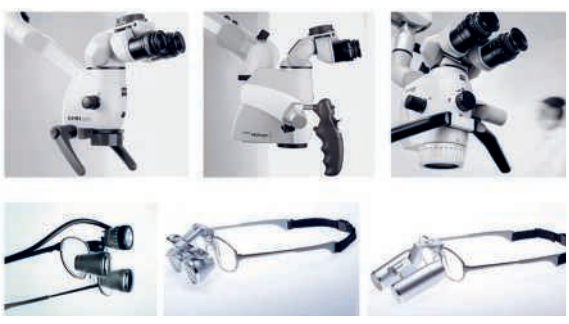
## Don't miss the opportunity

For first class magnification equipment with a reputation for quality and performance, visit Nuview on stand L25 at the upcoming BDIA Dental Showcase 2018.

Nuview will be exhibiting a range of Carl Zeiss solutions, including the EyeMag Pro and EyeMag Smart loupes and EXTARO 300 dental microscope, giving professionals the chance to try before they buy. To complete the experience, the team will be providing expert advice, demonstrations and loupes fitting and measuring over the course of the three-day event. The stand is definitely worth a visit.

Any professional interested in switching to non-alcohol disinfection and cleaning products should also swing by L25, as Nuview's very own water-based Continu range will be on display too. Delegates can expect to see a number of products this year, including the ever-popular Disinfectant for Dental Unit Waterlines and new Cleaning & Disinfectant Wipes for Loupes. It's an opportunity not to be missed.

For more information please call Nuview on 01453 872266, email info@nuview-ltd.com, visit www.nuview.co or 'like' Nuview on Facebook.



## Brand new

Dürr Dental's brand is synonymous with leading edge imaging equipment. Their panoramic device is so easy to use you won't need a second take, as the first one will almost certainly be perfect.

Unlike other devices it does not rely on experience or expertise, in fact both are almost negligible. Come and experience the difference yourself.

Also learn how the latest networking systems can be used with your compressor and suction system. By linking them to the network, practices can see the performance of equipment at a glance. Linking the compressor, for example, to the digital network yields numerous benefits: current status, faults or messages, such as for filter changes, are immediately displayed.

Launched in 2018, and available to try at Dental Showcase, is Lunos, the premium prophylaxis system, which includes the innovative MyFlow powder jet handpiece, with its unique exchangeable chamber, meaning powder containers can be replaced quickly and easily.

Visit stand L50 to find out more.

## The perfect set

Much interest is expected in the company's flagship power toothbrush, Oral-B GENIUS 9000. By combining built-in motion sensor technology and video recognition using a smartphone's camera with the Oral-B app, all zones of the user's mouth can be tracked, providing real-time feedback on which areas they've brushed and which areas have been missed!

The mechanical benefits of Oral-B's power toothbrushes compliment the chemical efficacy afforded by their toothpaste. Their Pro-Expert toothpaste includes stabilised Stannous Fluoride which provides 24-hour oral protection.

Those wanting more specific protection might prefer Oral-B Gum & Enamel Repair toothpaste, which actively protects gums and strengthens enamel.

Visitors will also be able to view Oral-B's new 'Strong Teeth Make Strong Kids' campaign, which this year will provide up to 20,000 dental professionals with educational materials on how to support parents with their kids dental care needs. Oral-B will also be running free 30-minute CPD sessions on their stand, focusing on children's oral health.

Visit stand I50 to find out more.

## Spoilt for choice

Delegates will be spoilt for choice on exclusive offers and innovative product launches at this year's BDIA Dental Showcase.

Industry-leading manufacturer W&H is excited to be exhibiting the latest clinical solutions including the advanced Osstell Beacon handheld device, which identifies when an implant is ready for loading, thereby improving osseointegration.

You can explore how the intuitive Implantmed can enable you to assume utmost control of surgical implant procedures, thanks to the unit's automatic thread cutter function and customisable W&H Osstell ISQ module.

The expert team from W&H can demonstrate how the Assistina TWIN handpiece care and maintenance unit provides a cost-effective solution to extending the working life of handpieces. Delegates can also find out how sterilisation procedures can be streamlined with the user-friendly Lisa type B vacuum steriliser, featuring Eco Dry technology that adapts the drying time to the mass of each load.

These innovative products make up an exciting catalogue of high quality dental technology, that also includes the Piezomed unit and the award-winning Synea Vision range of powerful handpieces.

