BDJ In Practice
February 2015

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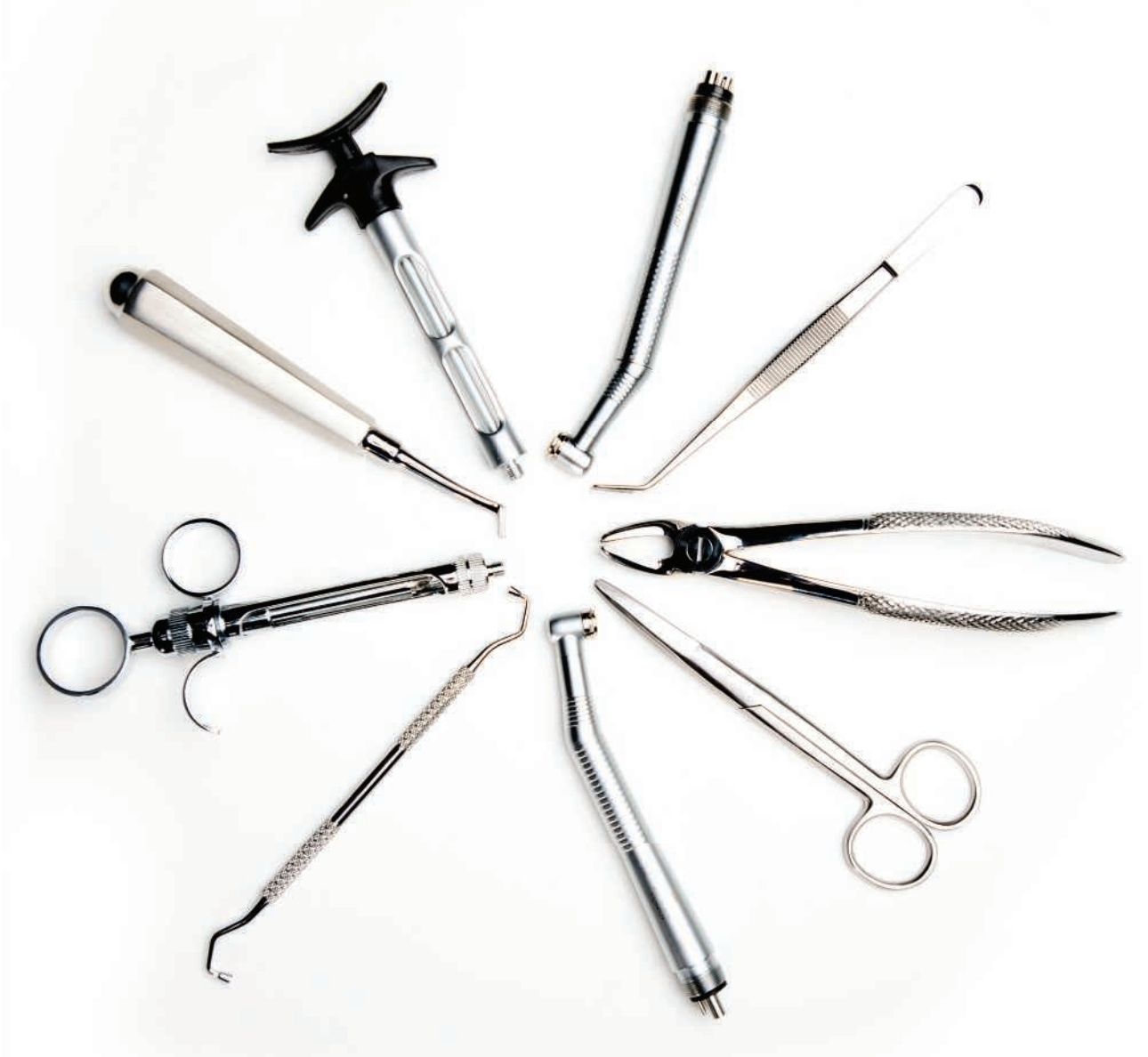

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Report anything suspect now to www.bdia.org.uk/device-reporting

BDIA CSIDI
COUNTERFEIT AND SUBSTANDARD
INSTRUMENTS AND DEVICES INITIATIVE

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

Image of counterfeit products confiscated by the MHRA.

