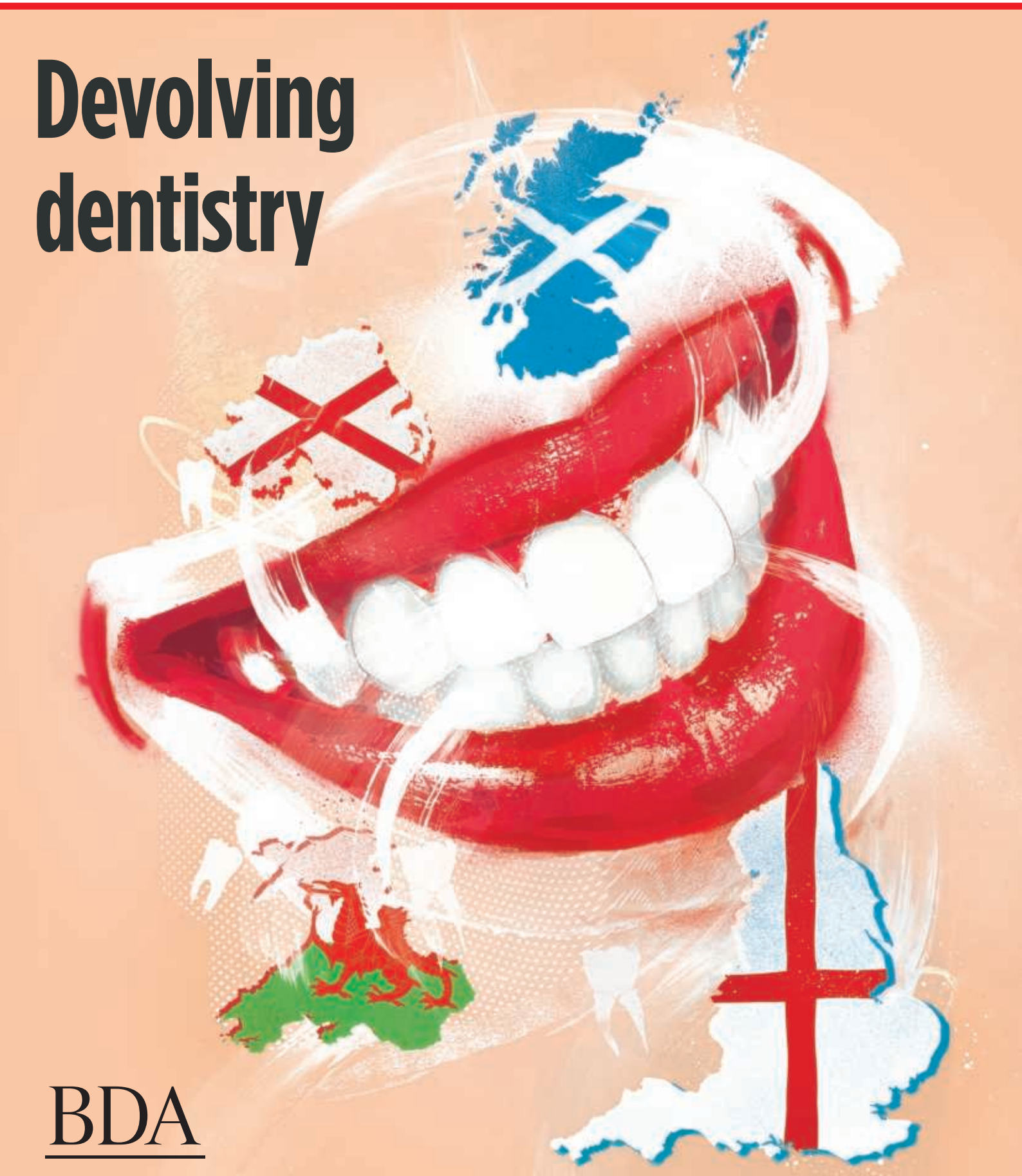
BDJ In Practice
April 2016

Devolving dentistry



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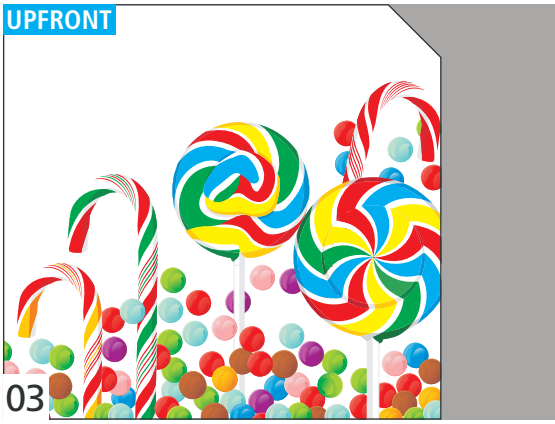

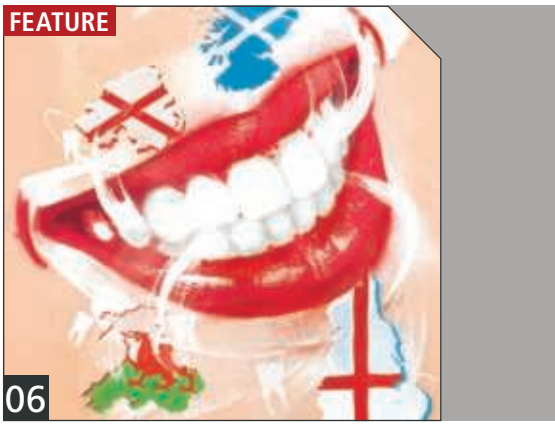

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SUGAR

Industry reacts to sugar levy

In keeping with George Osborne's policy of one 'blockbuster' Budget announcement, the Chancellor announced plans to introduce a sugar levy on the soft drinks industry from 2018.

The levy will be based on the volume of sugar with two bands: those with 5g per 100ml and those with more than 8g per 100ml - pure fruit juices and small businesses will be excluded. The Chancellor has claimed that the levy will raise £520 million.

The move was welcomed by the BDA, with Mick Armstrong, Chair of the BDA, commenting: 'Many were expecting half-measures from Government on sugar, so today's announcement looks like progress.

'Britain's sugar addiction is costing the health service billions, and it's only right the drinks companies should make a fair contribution. Health professionals are confronting a preventable epidemic, and parents, government and the food industry all need play their part.

'Sugar is cheap, addictive and-nutrient free, and industry finally has a reason to start cutting the dose.'

Dr Nigel Carter OBE, Chief Executive of the British Dental Health Foundation, also welcomed the announcement, but added: 'We feel that the measures outlined do not go far enough and more pressure needs to be put on manufacturers.'

Stephen Fayle, spokesman for BSPD echoed Dr Carter's thoughts. He said: 'We welcome the levy on soft drinks which are a major factor in the unacceptably high levels of dental decay in children. But we would like the levy to be the first step in an integrated campaign to eliminate childhood caries, including a national programme of prevention.'

Mick Horton, FGDP Dean, felt the government could have used this levy to 'challenge the culture in which the average person drinks two litres of high sugar soft drinks every week', and added that he is looking forward to seeing more in the Childhood Obesity Strategy.

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National Insurance changes for FDs

As a result of the abolition of Table D of the National Insurance (NI) tables, the reduced National Insurance rate will not apply to employees of the NHS Pension Scheme from 6 April 2016.

Unfortunately, as a result, both Foundation Dentists (FDs) and their practices will pay more national insurance on FD salaries.

In April 2016 the ability to contract out of a defined benefit scheme will be abolished when the new single tier state pension comes into force. This means that the employee NI rate for FDs will increase by 1.4% to 12% on earnings up to approximately £40,000.

In addition, practice employer's NI payments will increase by 3.4% to 13.8%. It is hoped that the NI rebate from your NHS payments agency (the Business Services Authority or BSA in England and Wales, Practitioner Services in Scotland or Business Services Organisation in Northern Ireland) to practices will be increased to cover this additional cost.

Fortunately tax allowances increase from April which will help to offset some of this additional cost for FDs.

Dentists employed in other roles within the NHS will also be affected by increased employee NI contributions on earnings up to £40000 from April 2016.

National Living Wage introduced

The new National Living Wage came into force on 1 April 2016. Set at £7.20 per hour, this is basically a higher rate of the *National Minimum Wage (NMW)* for employees aged 25 years or over. As with other rates of the NMW this is likely to be reviewed annually, with any changes probably being introduced each October.

BOOK REVIEW

Building trust is critical

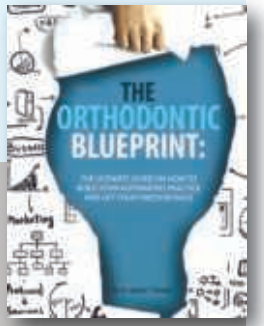
The orthodontic blueprint: the ultimate guide on how to build your automated practice and get your freedom back

Aalok Y Shukla

Click Convert Sell, 2015

ISBN: 978-1-5148-6673-3

£9.99



The title of this 36-page, near-A4, paperback belies its scope. It can be just as informative for general dentists as for orthodontists, writes BDA Librarian **Roger Farbey**.