Meet W&H at stand I22 at the BDIA Dental Showcase this October to discover the latest products on offer, including the new Piezomed Implant Tips and the Proxeo Twist Prophy handpiece for improved access to the oral cavity.


## Showcasing the latest water flossing technology

Make your way to stand H6 at the BDIA Dental Showcase to see the very latest in water flossing technology. The Waterpik team will present the Whitening Water Flosser – proven to help keep teeth white.

The Waterpik Whitening Water Flosser makes it easy to clean hard to reach areas between the teeth and below the gum line. It features an improved grip pressure control and handle hose swivel to help patients to remove debris and harmful bacteria that toothbrushes and traditional floss leave behind.

This hi-tech model also has an advanced pressure control system with 10 settings as well as a specially engineered handle that infuses patented whitening technology into the water. Waterpik Whitening Tablets effectively remove stains and polish away stubborn marks, but are as gentle as regular toothpaste.

To help your patients to achieve optimum oral hygiene levels, come and speak to the Waterpik team at stand H6.

## Gentle but effective interdental cleaning

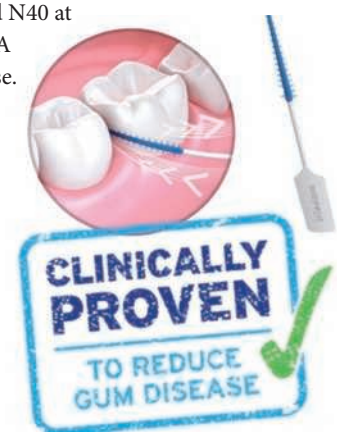
If you haven't yet discovered the benefits of the Wisdom Clean Between Rubber Interdental Brushes, don't miss your opportunity to do so at the BDIA Dental Showcase this year.

Clinically proven to reduce gingival disease, these are the No. 1 selling rubber interdental brushes in the UK. The wire and latex-free solutions feature flexible, tapered brush heads and micro-fine rubber filaments that glide smoothly between the teeth for a gentle yet effective clean.

Available in three sizes, the Wisdom Clean Between Interdental Brushes are ideal for anyone who has previously found wire interdental brushes difficult or uncomfortable to use.

Also on display at Showcase will be the Wisdom Clean Between Easy Slide Tensioning Flossers, with a new Waveform Tension Control System that ensures the tape remains taut so as to slide effortlessly between the teeth. The silk-like tape is shred resistant and gentle on the soft tissue, thereby maximising patient comfort.

To find out more about these and many other products, visit Wisdom Toothbrushes on stand N40 at the BDIA Showcase.




## Come take a seat

Belmont invites you to take a seat on one of its stunning treatment centres.

Their flagship Cleo II features a unique folding leg rest, which has a much smaller footprint than a conventional chair and is also far more familiar in design to patients, and thereby less intimidating for them.

For those requiring the flexibility of an ambidextrous unit, there's either the tbCompass or the Voyager III. With Belmont treatment centres you also have a huge array of colours from which to choose, so you can co-ordinate perfectly with the rest of your interior!

With your patient perfectly positioned, you need an operating light that will provide a flooded area of illumination, with minimum heat transfer and white light, which most closely matches daylight. The 900 LED light from Belmont does just that! Also, launching at Showcase will be an innovation designed to be as practical as it is impressive!

For more information visit stand J35.

## Stay at the cutting-edge

For every dental professional looking to utilise cutting-edge technologies in order to deliver outstanding care to all their patients, Carestream Dental has a solution for you.

The CS R4+ practice management system offers an array of features designed to make your everyday life easier. The KPIs enable you to monitor business performance in real-time and then decide for yourself what you'd like to change going forward. The seamless integration with DEPPA also means that all Denplan practices enjoy significant time saving benefits and simpler workflows.

With regards to imaging, Carestream Dental provides a comprehensive portfolio of solutions that caters to the needs of every practice. From the worldwide popular CS 8100 family of imaging units to the CS 3600 intraoral scanner and the CS 7200 imaging plate system, there is something for you!

To find out more about which technologies are ideal for you, meet the Carestream Dental team on stand L34 at the BDIA Dental Showcase this October.




## Meet the little sister!

At this year's BDIA Dental Showcase, visit decontamination experts EschmannDirect on stand M10 for the best disinfection and sterilisation equipment.