BDJ InPractice

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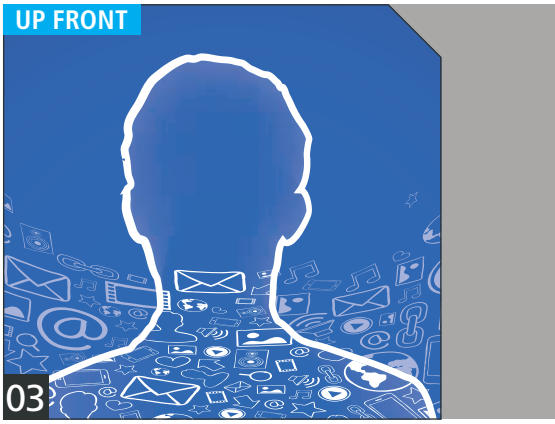

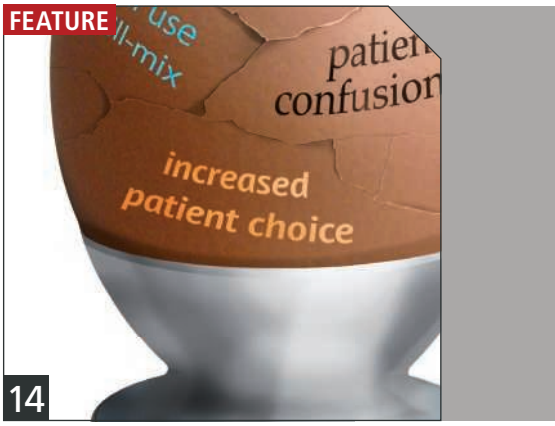

BDA

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Over half of small firms without flood plan

RESEARCH HAS FOUND that three out of five (59%) small business do not have a plan in place to deal with extreme weather conditions such as floods and snow storms.

This finding by the Federation of Small Businesses (FSB) comes despite the news that two-thirds (66%) of small businesses have suffered because of flooding, drought or snow over the past three years.

It also found that 59% of small businesses have no resilience plans to combat extreme weather and 29% do not have insurance for business interruption (loss of income, costs incurred) or damage caused to property by flooding.

National policy chairman for the Federation of Small Businesses Mike Cherry said: "Last year was the wettest winter on record and 3200 commercial properties were flooded in the UK. With such extreme weather events on the increase, small businesses need all the help they can get to make sure they can stay open whatever the weather.

"We remain concerned that small businesses will not be included in the Government's *Flood Re* agreement, designed to limit insurance costs for those at most risk of flooding. Firms need to be reassured that affordable flood insurance will be available in the future. Currently, three in 10 (29%) do not have the right cover in place.

"The Environment Agency has produced advice for businesses on how to make a flood plan and we want to make sure businesses are getting all the information, finance and support they need to deal with extreme weather."

Damage caused by last year's floods cost firms in affected areas an average of £1531. By protecting against such disruption, small firms can continue operating and avoid financial difficulties.

> "Of those businesses affected by extreme weather, the biggest problems reported, were disruption to staff and customers (46%) and disruption to suppliers, utilities and transport arrangements (32%)."

Of those businesses affected by extreme weather, the biggest problems reported, were disruption to staff and customers (46%) and disruption to suppliers, utilities and transport arrangements (32%).

The FSB is calling on more businesses to have an extreme-weather plan. Examples of extreme weather plans and a comprehensive guide to putting one in place can be found on the Environment Agency website (www.gov.uk/government/organisations/environment-agency).

"Small businesses need to get better prepared for extreme weather. However, we know that despite wind, water or fire, many small businesses do manage to stay open and continue to serve their customers. When disasters hit we would encourage people to continue to support their local businesses, many of which stay open whatever the weather," Mike Cherry concluded. ◆

Pitfalls of using social media to recruit

NEARLY THREE-QUARTERS of companies have successfully used social media to recruit new employees, according to a recent survey.