Aalok Shukla's main premise is that the key to a successful practice is marketing. For that you need a marketing plan, which must be underpinned by a business plan to plan the course your business takes. Part of the business plan is achieved by focusing on boosting productivity. This can be achieved in various ways. Targeting higher-value patients – those keen on improving their smile – involves precision marketing: for example, patients who need to look great for a very special occasion. The problem is how to find them.

So, a marketing system will involve researching your potential target audience. Here, because a 'marketing funnel' approach using an automated search engine is helpful, the Internet can play an important part of the marketing strategy.

But just robotically relying on the Web to attract customers is not enough Part of the marketing strategy has to be much more subtle. Getting to know patients and building trust is critical. Keeping in touch with patients is, therefore, important, say by email or text. Another way is specialising and so developing a unique selling point such as pain-free dentistry or treatment for nervous patients.

Although relatively short, this book covers many of the essential bases that dentists wanting to establish or grow their businesses will need to learn.

FINANCE

Crunching the Budget's numbers

Away from the sugar levy, one of the largest financial announcements came in the form of the 'Lifetime ISA'. This will allow those who are under 40 to save up to £4000 a year to which the government would then contribute £1 for every £4 saved, up until the age of 50. It is seen to be aimed at encouraging homebuyers and those saving for retirement and other life events.

However, growth forecasts for the UK have been revised sharply downwards by the Office for Budget Responsibility as expectations of outlook for global economy is 'materially weaker' and UK plc 'not immune' to the slowdown elsewhere. However, the UK is still expected to grow faster than any other major Western economy.

Alan Suggett, Chartered Accountant and Media Officer for NASDAL (National Association of Specialist Dental Accountants and Lawyers) said: 'Arguably the most significant changes announced are in relation to capital taxes. In the case of Stamp Duty Land Tax, with effect from midnight tonight the rates and limits are changed for commercial property but their impact is actually to reduce the SDLT paid on many properties. This is because the new rates will be applied only to the portion of consideration falling within each band. So, for example, a dental practitioner looking to purchase the freehold of a practice at a cost of £350k will find that under the new rules their SDLT cost will fall from £10,500 to £7,000 – a saving of £3,500.'

There was good news for dentists across a number of other key areas:

- Capital Gains Tax - current rates are reduced from 18% to 10% for basic rate income tax payers and 28% to 20% for higher rate income tax payers – except for disposals of residential property (which do not qualify for principal private residence relief) and 'carried interest' from investment funds. Therefore anyone contemplating disposals giving rise to a CGT charge would benefit from deferring the transaction until after 5 April 2016
- The reduction in the higher CGT rate from 28% to 20% means that those dentists contemplating a disposal of their practice but who, for various reasons, might not qualify for the Entrepreneurs Relief rate of 10% will be at less of a disadvantage
- For those who have incorporated, corporation tax to be reduced by 1% to 17%
- Personal Allowance thresholds were raised to £11,500 and £45,000 for basic and higher rate tax respectively for 2017/18
- ISA annual tax free saving limits for all will increase from £15,000 to £20,000
- Annual threshold for small business tax relief to be raised from £6,000 to a maximum of £15,000, exempting many practices
- Class 2 National Insurance contributions abolished which should see a tax cut of more than £130 to many self-employed dentists.

Charles Linaker, tax partner at dental accountant UNW LLP sounded a word of caution. 'One area of concern for some dentists may be however, if they have been a bit lax in borrowing from their companies without ensuring that the cash taken out has been properly treated as either dividends or salary taxed under PAYE, they need to be aware that the rate of tax charged on 'overdrawn loan accounts' is to be increased from 25% to 32.5%.' ◆

© Steve Weinrebe/Getty

HEALTH & SAFETY

Changes to the Hazardous Waste Regulations

For practices in England, two changes to the Hazardous Waste Regulations came into effect on 1 April:

- The removal of the need to register premises
- Changes to the consignment note code used.

These changes are part of the government's attempt to reduce the burden of regulation on small businesses (known as its 'Red Tape Challenge').

Registration changes

Daniel McAlonan, Head of Compliance at the BDA, explained: 'You no longer need to register your premises with the Environment Agency, even if you produce or store 500kg or more of hazardous waste per year. These changes only apply to England. It does not affect premises in Wales who should continue to register with Natural Resources Wales if they produce or store over 500kg of hazardous waste per year.

'Practices in Northern Ireland and Scotland continue to be exempt from the need to register as a producer of hazardous waste regardless of how much they produce.'

Consignment note changes

The consignment note – that must accompany hazardous waste when moved from any premises – and the way you fill it in has changed to accommodate the removal of premises registration.

'Since 1 April, if waste is produced in England, you will need to amend the first six characters of your consignment note code – previously the premises registration number – replacing them with the first six letters or numbers (though not symbols) of the business name', Daniel Added.

'The producer should ensure consistent use of the organisation name in this regard. This applies regardless of the amount of hazardous waste you produce, store or handle, so 'EXEMPT' can no longer be used. The second set of characters will continue to be five numbers or letters of your choosing. This may, in a few specified occasions, be followed by an additional letter. We advise all members – and indeed all practices – to check you are using the correct format of the consignment note number.'

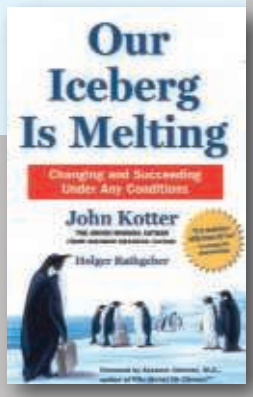
The Environment Agency is able to assist with any queries on these changes, email enquiries@environment-agency.gov.uk or telephone 03708 506 506.

BDA Extra and Expert members can also contact the Compliance Team for further advice email compliance@bda.org or telephone 020 7563 4572.

BOOK REVIEW

If your practice faces meltdown

Our iceberg is melting: changing and succeeding under any conditions
John Kotter and Holger Rathgeber
Macmillan, 2006
ISBN: 978-0230014206
£10.99



It is perhaps not immediately apparent how an allegorical tale about a bunch of penguins in the Antarctic can be relevant to business or management strategies. But by the end of this short and easy-to-digest hardback, its relevance is only too clear in explaining the processes of managing change in the workplace, writes BDA Librarian **Roger Farbey**.

John Kotter, an academic at Harvard Business School, understands exactly what processes need to be implemented to save a business from potential disaster. He imparts key messages through these anthropomorphised birds facing impending doom because their iceberg home is threatened with melting from global warming.

The birds eventually come to realise that their environment (the iceberg) is going to melt eventually and they will be homeless. So, they devise a plan of action after spotting a seagull 'scout' looking for new nesting grounds.