Eschmann will be introducing a brand new Little Sister steriliser that builds on the unrivalled technology of market leading products such as the SES3000B and SES 2010. It represents the next generation of decontamination equipment.

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To find out more, visit M10 for the grand unveiling!

# Before your pay is too low

# Before indemnity is not enough

# Before you fall ill

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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

## South East

### MOOR PARK SPECIALIST DENTAL CENTRE

www.moorparkdental.com

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

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

**Dr Lydia Hopkins BDS MSc Ahea**
Specialist in Periodontics

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

**Dr Norman Gluckman BDS Rand**
Specialist in Endodontics

**Dr Neeta Patel BDS FDS RCS**
Specialist in Oral Surgery

**Dr Sheetal Patel BDS MFDS RCS MSC Morth**
Specialist in Orthodontics

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

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

294230

### MOUNT VERNON DENTAL SPECIALISTS

www.mvdentalspecialists.co.uk

**Specialist Referral Centre In London**
Mount Vernon Hospital, Gate 1, Rickmansworth Road
Northwood, Middx, HA6 2RN
**Tel:** 01923 840 571
**Email:** info@mvdentalspecialists.co.uk

**Specialist in Periodontology: Dr Zanaboni, Dr Stern**
**Specialist in Prosthodontics: Dr Yerbury**
**Specialist in Endodontics: Dr Ardeshna**
**Special Interest in Periodontics: Dr Jagdev**

**Interests:** Prosthodontics, Restorative and Implants Dentistry, Implant complications, Aesthetic Dentistry, Endodontics, Periodontics, Hygienist, OPG

302373

### 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

## BOSTON HOUSE DENTAL CLINIC
www.bhddc.com

### SPECIALIST REFERRAL CENTRE IN THE CITY OF LONDON

82 London Wall, City of London EC2M 5ND
**Tel**: 0207 6284869
**Email:** info@bhddc.com

Interests: Prosthodontics, Restorative & Implant Dentistry, Implant complications, Endodontics, Periodontics, Orthodontics, Oral Surgery, Oral medicine, Sleep Medicine & Sleep Apnoea, Mentoring.

**Specialist services:**

| | |
|---|---|
| **Farid Fahid** | Specialist in Prosthodontics |
| **Farid Monibi** | Specialist in Prosthodontics |
| **Hatem Algraffee** | Specialist in Periodontics |
| **Natasha Wright** | Consultant and Specialist in Orthodontics |
| **Anish Shah** | Consultant and Specialist in Oral Surgery/ Special Interest in Oral Medicine |
| **Robert Crawford** | Consultant in Restorative Dentistry, Specialist in Prosthodontics, Endodontics & Periodontics |

**Special Interests services:**

| | |
|---|---|
| **Kostas Papadopoulos** | Aesthetic and Implant Dentistry |
| **Aditi Desai** | Sleep Medicine & Sleep Apnoea (President of British Society of Dental Sleep) |

295045

## DENTAL SPECIALISTS ST ALBANS
www.thedentalspecialists.co.uk

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

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

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

239826

## 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

## J SMALLRIDGE DENTALCARE
www.jasdental.co.uk

### Childrens Dentistry

82 Berners Street, Ipswich, Suffolk, IP1 3LU
**Tel:** 01473 550600 **Email:** jo.carey@jasdental.co.uk
Consultant Paediatric Dentists
Specialist Prosthodontist - including implants for adults
Consultant Orthodontist
Oral Surgeon
Dentist with special interest in Periodontology
Clinical Psychology

301883

## 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**

296176

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The BDA is owned and run by its members. We are a not-for-profit organisation – all our income is reinvested for the benefit of the profession.

# In Practice CPD

**Q1:** Which of these does not need to be in a privacy notice where you hold personal information?

**A** What information you hold
**B** Where you got it from
**C** How long you will hold it for
**D** What you intend to do with it

**Q1:** Which of these methods can you use for settling financial discrepancies?

**A** Talk to the practice owner
**B** Seek a response in writing
**C** Recover your losses through the courts
**D** All of the above

**Q3:** What is the remote area allowance in Scotland for associates?

**A** £7,000
**B** £8,000
**C** £9,000
**D** £10,000

**Q4:** What is the industry norm for notice of termination?

**A** Three months
**B** Four months
**C** Five months
**D** Six months

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

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For support use: cpd.hub@bda.org

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