The research, from Flo Software Solutions, found that 73% of businesses questioned had used social-media platforms to attract new employees, finding it an "indispensable tool" for recruitment.

But, according to Acas, there are a few pointers that employers should bear in mind when using social-media channels to recruit new staff.

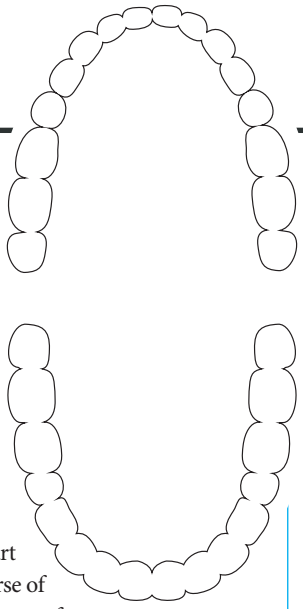
It is best to use at least one other channel to publicise vacancies. If an employer only targets people who are similar it may be accused of discriminating against people from other social groups.

Not everyone uses social media. While at least 80% of Britons use the Internet, only around one-half of them use social media. Employers should, therefore, think about how to reach people who are not on social media and if it is fair to use this exclusively to find candidates.

Screening applicants through their social-media profiles can be very informative. But employers should be aware that deciding not to interview or employ someone because of a "protected characteristic" under the *Equality Act 2010* (age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity) that they see on a social-media profile could be unlawful. ◆

MOUTH EXAMS

Keep recording mouth exams



NHS DENTISTS IN England and Wales should continue to carry out and record a full-mouth exam for banded courses of treatment despite a recent court ruling.

The Court of Appeal judgment in the case of *Powys Teaching Local Health Board vs Piotr Dusza and Hako Sobhani* does not remove the obligation to do such an examination and when done this should still be recorded in accordance with record-keeping obligations.

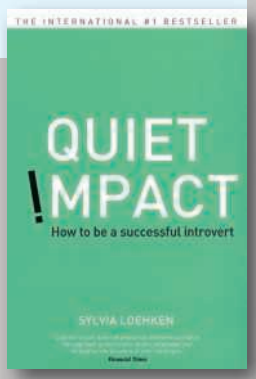
The case merely confirmed that, where a full-mouth exam has been carried out on a NHS patient, the inclusion of this in the clinical record is not a "precondition to payment" and that "Records are at most evidence of work done; payment is made in respect of work done not for keeping records of work done." Nevertheless, failure to meet the contractual obligation to record examinations could still attract other sanctions.

Where a full examination has not been carried out as part of a banded course of treatment, the Court of Appeal concluded that: "There is nothing in the wording … which deprives the dentist of all entitlement to payment." The consequence of not carrying out a full-mouth examination will: "Simply be that there will be a *pro rata* deduction in his entitlement to payment." No information was provided by the Court, however, on how any such "*pro rata* reduction" should be calculated. ◆

BOOK REVIEW

Introverts make good leaders

Quiet impact – how to be a successful introvert
Sylvia Loehken
John Murray Learning, 2014
ISBN: 978-1-444-79285-0
£11.99



Author of this 200-page paperback Sylvia Loehken is a self-confessed introvert, writes BDA librarian **Roger Farbey**. She begins by inviting the reader to determine, by a series of quiz questions, whether they are an extrovert or an introvert. The result can be surprising and she even names some eminent introverts by way of reassurance. Among these are Woody Allen, Bob Dylan, Charles Darwin, and even President Barack Obama.

There are clearly obstacles to life in being an introvert, such as fear, passivity and self-deception (eg, repressing one's introvert characteristics). But there are also strengths: introverts tend to be cautious, are able to concentrate well, appear (outwardly) calm and are far better at listening than are extroverts.