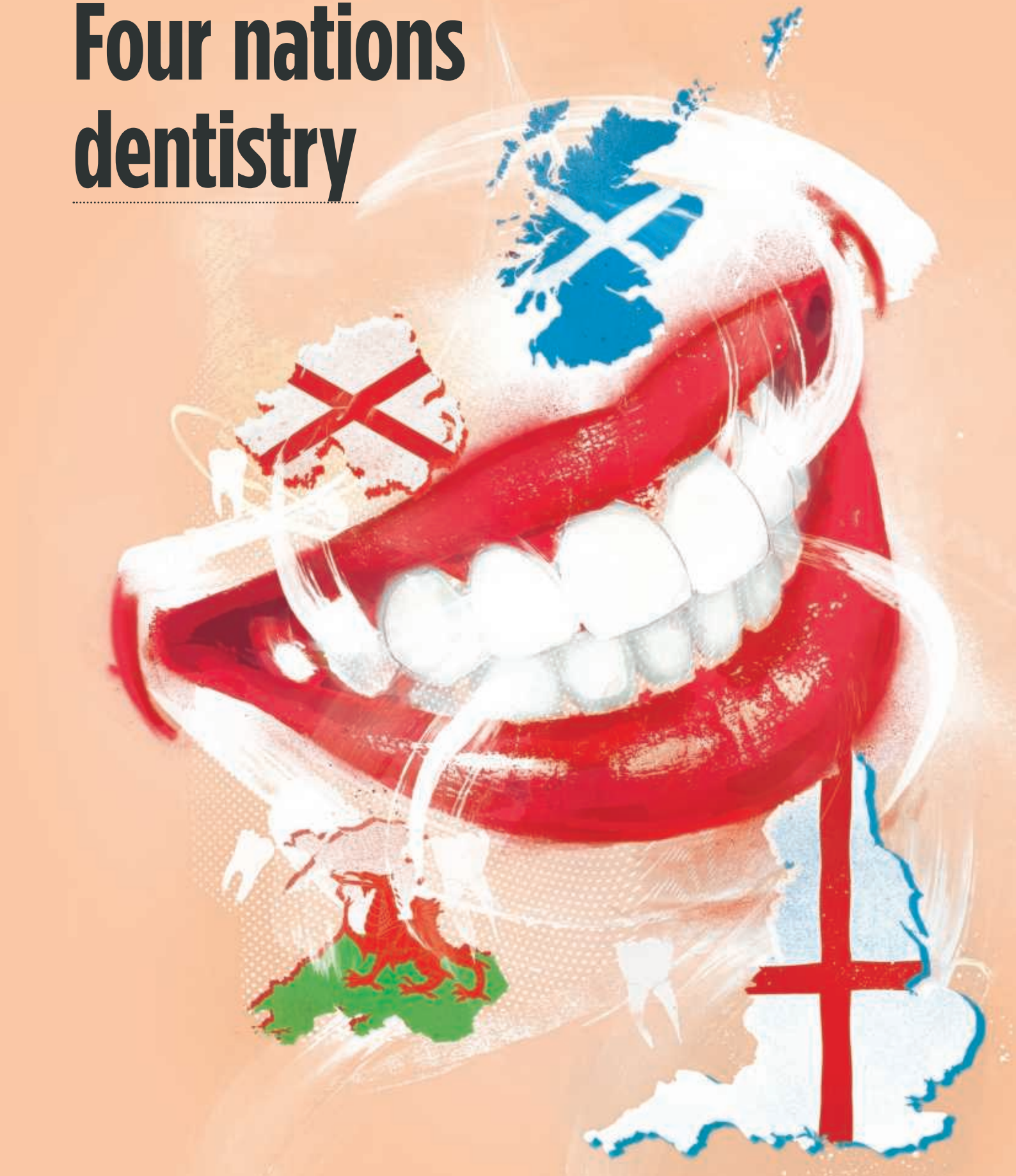
They decide to send out their own scouts to look for a new home but ultimately realise that the only way to survive is to become nomadic, periodically moving home. It sounds trivial, but to the penguins this is a major paradigm shift.

When faced with critical challenges the first thing to do is reduce complacency and increase urgency in tackling the problem. Then build a team to drive the change. The team needs to create a vision and this must be continually communicated to the rest of the workforce to embed it as a new culture.

There will inevitably be, as the penguins discovered, resistance to change or to adopting new, sometimes radical ideas. But the process will often be won over by a series of 'short-term wins'. Also, the changes should not be allowed to stall by hard-to-die traditions. Kotter and his co-author Holger Rathgeber conclude the book with half-a-dozen pages outlining a critical eight-step process to successful change.

It does not matter that this book was first published in 2006. It is a timeless and timely reminder of how important change management is when creating a new culture in the workplace and perhaps seeing your business melt away.

Four nations dentistry



Martin Woodrow,
Director of Member Services

Dentistry in Britain has never been one size fits all.

Certainly the contracts, public health priorities and funding constraints are very different for dentists operating out of Andover, Anglesey, Antrim or Auchtermuchty.

Increasingly the decisions that are being made that will end up being felt in your practices and by your patients are being made closer to home. And that process show no signs of letting up.

Wales, Scotland and Northern Ireland all go to the polls on 5 May. The winners will be setting national dental policy for the next five years so it's vital the profession engages.

There are common challenges, fixing broken contracts, and real action on sugar. But away from Whitehall there has been, perhaps, a greater willingness to embrace needed change.

Prior to the Chancellor's latest budget policymakers in Holyrood, Stormont and Cardiff Bay seemed far more open to a sugar tax than their opposite numbers in Westminster. Now they have the opportunity to assess the intended way this new revenue will be spent. We have already seen a concerted drive to support early years programmes in Wales and Scotland, so we could well see this levy translating into fresh investment for children's oral health.

In each nation the oral health challenges are unique, and the responses should be too.

Colleagues in Northern Ireland have had to lobby for needed changes on contracts and regulation without a health minister in post, as political crisis swept the Stormont government. The threat presented by oral cancer in Scotland has focused BDA Scotland's thinking. The Welsh government has already chosen to break with England's inflation busting increases in dental charges and back a freeze. So BDA Wales is pressing to take this one step further, with calls for charges that are genuinely affordable for patients on modest incomes.

Devolution is something every dentist will have to get used to, and that includes those based in England. The UK government has already pressed ahead on handing health powers to local authorities in Manchester.

Better dentistry and better oral health are no longer the gifts of mandarins off Whitehall. This profession has to ensure it's ready for the challenges and opportunities ahead.

COMMENTARY

Scotland

Pat Kilpatrick,
Director BDA Scotland

Scotland is an oral health innovator. The *Childsmile* programme has been a great success, lowering treatment costs and delivering enormous improvements in the oral health for children under the age of five.

Once you look past that age group, you see 36% of children living in areas of higher economic and social deprivation have obvious tooth decay compared to 15% in more affluent areas. 7,025 children were admitted to Scottish hospitals in order to undergo dental extractions in a single year. That is why we are calling for *Childsmile* to be extended to tackle decay among 5-12 year olds.

> 'The sad reality is that Scots are more likely to develop oral cancer than their English and Northern Irish counterparts.'

The major shortfall in the funding of NHS dentistry also must be addressed. Candidates from all parties need to demonstrate their commitment to NHS dentistry and ensure services are funded in line with costs. A more transparent system where patients can make informed choices about their treatment and have options to supplement NHS care is essential. The current remuneration system for dentistry is no longer fit for purpose and we will be calling on all parties to bring forward realistic proposals which will secure the future of NHS dental services.

We know an ageing population coupled with people keeping their natural teeth for longer is another huge challenge for oral health. Registering every patient with a dentist should be a standard part of their induction. The dental care of elderly patients is getting more and more complex and demand for domiciliary care is currently unmet in many areas.

The sad reality is that Scots are more likely to develop oral cancer than their English and Northern Irish counterparts. Better education on the early signs and symptoms is crucial to reversing this fact. Allied to this there is a serious shortages of oral maxillofacial surgeons and oral medicine specialists in Scotland. Oral cancer patients often require immediate surgery and this shortage could cost lives. We need the next government to ensure Scotland has the workforce in place to meet the needs of oral cancer patients.

Like many of my colleagues I am pleased to see forward-thinking steps being taken on sugar. A sugar tax will deliver much needed improvements to oral health in Scotland , but the current system of food labelling remains too complex, and we will be pressing the next government to make clear, easy to understand front-of-package traffic light labels mandatory for all processed foods.

Targeted fluoridation could also play a big role in the fight against decay. It is a cost effective measures that will deliver significant and sustained improvements in the oral health status of the population.

Implementation of these points will see the next government in Edinburgh focus on prevention and addressing inequalities in oral health.

www.bda.org/scotland2016 ◆

5 pledges to deliver better oral health in Scotland

- → Tackle inequalities early
- → Address the NHS funding shortfall
- → Improve the oral health of the elderly
- → Action on oral cancer
- → Deliver effective oral public health

COMMENTARY

Wales

Caroline Seddon,
Director BDA Wales

Delivering better oral health for Wales means investment in the next generation.

The last Child Dental Health Survey showed 66% of Welsh 15-year-olds have decay, compared with 41% across the border.

Assembly Members backed a 20% sales tax for sugary drinks in a symbolic vote last December. Now a UK-wide levy is on the cards we have to push further.

> 'The right blend of education and intervention will pave the way for a cavity-free future.'

We can fight this decay epidemic on two fronts. The sugar levy should give manufacturers an incentive to cut back on excessive sugars, and the Assembly must use its discretion to direct a slice of the revenue raised towards pioneering preventative programmes. Since 2008 the Welsh Government has funded *Designed to Smile*, the Wales National Oral Health Improvement Programme. Supervised brushing and fluoride varnish programmes have helped young children establish good habits and are already reducing caries.

We believe that in areas of high oral health deprivation all schools and nurseries, including those under three, should be compelled to take part in this innovative programme. The scheme works, and the sugar levy gives us a chance to build on its success. The right blend of education and intervention will pave the way for a cavity-free future.

Wales has not been afraid to break the Whitehall consensus on health. Prescription charges have been abolished, while dental charges remain frozen. We now believe the Welsh government should take this approach a step further, and ensure dental charges remain genuinely affordable for all who have to pay.

Nearly 400,000 people in Wales have delayed or avoided dental treatment because of costs. The Assembly has a duty to those on lower incomes that charges do not represent a barrier to those in need of care.

> 'The Welsh health system is still young, and needs to become more resilient.'

The Welsh health system is still young, and needs to become more resilient, with quality and patient care at its heart. We will be pressing for more concrete levers for our Health Boards, so they spend their full allocation on primary dental care, while driving innovation and core standards across the board.

We know that effective dental regulation is vital, but it must be proportionate and appropriate for patient safety. We will be calling on the Assembly to ensure patients and practitioners can benefit from a genuinely progressive regulatory regime.