And she says, despite the assumption that introverts (or "quiet people") are not good at working within teams, this is not the case. Some projects, Loehken contends, would actually fail without introverts. Introverts also make good leaders owing to their calm personas and ability to empathise more readily.

Ideas for helping introverts succeed in the workplace include using the phone rather than email but making notes beforehand, even to the extent of composing an opening gambit.

The final section of the book tackles the more public side of dealing with introversion. Cultivating contacts by means of networking can provide strength by gaining help from a group and are often mutually beneficial. There are thoughts on public speaking – and again, preparation is everything. She suggests using a structure sheet (introduction, central section and conclusion) an example of which is provided as is an analysis of the causes of "stage fright" and how to overcome it. For more about this book: www.bda.org/booknews

NHS needs to become **mobile savvy**

HOSPITALS ARE FAILING to keep pace with the increasingly mobile-savvy patients they serve, according to research.

The study, conducted by digital healthcare agency Integrated Change, sent *Freedom of Information Requests* to a number of NHS trusts. It found that, despite a 118% increase in mobile visits to hospital websites, just 43% of these websites are optimised for mobile. This means that less than one-half of NHS hospitals present their content in a way that smartphone users can navigate and access clearly and easily.

"It's apparent that patients are incredibly receptive to mobile technology," Integrated Change founder and development director Scott Hague said.

"And the NHS has some brilliant web resources for users and plenty of content for those looking for accurate healthcare information.

"The sheer volume and quality of what's available freely to users is certainly something to boast about.

"However, what the NHS is failing to do is to ensure that this wealth of information is available to users in a format that reflects how they're trying to access it. You could go as far as to say that failing to mobile optimise this content means the investment in maintaining it is wasted for a huge proportion of users."

The study also assessed the mobile apps being made available to patients and users by 159 NHS trusts and found just 15% of trusts had invested in mobile apps.

For the full study go to: https://www.integratedchange.net/wp-content/uploads/2014/12/Mobile-Healthcare-White-Paper.pdf ◆

GDC ACCOUNTABILITY

Scrutiny of GDC by Health Committee applauded

THE BRITISH DENTAL ASSOCIATION (BDA) has welcomed news that the General Dental Council (GDC) is to be the subject of a Health Select Committee accountability hearing on 3 March 2015.

Professional regulators, including the General Medical Council and Nursing and Midwifery Council, have been subject to regular accountability hearings since 2010. But the GDC has thus far avoided a formal hearing despite being repeatedly taken to task by the Professional Standards Authority.

The BDA wrote to health ministers and the Health Select Committee after the regulator was found to have acted unlawfully in the High Court in its consultation on the setting of professional fees.

Chair of the BDA's Principal Executive Committee Mick Armstrong said: "We've told MPs and ministers that patients and practitioners are best served by a regulator that is subject to real scrutiny. So we are delighted that the Health Select Committee has decided to call its first accountability hearing on the General Dental Council.

"For far too long our regulator has appeared to have been operating in a consequence-free environment. And, as a result, we have not seen the efficient and effective regulation our profession deserves. From 18-month fitness-to-practise cases to unlawful consultations, it's finally time to look at the impact of the GDC's decision-making in the cold light of day.

"Westminster is waking up to the fact that Britain's most expensive healthcare regulator is also the least efficient, most troubled and enjoys little confidence among the profession and the PSA. Politicians need to act, and holding the GDC to account is an essential first step." ◆

©Derek Bacon

BDA PEC

PEC-election results

THE FOLLOWING CANDIDATES have been elected to the British Dental Association (BDA) Principal Executive Committee (PEC).

Newly elected are: Eastern Constituency– Jason Stokes (see also page 9); and UK-wide – Len D'Cruz. Re-elected are N West – Stephen Shimberg; Wales – Tim Harker; and West Midlands – Eddie Crouch.

BDA members had to pick from 50 candidates drawn from the whole spectrum of the dental profession. The unprecedented interest in the election saw 44 members contest the UK-wide seat.