And of course we need to see the next Assembly planning for the future. Evidence-based research into workforce planning is now essential. We want to see incentives to keep Welsh-trained dentists in Wales and real progress towards a reformed contract with prevention at its heart.

www.bda.org/wales2016 ◆

5 pledges to deliver better oral health in Wales

- → Invest in children's oral health
- → Make dental charges affordable
- → Advance the Health Boards
- → Progress dental regulation
- → Plan for the future

COMMENTARY

Northern Ireland

Claudette Christie,
Director BDA Northern Ireland

Northern Ireland has some of the worst oral health inequalities in the UK. And with an oral health strategy that is almost 10 years out of date, the next Executive has a chance to put prevention at the heart of policy.

Securing Better Dental Health for all is the BDA Northern Ireland Manifesto, setting out areas for priority action over the next five years.

> 'Northern Ireland has some of the worst oral health inequalities in the UK.'

More than double the number of 15-year-olds in Northern Ireland have teeth missing due to decay compared to those in England and Wales. Members of the Legislative Assembly (MLAs) have already backed a consultation on the introduction of a tax on sugary drinks. The advent of the sugar levy now means we can widen this debate.

We're clear the Assembly needs to develop a comprehensive plan on reducing sugar consumption and no option should be ruled out, whether that is further steps through the tax system, or action on, labelling, marketing or public education.

Dental practices in Northern Ireland are regulated as 'independent hospitals'. It's time the size and nature of dental practices in Northern Ireland, as well as the low risks posed, were taken into account. BDA will continue to push the Assembly to address the fundamental issues in the current regulatory regime, aiming for a risk based approach to utilise resources more effectively and importantly deliver real benefits for patients.

All colleagues have to grapple with red tape, but our dentists are required to submit claims for approval to carry out health service treatment if the cost of the dental work exceeds £280. That threshold has not increased since 2003. It means unnecessary bureaucracy and delay and confers no patient benefit. Take any opportunity to share your story with candidates and highlight what this means to your patients and their experience of health service dentistry.

> 'BDA will continue to push the Assembly to address the fundamental issues in the current regulatory regime.'

With ever-growing demand, we also need to ensure we're training the dental professionals we need. Dedicated workforce planning is now vital, so the service and the skills available in the whole dental team are where patients need them.

Inevitably this work will need to be underpinned by new contracts that are fit-for-purpose. Funding of dentistry continues to be a major problem in Northern Ireland, with a refusal by government to implement recommended pay uplifts. We will be pressing the Executive and Assembly to renew commitment to the funding, development and introduction of new contracts for general dental services and community dentists.

www.bda.org/northernireland2016 ◆

5 pledges to deliver better oral health in Northern Ireland

- → Deliver a new oral health strategy
- → Real action on sugar
- → Efficient and effective regulation
- → Cut red tape
- → Plan for the future

COMMENTARY

Devolution: what does it mean for GDPs in England

Dave Cottam,
Vice Chair of General Dental Practice Committee

Unless you live or work in Manchester you probably haven't heard of the phrase 'Devo Manc'.

We have already seen responsibility for health devolved to the national governments across the UK and with new devolved decision-making bodies taking charge of the £6billion health and social care budget in Greater Manchester on 1 April, this is a good time to flag up what devolution is, and what the wider impact of it might be for dentistry across the UK.

> 'The Greater Manchester health and social care system is facing an estimated financial deficit of £2billion by 2020/21.'

In a nutshell

In February 2015, the Government agreed a deal to devolve responsibility for health and social care to statutory organisations in Greater Manchester. Many see this process as positive for the future of health and social care, with the idea that devolution will enable decisions being taken much closer to the populations served, and with local councillors having more influence on decisions.

The numbers are huge. The Greater Manchester health and social care system is facing an estimated financial deficit of £2billion by 2020/21 from this £6 billion devolved budget. The devolved structure is going to have to make big changes to balance the books. This is a massive undertaking and whether it can be achieved within the timeframe NHS England is pushing for, is – I fear – a long shot. And the question is: will dentistry end up bearing the brunt of this restructuring in healthcare, yet again?

It's not just about Manchester; 38 bids have now been made across England for devolved powers. NHS policy makers are shifting their commissioning models from organisations to places, and part of this is the will to 'dissolve the traditional boundaries' between GPs, hospitals, health and social care and mental health, originally set out in NHS England's Five Year Forward View.

What is the BDA doing?

Since early 2015 we have had a watching brief on the process of devolution and have been raising the questions that need to be asked about the impact of devolution on dentists and the way our contracts are to be commissioned in the future and the form these contracts will take.

GDPC has a working group focusing on devolution and has been speaking to the Department of Health, the commissioners in Manchester. We will continue with these discussions.

Continued on page 10

The outcome of this is supposed to provide more 'person-centred' care for patients, but don't we already do this in dentistry?

There are risks and rewards for dentistry, some of which I'll try and outline here, but ultimately I think we are headed for (yes, yet another) sea change in the way dentistry is commissioned and delivered, and the waters are likely to be rough.

Dentists cannot bury their head in the sand about the ramifications of these changes. The BDA's General Dental Practice Committee, of which I am Vice-Chair, has been focusing on the impact of these policies and we continue to support the Greater Manchester Federation of Local Dental Committees and negotiate on your behalf with those holding the management and the purse strings, to fight for a better deal for dentists and our patients.

What does it mean for me?

In the short term, NHS England will continue to commission dental services in Greater Manchester even after 1 April 2016, when the health and social care budget was officially devolved. What exactly might happen in the future is not definite yet, and I very much doubt dentistry will escape these huge changes taking place in commissioning of care.

It is vital that the profession engages with these changes in Greater Manchester, and beyond, to assess what will happen in the long term. The Local Dental Committees in Greater Manchester, through the Greater Manchester Local Dental Committee Federation, have sought to engage proactively with the 'Devo Manc' developments to keep the voice of dentistry heard and ensure the wider oral health agenda stays on the table.

What will happen in Greater Manchester?

The plan is that local GPs will be driving the new devolved models of care. Bodies known as Local Care Organisations (LCOs) will include community, social care, acute, mental health services, and the full range of third sector providers such as schools. The population base they are looking to commission for is 30,000 to 50,000.

We have concerns that the GP Federation model may be rolled out, including for dentistry, without questions being asked about whether it works for the profession or patients.

The impact on dentistry

There are a range of risks for dentistry under the proposals being put forward by 'Devo Manc':

- What will happen in regard to practice sales and goodwill?
- Are practices going to continue to hold contracts or become sub-contractors?
- What about contract values?
- What will happen to our investment in our estate, and what are the financial risks for that?
- How is contract regulation going to work in devolved areas?
- What about superannuation arrangements?
- What flexibility and autonomy do we currently have, and will devolution really will be better for our patients?

> 'We have concerns that the GP Federation model may be rolled out, including for dentistry, without questions being asked about whether it works for the profession or patients'

To add to the jargon, it's proposed that the system will be run by groups called 'Multispecialty Community Providers' (MCPs), which will issue contracts that are based on a capitated model with a quality payment. The intention is to pool all provider contracts into one MCP contract, so that an integrated service is developed and the pooled funds can be reallocated to providers where needed.

We have discussed the idea of a parallel model to MCPs, such as a dental federation with a dental contract, to ensure that commissioning works for dentistry, current contractual benefits are preserved and that we aren't just shoe-horned in with the doctors.

Supported by the BDA, dentists in Manchester have been working to develop proposals for a formal Senior Commissioning and Clinical Leadership team for oral health improvement and dentistry. We have called for an inclusion of all dental stakeholders in the process.

An unclear future?

It has been a decade since the imposition of the 2006 dental contract, and as yet, there is no definite date when any new contract may come into play.

The GDPC is extremely concerned that the work and effort put in by many dentists who have taken part in the contract reform pilot and prototyping exercises may get swept aside with these new devolving powers, and the GDPC is keen to see that the data and economic modelling processes which have been undertaken are not wasted. We are seeking clarity from NHS England and have raised this issue with the Chief Dental Officer for England and we will continue to do so until assurances are given.

My concern is that at heart, we still have the same problems to solve. As dentists, we want to do the best for our patients and ensure that the oral health of the nation improves, rather than regresses. I have yet to be convinced that devolution can deliver on that, and I've yet to be convinced that moving responsibility for the budgets from one group to another is really going to make any difference. ◆

Devo Manc key facts:

- The current primary care transformation programme is largely focused on GP practices: there are currently 500 GP practices in Greater Manchester. For comparison, there are 450 dental practices.
- The 37 local organisations in Greater Manchester have agreed to pool £2.7b of joint resources across the 10 local authorities
- The Greater Manchester health and social care system is facing an estimated financial deficit of £2billion by 2020/21, from the £6 billion devolved budget agreed on 1 April 2016.

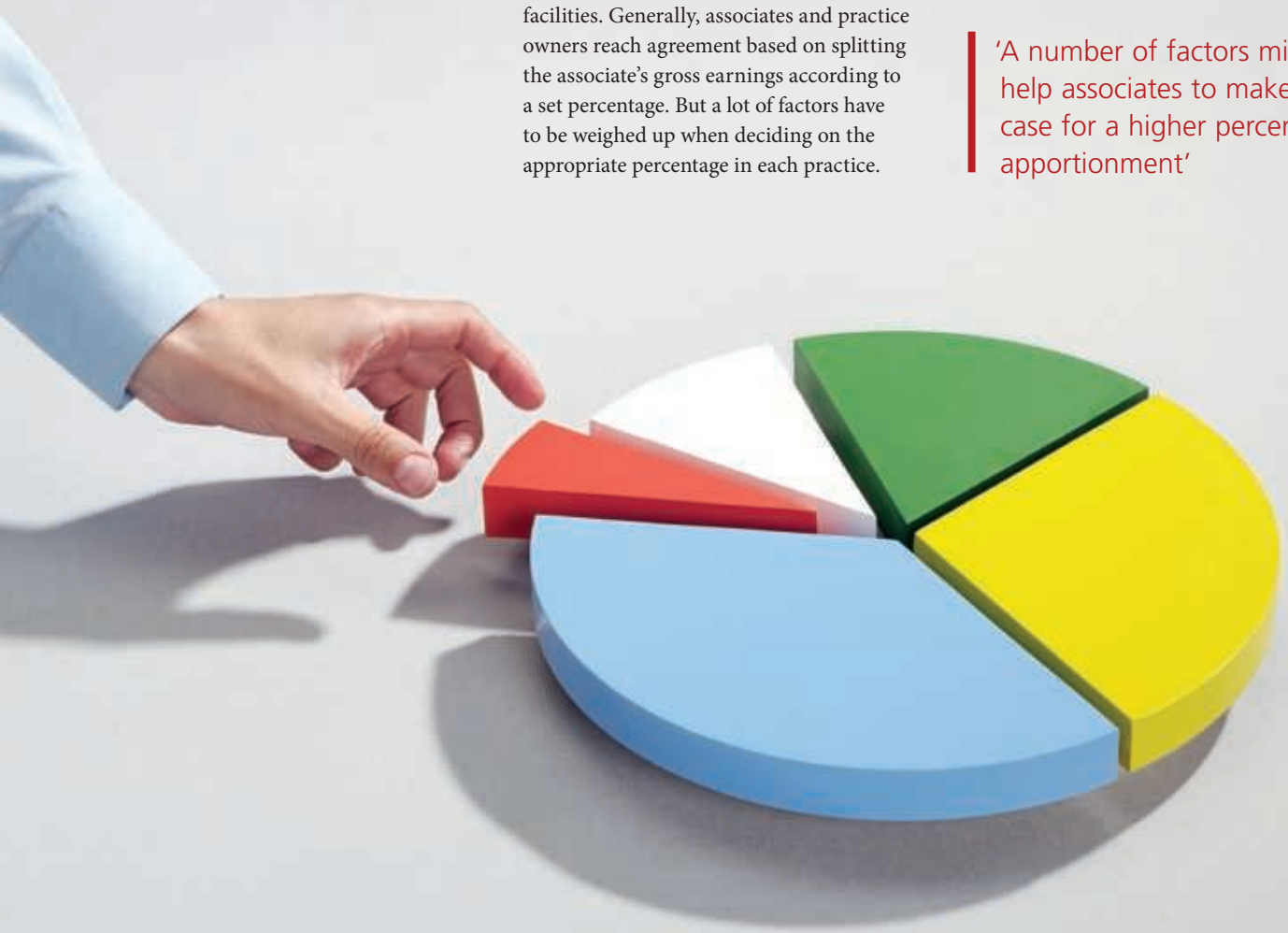
Associate negotiations – always a balance

Shabana Ishaq
a practice management consultant in the BDA Practice Support Team. Shabana trained as a solicitor and advises general dental practitioners on associate contracts and a wide range of employment and other law

Essentially, working as an associate is a freelance arrangement – with the associate using someone else's surgery space to see and treat patients. Practice owners fulfil their part of the bargain by providing the surgery space, equipment, heating, lighting and staff support. Associates need to strike a deal with the practice owner over how much they are going to pay for the use of the premises and facilities. Generally, associates and practice owners reach agreement based on splitting the associate's gross earnings according to a set percentage. But a lot of factors have to be weighed up when deciding on the appropriate percentage in each practice.

The BDA does not recommend a percentage, not least because all practices and their circumstances are different. However, we have observed that the associate contracts reviewed by the BDA's Practice Support team often suggest that associates retain between 40-50% (with the practice owner getting 50-60%). This is only an anecdotal analysis and it must be borne in mind that the fee

> 'A number of factors might help associates to make the case for a higher percentage apportionment'



apportionment decided upon has to be a commercial decision influenced by practice circumstances. Nevertheless, we recommend that associates and practice owners should review the agreed apportionment every year, looking at recent performance and practice costs.

Fees and costs

As indicated above, it is necessary for both parties to look at their own specific circumstances. For the practice owner a starting place will be the likely gross fees of the practice and the overall costs they have to meet; for the associate it will be their contribution to gross fees. The practice has to cover all its costs and expenses and return a suitable profit. Apportioning practice costs to each associate can be a tricky mathematical exercise. A simple approach is to use a straight fraction, a half, a third, a quarter, etc. depending upon how many dentists are at the practice. Some costs, for instance the equipment, materials used by the associate and the wages paid to the associate's nurse are directly incurred by the associate. Other costs such as the rent or mortgage on the premises are fixed, regardless of the associate's presence; even so it would not be unreasonable to apportion a share of general costs to the associate. The main point is for the parties to discuss the approach that they wish to take.

DDRB effects

NHS fees are considered each year by the Review Body on Doctors' and Dentists' Remuneration (DDRB) which may lead to NHS fees or contract values being increased. This should increase an associate's gross income but how, given other considerations, this uplift should be applied to an associate's earnings it is not necessarily easy. Nevertheless, last summer the General Dental Practice Committee (GDPC) issued a statement on the 2015 award:

> 'The quality of the surgery and equipment and experience and expertise of the team members who work with the associate will be significant'

'The Doctors and Dentists Review Body this year [2015] recommended an increase in net pay of 1% for independent contractor general dental practitioners in all countries of the United Kingdom. The award has been implemented by the Department of Health in England and by the Welsh Assembly Government, although they have both abated the amount allowed for staff costs, resulting in a gross uplift of 1.34%. In Scotland, the recommended gross award of 1.61% was implemented. No decision on implementing the uplift has yet been made in Northern Ireland. Whilst the DDRB recommendation does not relate directly to the pay of associate dentists, associates might reasonably look to the award for an indication of an expected uplift in their own income. The GDPC recognises that practice income has been under enormous pressure for a number of years and therefore any decision on pay increases for associates will inevitably reflect local business circumstances, and will be a matter for direct negotiation between the parties. However, the GDPC would expect practices to recognise that associate income has also declined significantly in real terms, and to reflect the DDRB award in associate pay wherever possible. Associates are encouraged to engage with practice owners to discuss their contractual arrangements in light of the DDRB uplift.'

The same principle continues to apply this year. ◆

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The Beauty of Dentistry

Dealing with bad debts; £ a step-by-step guide

by Jaime Lindsey
a practice management consultant in the BDA NHS and Business Team. Jaime advises on all aspects of NHS general dental regulations

Recovering outstanding fees is a key part of maintaining a successful business. Sometimes patients do not pay for the work they have received and there needs to be a procedure so that you and your team know the steps to take to recover money that is owed. Reception staff or practice managers are likely to be the team members most closely involved in collecting fees so it is important that they are familiar with the policy and recognise the importance to the practice's cash flow of chasing bad debts.

Of course there would be no bad debts if it was possible to make sure that all fees were paid promptly upon the completion of treatment. The real world does not always work like that but you can try to minimise the number of outstanding bills by informing patients:

- £ As soon as possible about the cost of their treatment
- £ Of the details of their treatment plans and estimates
- £ That you will ask them for payment at the end of treatment
- £ About the methods of payment that the practice accepts.

(Also see *Stress value to smooth fee collection, BDJ In Practice*, August 2015, pages 18-19).

Finding the best approach

Where money for treatment is outstanding – for either NHS or private patients – you need to think about the best approach to recovering that money. This will depend on the circumstances of each case, but the following guidelines set out what might generally be appropriate.

Where the patient fails to pay for the services at the end of treatment, they should be sent a bill. A reasonable period for them to settle the account from receipt of this bill would typically be two weeks, at which point a reminder should be sent. If you have still not received payment (or negotiated a payment schedule with the patient), after a further two weeks then try telephoning them; ask the patient whether they received the bill and are intending to make payment.