And Mick Armstrong has been re-elected, unopposed, as PEC chair. He has been a member of the PEC since its inception in July 2012 and was first elected chair in March 2014.

During his term as chair he has seen major campaign wins over dental foundation training (DFT) pay cuts and defeat for the General Dental Council in the recent judicial review.

"I am privileged to have been re-elected as chair of the Principal Executive Committee," Mick said.

"This last year has seen our profession take a stand. We've united to defend the pay and conditions of the next generation of dentists. We proved that our inefficient and ineffective regulator acted unlawfully. In 2015 I know we must do more.

"I set out to serve this profession and show that together we can make a difference. And that work goes on. My thanks go out to every BDA member whose support has made this possible and to staff and my fellow PEC members for their unrelenting commitment.

"We have shown our mettle, our resolve, and our expertise. We will need more of the same if we are to build a better future for our profession." ◆

NEW CQC ADVISOR

John Milne to take on CQC role

PRACTISING-DENTIST John Milne has been appointed the National Professional Dental Advisor with the Care Quality Commission (CQC).

He will take on the role in March this year, after his role as chair of the BDA's General Dental Practice Committee comes to an end.

John will be working closely with CQC's primary medical services' senior management team and inspectors and with dental providers and stakeholders to help develop the CQC's new model. He will also work with its inspection teams to give expert advice on best practice in dental care.

"I'm extremely happy to take on this new role with the CQC," John Milne (**left**) said.

"I think it's an exciting time in the development of the regulation of dental services, and it's vital we get it right.

"We need to ensure we listen to the voice of dentists and understand the considerable pressure and challenges they face on a day-to-day basis, balanced with the need to ensure patients receive the quality care we all agree they should expect to receive."

CQC deputy chief inspector of primary medical services and integrated care Janet Williamson said: "John brings with him a wealth of experience. His expertise and insight into what quality care looks like and his ability to challenge us on the implications of regulation will be invaluable."

"I am thrilled that John is joining us. He has a vast understanding of dentistry and will a tremendous addition to our team," chief inspector of primary medical services and integrated care Professor Steve Field added.

Welcoming the news, chair of the BDA's Principal Executive Committee Mick Armstrong said: "In the past, hands-on knowledge of our profession has been missing from the CQC inspection processes, and it has shown.

"John Milne's appointment as National Professional Dental Advisor is therefore welcome news and another step in the right direction. Dentists have a track record for delivering high-quality care, and it will require real insight to target the time, money and effort to where it is most needed.

"In an ever-more challenging regulatory environment, the CQC needs to engage with dentists and understand the demands placed upon us. With long experience on the front line of NHS practice and representing the profession, John is uniquely qualified to do just that." ◆

Proposals need **evidencing**

ANY FUNDAMENTAL CHANGES to secondary-care contracts for consultants and dentists in training must be underpinned by appropriate evidence, the Review Body on Doctors' and Dentists' Remuneration (DDRB) has been told.

Contract negotiations between the British Medical Association (BMA) and the Department of Health (DH) stalled last year because of concerns about the lack of evidence to support the proposals being put forward by the DH. The Government has extended the remit of the DDRB to look at contract reform, which the British Dental Association (BDA) finds concerning.

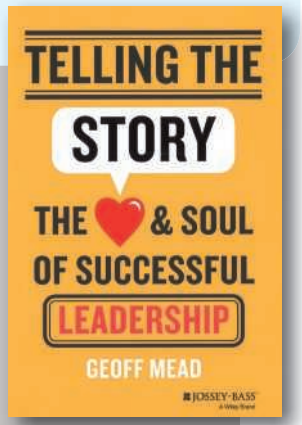
The BDA has submitted evidence directly to the DDRB on behalf of secondary-care dentists because of the impact the suggested changes may have on NHS sustainability and patient safety, as well as on dentists' welfare.

It has highlighted a number of concerns about the proposals to introduce seven-day working and to make changes to terms and conditions for secondary-care consultants and has stressed the need for contractual safeguards to ensure that patient safety is protected. And it has also raised concern about proposals in the junior contract negotiations for dental trainees surrounding location and travel, quality assurance, pay progression and entry requirements for working in hospital trusts. ◆

BOOK REVIEW

Leaders tell stories

Telling the story - the heart and soul of successful leadership
Geoff Mead
Jossey-Bass, 2014
978-1-118-61716-8
£24.99



Storytelling is one of the oldest art forms in any society. Stories are usually fictional, sometimes accompanied by a moral message, but there are also those used to communicate how we fail or succeed in life, writes BDA librarian **Roger Farbey**.

Geoff Mead, founder of Narrative Leadership Associates, says that it's pretty much impossible to claim leadership unless you make yourself available to people so they can *connect* to you about something that is real. The use of the story is its paradoxical quality of being both "a story" while – within the workplace – acting as a vehicle to make things real. Such stories are concrete and grounded and not, as is the common assumption, just "made-up" to make a point. Listening (carefully) is also important because, he says, you're not actually listening to someone unless you're willing to be changed by what you hear.

Stories connect us

Mead also talks about praxis, where ideas and actions meet. Over the course of three chapters he expands the narrative-leadership theory into an existential argument about what we are here for. These chapters are: *Know thyself and know thy story* (how can you claim to do anything in the world if you don't know who you are); *Only connect* (because stories connect us); and, finally, *Stand for something* (if you don't stand for something you'll fall for anything).

For more about this book: www.bda.org/booknews

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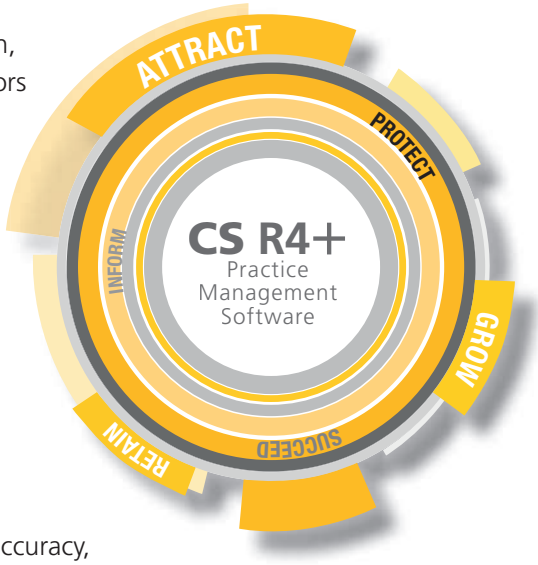

Confirmation: identify any unconfirmed appointments and contact the patients to avoid FTAs
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LDC 2015

Influence LDC Conference 2015

ALL DENTISTS ARE being urged to help draft motions for this year's Local Dental Committee (LDC) Conference.

To do so, they should get in touch with their LDC secretary. Contact information for LDCs is available from Alexandra Cenic at Alexandra.cenic@bda.org

The deadline for motions is 12 noon on Monday 6 April but it would be helpful to have them as early as possible.

It will be held at The Grand Connaught Rooms, London, on Friday 12 June.

The annual LDC Conference is the chance for LDCs and the General Dental Practice Committee (GDPC) to debate the issues confronting general dental practice and to contribute to policy creation for the GDPC and the British Dental Association to work on throughout the following year.

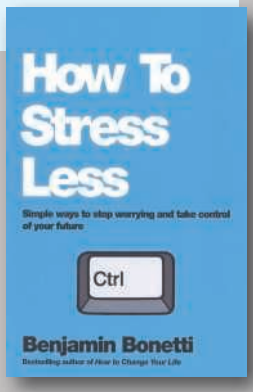
"Funding cuts, contract changes, the organisational changes in the NHS, increasing regulation. The list of issues faced by general dental practitioners doesn't get any shorter and the role of LDCs in supporting and representing practitioners becomes ever more complicated," chair of the Conference Agenda Committee Jonathan Randall said.