> 'Where the patient fails to pay for the services at the end of treatment, they should be sent a bill'

Avoiding further action

It is in everyone's interests to resolve outstanding debts without taking further action as it is cheaper and less stressful. However, if you have no luck at that point you can consider taking further action. It is always best to give the patient one final chance to pay though. Often writing to them at this point and threatening to take enforcement action will result in payment. Also be prepared to agree a programme for repayment, in instalments if necessary (generally, you can allow patients to pay in up to 12 instalments without needing

official Consumer Credit Authorisation (Also see *Consumer credit rules relaxed BDJ In Practice*, June 2015, page 3), as it will save you the cost of debt collection.

Once you have sent reminder letters, telephoned the patient and given them a final chance to pay, you need to decide whether you really want to take further action. This includes a cost-benefit analysis of whether it would be economic to pursue the debt as debt collection agencies and courts can be very expensive. Your practice policy should set out the level of debt that can be written off and at what stage.

Formal action

One option is to use a debt collection agency. They can pursue debts on your behalf but be aware that they do not have any special powers to reclaim debts and you will want to ensure their practices are ethical. This is particularly important for dentists because of your ethical obligations under the General Dental Council's (GDC) *Standards for the dental team*. However, choosing a good, experienced agency can have good results because fees are often based on a percentage of the debts recovered plus costs, which gives the agency an incentive. Though, equally it can mean that, in some cases, the debt may not be worth pursuing so make sure you do the calculations in advance and get clear quotes from different, reputable agencies.

Whilst you can always pursue a debt as a matter of principle, be aware of the cost implications. You should always notify patients, in your final reminder to them, that a debt collection agency may be used if the debt remains unpaid. All debt collection agencies in the UK are regulated by the Financial Conduct Authority (FCA) and the trade association for debt collection agencies is the Credit Services Association (CSA). Further information about the CSA's members can be found at www.csa-uk.com

> 'In most dental cases the small claims procedure is likely to be appropriate'

Court claims

Another option is to recover bad debts through the courts. However, court claims are expensive, time consuming and bureaucratic. It could also lead to counter-accusations about your standard of care in order to avoid liability for your fee, whether well-founded or otherwise. Court action should therefore be a last resort.

Claims can be brought in the County Court in England, Wales and Northern Ireland and in the Sheriff Court in Scotland. There are different procedures depending on the value of the claim, but in most dental cases the small claims procedure is likely to be appropriate. Small claims are those of up to £5,000 in England and Wales and £3,000 in Scotland and Northern Ireland. For more information on taking legal action, see www.bda.org/advice for BDA advice document Court claims. We would always advise that you consult a solicitor before starting any form of legal action because if your claim is unsuccessful you may have to pay the other party's costs as well as your own.

Collecting unpaid fees can be an unwelcome distraction but are an essential aspect of running a business, particularly if you are owed large sums of money for complex work. You are entitled to recover money owed for work done and should consider how best to go about it. It is a situation that you and all your colleagues will face. In reality very few practices avoid bad debts but when they do occur it is important to keep a perspective on the options for dealing with them. ◆

Appraisals – discussing performance and setting targets

by Jacinta McKiernan,

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

The key to successful appraisal meetings is to find out what your staff want from their job. Appraisals are a good time for reflection for the employer and employee, taking time out and helping both to prioritise their tasks. It is an opportunity for you and your employees to:

- Discuss current performance
- Address any concerns
- Set targets to improve future working.

This process can help employees to focus on the aspects of their role that are important for the success and wellbeing of the practice. The meeting should not be a top-down monologue or merely an opportunity for one person to ask questions and the other to reply. It should be a free-flowing conversation during which a range of views are exchanged. It is best if both employer and employee share feedback on the working environment, workload and performance.

Setting the tone of these meetings is also important, the Chartered Institute of Personnel and Development's (CIPD) Performance Appraisal factsheet stresses the importance of a 'positive relationship between individuals and line

'The meeting should be a free-flowing conversation during which a range of views are exchanged'

managers. Carried out sensitively, the performance appraisal is an important vehicle in developing and maintaining this relationship'. Where employees feel comfortable about voicing their feelings or concerns, they are likely to feel a strong sense of engagement and a common purpose with the practice.

Format

To get the most out of the meeting draw an agenda in preparation. It is helpful to have a structure to the appraisal conversation such as following a standard appraisal questionnaire that prompts responses on all aspects of their work. Give your employee a copy in advance so they can think about their answers. Getting them to consider it beforehand encourages self-awareness and open communications. Most self-assessments are reasonable and accurate, although there can be problems with over-inflation and under-rating achievements due to their personality; but you can address this in the actual appraisal meeting. As a general rule, start by listening to their views on their workload, recognising achievements, then give more critical feedback and conclude by discussing targets or objectives.

Listen

Ask their views first on each issue before giving your observations. Questions could be along the lines of what they think has gone well during the year; how they think they can build on their achievements; or the support they would like from the practice. You can then move onto ask what has not gone so well. In this encourage your employee to suggest solutions on what improvements can be made and how.

Recognise achievements

Formally acknowledge:

- Good work
- Good attendance
- The strengths that your employee has shown.

Be specific about:

- What they have done well
- Things they do that shows you pay attention to them
- Providing a useful guide for the sort of effort you require.

This will make them feel valued and motivated. Praise has to be genuinely deserved, do not put a positive spin on areas of concern as giving false praise can undermine tackling such concerns in future.

Constructive criticism

Where you have to give some critical feedback it is important to:

- Have recognised achievements first
- Discuss concerns in a non-accusatory manner focussing upon tasks, difficulties and outcomes
- Not focus on personality
- Be objective and reasonable with your comments
- Back comments up with examples.

Set realistic targets

A target could be something formal, such as to complete the Certificate in Dental Radiography within an agreed time frame. Or it may be something more everyday, such as sending laboratory request forms within 24 hours. Whenever setting targets it is important that you are sensitive towards your employee's abilities. Look at their level of experience and ambitions for the future. Remember, there is only so much they can do within a given time frame so make sure that targets are achievable. It is a good idea to tackle each area of work separately.

Within each category you can discuss their current achievements or performance and what they could aim for; the initials SMART are useful, which stand for:
Specific
Measured
Agreed
Realistic
Time-based.

Talk about how an objective complies with these criteria. If it does not then it is likely to be impractical.
Do not forget to:

- Keep a record of the meeting
- Make a note of what was discussed
- Make a note of what was agreed
- Give your employee a copy and ask for their comments. ◆

A template Performance appraisals is available at www.bda.org/expertsolutions for BDA Expert members

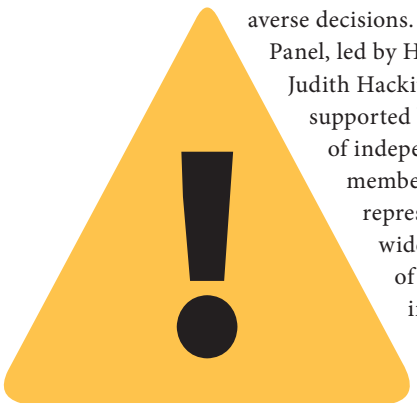
Health and safety: Myth busting

by Daniel McAlonan
Daniel heads the BDA's Compliance Team, helping members on all aspects of health and safety law, infection control requirements, practice inspections and compliance with professional regulations.

Health and Safety, or *'elf and safety'* as its humorously referred to, is often incorrectly used as a convenient excuse to stop what are essentially sensible activities going ahead. Dental practices should therefore bear in mind the distinctions that have been made between sensible precautions and being over cautious. Both the Health and Safety Executive (HSE) and England's Care Quality Commission (CQC) have taken steps to counter misconceptions.

Myth Busters Challenge Panel

The Health and Safety Executive (HSE) set up its independent Myth Busters Challenge Panel in 2012 to combat over-cautiousness and to scrutinise risk-averse decisions. The Panel, led by HSE Chair Judith Hackitt, is supported by a pool of independent members representing a wide range of interests including small businesses, trade unions, the insurance industry and lay members. They look into enquiries regarding the advice given by non-regulators such as insurance companies, health and safety consultants and employers and quickly assess if a sensible and proportionate decision has been made. The aim of the HSE panel is to make clear that health and safety is about managing real risks properly, not being risk-averse and stopping people getting on with their lives. At the time of writing nearly 400 cases have been reviewed by the panel.



> 'Distinctions have to be made between sensible precautions and being over cautious'

In addition, the HSE will often publish letters responding to newspaper stories perpetuating the myth of 'health and safety gone mad'. One such dental story last year resulted in the HSE writing to the editor of The Daily Telegraph following its headline story '*Dentist tells the obese they are not welcome*' (31 July 2015). In reality this was simply a case of some patients being beyond the weight limit of the dentists' chairs.

The CQC Mythbusters webpage

Within dentistry, it is probably fair to say that staff in many dental practices will have heard (and possibly spread) reports of some bizarre requirements being made or inappropriate judgments reached during CQC practice inspections. This seems a peculiarly English thing – it is much less likely in Scotland, Wales or Northern Ireland where the equivalent bodies use specific inspection documents. While some of these inspection stories will undoubtedly have been true, others will not.

To address this the CQC has developed its own approach to rebutting rumours. Through it's '*Mythbusters and tips for dentists*' webpage – see www.cqc.org.uk/content/mythbusters-and-tips-dentists – the Senior National Dental Adviser John Milne tries to clear up some common myths about CQC inspections and shares agreed guidance (right).

These resources are designed to support inspectors as they assess the quality of primary care dental services; but more importantly, they help dentists know the stance their regulator will take when assessing whether the care they provide is safe, caring, effective, responsive and well-led.

Safer sharps

The CQC's mythbusters usually sets out what it sees as mandatory requirements and recommended practice. A good example of this is the CQC position on the use of safer sharps. It correctly states that practices must substitute traditional, unprotected sharps with a 'safer sharp' where it is reasonably practicable to do so, but goes on to say that where these are not used there needs to be a written protocol in place, including a risk assessment, explaining why traditional methods continue to be used. Further advice on safer sharps including how to decide if their use is 'reasonably practicable' is available at www.bda.org/sharps

CQC Myth buster topics

1. Disposal of dental amalgam
2. What do dentists and the dental team need to do to keep up to date with their training?
3. Dental radiography / X-rays
4. Drugs and equipment required for a medical emergency
5. Legionella and dental waterline management
6. Storing Glucagon injection
7. Use of safer sharps
8. Dental care records
9. Hand hygiene
10. Safe and effective conscious sedation
11. Disruption to services – notifying CQC
12. Validation of decontamination equipment
13. Safeguarding training

Fridge temperatures

Another clear example where the CQC have provided clarification is the storage of some emergency drugs. Its myth buster explains that the most commonly available form of Glucagon injection is the GlucaGen HypoKit 1mg which can be stored at a temperature of 2–8°C in a refrigerator giving it a shelf life of 36 months. However, it can also be stored outside the refrigerator at a temperature not exceeding 25°C for 18 months provided that the expiry date is not exceeded. Importantly, the CQC position does not include a mandatory requirement or recommended practice to record fridge temperatures.

> 'Managing real risks, not stopping people getting on with their lives'

Criminal record checks

Confusion also exists on the status of criminal record checks. In England, Scotland and Northern Ireland these do not have a fixed expiry date. Once undertaken, the practice owner can decide if they are happy to accept these from dentists or staff members who had them done for a previous practice. The candidate's credentials, references and work history can help with this decision. However, in England an updated Disclosure and Barring Service (DBS) check is required by the CQC when there is a change of legal status in the practice. For example, if a sole trader forms a partnership or the practice incorporates. With a newly formed partnership all the partners will need new CQC-countersigned DBS checks if their existing check is more than six months old. In addition, the Registered Manager at the practice will also require a CQC-countersigned DBS check (though if they are also one of the partners they will be getting one anyway). In the case of incorporation the Registered Manager again needs a new DBS check if their existing one is more than six months old.

In Wales, anyone registered with Health Inspectorate Wales (HIW) is required to have their DBS check repeated every three years – but this requirement will be removed when new private dentistry regulations come into force later this year.

Colourful cleaning

One myth not covered by CQC that most practices will surely recognise as needing to be tackled is the 'requirement' to have a range of colour-coded mops and buckets for use in different areas of the practice. This was proposed back in 2010 by the National Patient Safety Agency in its publication *The national specifications for cleanliness in the NHS: Guidance on setting and measuring performance outcomes in primary care medical and dental premises.* It was developed as a tool to help practices meet their obligation to provide a clean and safe setting, however, the document itself states that 'no part of these specifications is mandatory and individual providers will need to take a view on the extent to which the processes set out are followed exactly or are adapted locally'.

> 'Health and safety is about managing real risks properly'

Double check requirements

We have only touched on a few areas where there has been confusion and misinformation on what practices need to do to comply – no doubt others will have examples that would benefit from being exposed. One of the roles of the BDA's Compliance Team is to help practices respond to inappropriate requests and raise these queries with the regulators. BDA Extra & Expert members can get in touch via compliance@bda.org or Tel.020 7563 4572 ◆

Selling a practice – Heads of Terms is crucial

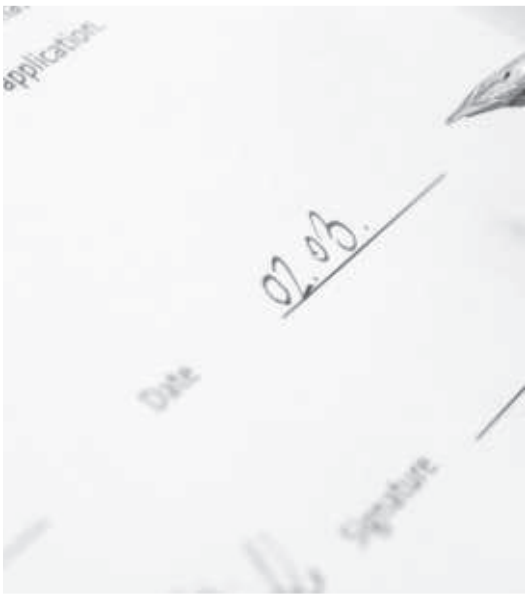
By Victoria Michell,
a practice management consultant in the BDA Practice Support Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and associate contracts

During the process of selling a dental practice many formal documents will pass by the seller for signature. One document which can get overlooked and sometimes (particularly in private sales) does not even get written is the *Heads of Terms* agreement. Generally, this should be the first document a seller sees once they have found a prospective purchaser. It should be the first document that both the buyer and seller enter into together. Never ignore this step.

Heads of Terms set out the basis of the practice sale in broad terms. It lists the main intentions of the buyer and seller ahead of working out the detailed contract. Essentially it is an 'agreement to agree' and sets out guidelines for how the parties will progress throughout the transaction and the scope of the transaction.

> 'Heads of Terms set out the basis of the practice sale in broad terms'

If you are selling your practice through an agency often they will produce the *Heads of Terms* document for you. But you should still get your solicitor to go through this for you. If you are conducting a private sale it is unlikely you will get this document drawn up as a matter of course and it is therefore worth raising this with your solicitor and asking them to prepare a document for you and the buyer to sign at the outset.



What to include

Since the *Heads of Terms* reflect the agreement you want to make with the buyer it will usually set out the:

- Price you will be paid
- Assets you will be selling, such as the premises, equipment, goodwill
- Timeframe for the transaction.

Six months is usually the timeframe set for the transaction although many

transactions (if not the majority) end up taking longer than six months to complete. Often there will be an exclusivity clause, which means during the initial six months both the buyer and seller will exclusively deal with each other with regards to the transaction. This will tie both parties into the transaction for that period. This clause can also state the consequences for non-compliance and other restrictions.

There will usually be several other clauses specific to the practice as well as a governing law and jurisdiction clause which usually states that the *Heads of Terms* will be governed by the laws of whichever jurisdiction the practice is in, this is crucial if the buyer is based in another part of the UK or even abroad.

Confidentiality

A confidentiality clause is probably one of the most important clauses in the *Heads of Terms* because it prevents buyers and sellers from discussing the transaction with anyone other than their professional advisers until contracts have been exchanged and both parties are legally bound to the transaction. This protects sellers and above all particularly details relating to patient numbers, goodwill and hence the value of your practice. Also if your patients found out you were selling and leaving the practice they may look for another practice undermining your goodwill.

> 'A confidentiality clause is probably one of the most important'

Similarly it will be difficult not to tell your staff that the process is ongoing, but it is in both your and their best interests not to do so. The news could cause them confusion and they may worry (although their rights and jobs will almost certainly be protected) about their future. This will be hard to manage through the sales process as you may not be able to answer all their questions with certainty and staff may consider leaving. Telling your staff once the transaction is more or less certain at exchange will reduce anxiety and not subject them to a prolonged (and potentially unnecessary) period of stress. Additionally it is easier to assist staff at this stage as you will be able to answer more of their questions and can involve the buyer at this stage to alleviate their fears and concerns.

Enforceability

Legal enforceability of a *Heads of Terms* agreement is a hotly disputed topic in legal circles. The basic principle is that it is merely an 'agreement to agree' and so not a legally enforceable contract, however particular clauses within it are sometimes legally enforceable. Essentially those clauses which are specific and do not relate to something to be agreed later are likely to be binding on you. For example, in the *Heads of Terms* agreement you will be agreeing to agree that the price is a set amount, this is a precise term but final agreement on price will take place in the full contract so this specific term is unlikely to be binding; and the price will become negotiable as the due diligence process unearths new factors to consider. However the confidentiality clause is likely to be legally binding because you are agreeing to keep the discussions confidential for the duration of the transaction. This is something that has immediate effect – you are not agreeing to keep them confidential at a later date.

Nevertheless, always be careful about the *Heads of Terms* that you agree and consider whether you are prepared to be bound by the terms if they were found to be legally enforceable.

Usefulness

Having a *Heads of Terms* document allows you to set out immediately the parameters of the transaction. This provides clarity to both the seller and buyer and helps to guide your legal representatives (often reducing costs for drawing up the full sales contract). Getting the broad details down and managing everyone's expectations at this early stage should help prevent misunderstanding arising later in the process. ◆

For further information on this and other aspects of practice sales see www.bda.org/advice for BDA Advice Buying and selling a practice. Additionally the BDA is arranging a seminar *Selling your dental practice* in London on Friday 13 May 2016. More information can be found at www.bda.org/workshops or by contracting the BDA Events Team on 020 7563 4590.

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The gum health benefits do not stop there, thanks to the perfectly matched inclusion of sodium hexametaphosphate. This polymer protects against calculus formation, as well as staining, thereby reducing a further cause of plaque retention on the roughened surface of the calculus. The combined force of these two plaque reducing agents, help protect against gum problems.

All toothpastes are not the same. Whilst the inclusion of fluoride is a taken, to afford maximum protection, a formulation must contain other proven ingredients that work in harmony together to promote good oral health.

1. Mankodi S, Bartizek R D, Winston J L, Biesbrock A R, McClanahan S F, He T. Anti-gingivitis efficacy of a stabilised 0.454% stannous fluoride/sodium hexametaphosphate dentifrice. *J Clin Periodontol* 2005; **32:** 75-80.

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Introdent have introduced an inexpensive and easy upgrade for your Piezzo scaler. A free standing fluid reservoir that allows you to switch from water, to your choice of hypochlorite or chlorhexidine – for example – quickly and simply.

Until now, if you used a Piezzo scaler, you either had to have it plumbed in to your water line or have one with an integral water supply.

Having a free standing water supply allows you to switch between irrigants according to the task. For example water might be most suitable for a simple scale and polish, whereas for a deep scale or root planning Chlorhexidine could be used.

During endodontic treatment, switching the scaler's connection from your water line, to a free standing unit containing hypochlorite, using it with Piezzo type Endo Instruments, would be most useful for disinfecting root canals. Thereby penetrating the dentinal tubules actively killing pathogens and removing the smear layer.

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Dr. Oliver Bowyer BDS MFDS RCS(Eng) MSc MOrth RCS (Eng) FDS RCS (Eng)
Consultant Orthodontist. Specialist in Conventional and Aesthetic Orthodontics including aligners and lingual appliances.

Dr.Jeremy Edmondson BDS MSc(Endo) MFGDP(UK) MGDS RCSI
Endodontics (primary and re-treatments). Removal of fractured files, posts and perforation repairs. Surgical Endodontics. Endodontic Trauma Management. Internal Bleaching.

Dr.Richard Gatenby BDS MFGDP(UK) FFGDP(UK) Dip Imp Dent RCS(Eng) Dip LM RCS(Eng)
Implant placement, autogenous bone grafts and sinus lifts.

Mr.Ahmed Messahel BDS FDSRCS(Eng) MB ChB MRCS(Eng) PGA Med Ed. PGA MLiP FRCS(Eng) OMFS.
Consultant Oral & Maxillofacial surgeon. Specialist in Oral surgery.

Dr.James A Russell BDS
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261047

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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

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www.parkroaddentalpractice.co.uk

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

South East

TOOTHBEARY RICHMOND
www.toothbeary.co.uk

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

258051

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

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

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

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

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

263521

DENTAL SPECIALISTS MK
www.dentalspecialistmk.com

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

209440

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

239826

AYUB ENDODONTICS
www.ayub-endo.com

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

270171

WOODBOROUGH HOUSE DENTAL PRACTICE
www.woodboroughhouse.com

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

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

266913

North West

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

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

261006

North

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

261782

East Anglia

DEVONSHIRE HOUSE
www.devonshirehousedental.co.uk

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

Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

269120

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

237823

Scotland

Business skills CPD

Q1: Which body issued a statement on the 2015 pay award?

A The General Dental Practice Committee (GDPC)

B The General Dental Council (GDC)

C The Doctors and Dentists Review Body (DDRB)

D The British Dental Association (BDA)

Q2: Which of the following is NOT one of the ways to minimise bad debts?

A Informing patients that you will ask them for payment at the end of their treatment

B Providing information about payment systems

C Asking patients for permission to link their bank accounts to debt collection agencies

D Telling patients as soon as possible about the cost of their treatment

Q3: In which country does a Criminal record check have a fixed expiry date?

A Scotland

B Wales

C England

D Northern Ireland

Q4: Complete this statement: A *Heads of Terms* agreement:

A Should be the first document a buyer and seller enter into together

B Contains a confidentiality clause as one of the most important clauses

C Is basically an 'agreement to agree'

D All of the above

Q5: What does the 'R' in SMART stand for?

A Robust

B Realistic

C Ridiculous

D Reliable

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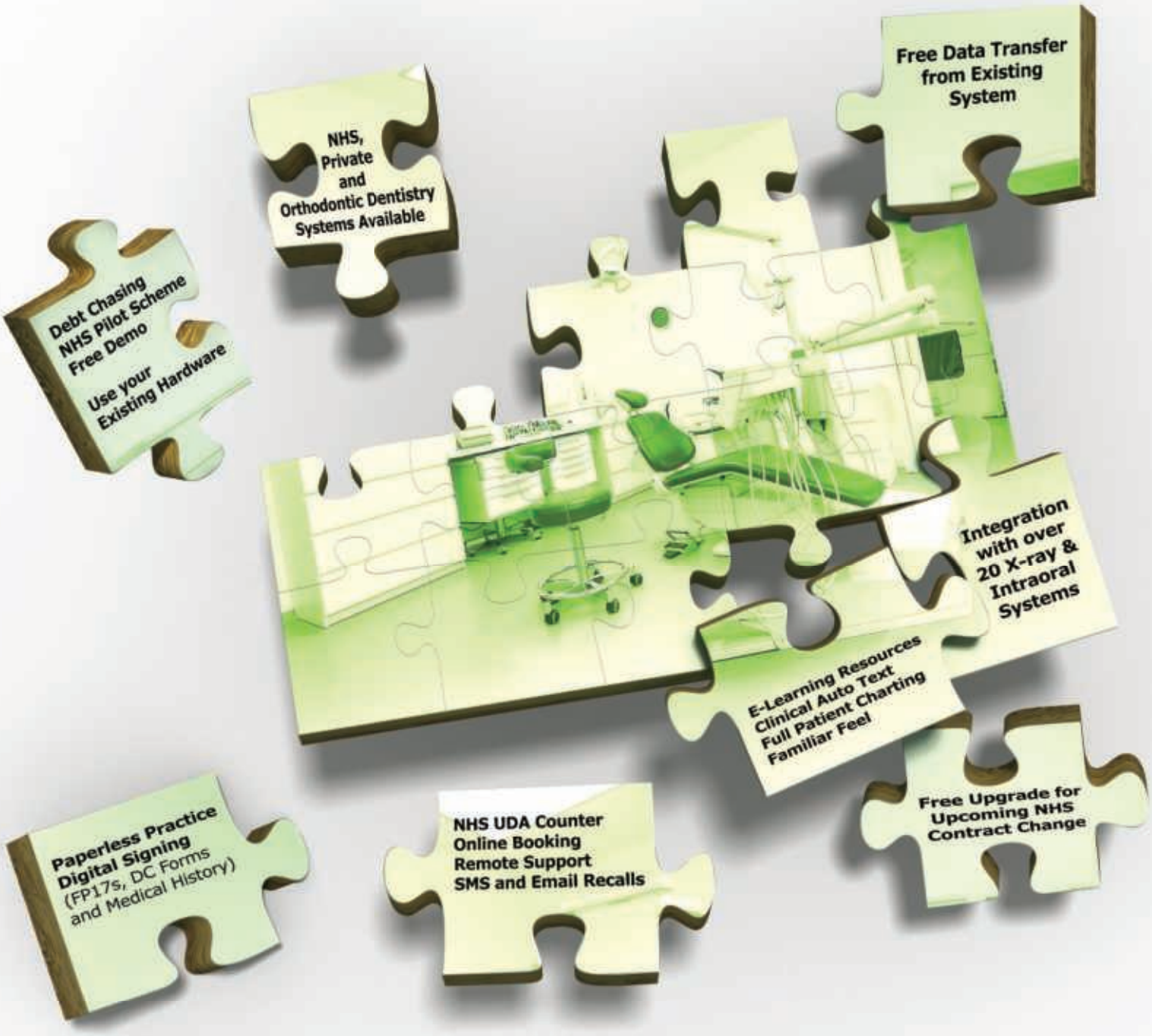

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