At the 2014 LDC Conference in Manchester, a motion was passed agreeing to a yearly award from the Conference to "unsung" heroes of the LDC world who have voluntarily served their LDC. The first awards will be made this year. Information about the nomination and judging process can be found at www.ldcuk.org/awards The closing date for nominations is 28 February. ◆

BOOK REVIEW

Play games to ward off stress

How to stress less – simple ways to stop worrying and take control of your future
Benjamin Bonetti
Capstone, 2014
ISBN: 978-0-85708-468-2
£10.99



Stress is *not* all in the mind – or at least the causes of stress are not all psychologically determined.

Dealing with stress can be tackled in a variety of ways (there is no silver bullet), even "faking it", where you change non-verbal cues to create a positive outlook on life. This, in turn, generates a release of "feel-good" hormones. This form of positive thinking is something athletes have been using for years, writes BDA librarian **Roger Farbey**.

So, what else can be done to overcome stress apart from "faking it"? Challenging your mind at least twice a day by playing games with mind-games apps or books is one way. Or learning six new words in a foreign language each day.

Bonetti is also keen to stress (no pun intended) the importance of physical exercise, which he sees as crucial. He maintains that it's important to adopt a no-nonsense approach to exercise and that "reasons" for not exercising are nothing more than excuses. He quotes Edward Stanley, Earl of Derby, (1826-1893) who said: "Those who think they have not time for bodily exercise will sooner or later have to find time for illness."

Finally, he discusses the importance of the correct nutrition, which includes the right vitamins and minerals and he espouses the benefits of fruit smoothies. He also cautions against "mood foods" or "comfort foods" such as sugary treats, caffeine, alcohol and, in the case of smokers, nicotine. He also warns of the dangers of junk foods, which he says should be avoided at all costs because they "provide nothing more than empty calories…and lead to symptoms of anxiety, irritability and depression."

For more about this book: www.bda.org/booknews

Bupa focuses on convenience for patients

HEALTHCARE-GROUP BUPA has launched a scheme to help dental-insurance customers find dental practices close to their home or work.

Called Bupa Dental Plus Network, it will be formed of Bupa's dental centres and partner dental centres. By next month, the network is expected to encompass 200 practices across the UK.

The launch comes as nearly one-quarter (24%) of respondents in a Bupa survey said they would visit the dentist more often if their dental clinic was in a more convenient location and it was easier to get an appointment at a time to fit around work.

Corporate director at Bupa Patrick Watt said: "We know how important it is for businesses to offer their employees access to high-quality healthcare, including good-value dental care, provided by dentists they can trust. That's why we've established our new dental network – to give employers confidence that the dental care that their employees receive is high quality and trusted by us."

Bupa plans to own 50 dental centres by the end of 2015. ◆

Prototypes guidance

INFORMATION FOR PRACTICES who might be considering taking part in the prototype process as the next stage in the reform of NHS dentistry has been developed by the British Dental Association (BDA).

This includes a video and a blog post by General Dental Practice Committee (GDPC) chair John Milne, which outlines what practices need to think about when deciding whether or not to participate.

Following the learning from the pilot schemes, the prototypes will trial a new system in selected dental practices.

The DH has also published detailed findings on the dental contract reform engagement exercise, to which the BDA submitted evidence. ◆

From GDC to BDA

Jason Stokes tells *BDJ In Practice* why he moved on from the GDC

Absolutely not!" Jason Stokes (**right**) is abundantly clear that his move from the council of the profession's regulator to its trade union and professional body is not a case of "gamekeeper turned poacher".

The Norfolk-based practitioner announced his resignation as one of the six registrant members of the General Dental Council (GDC) in October 2014. A little over a month later, he won election to the BDA's Principal Executive Committee, representing Eastern Region.

The former fitness-to-practise (FTP) panellist joined the regulator's Council in 2013, with the scene already set for the annual retention fee (ARF) hike.

"By the time I arrived too many decisions had been made that destroyed the prospect of a reasonable reception to any ARF increase," he says.

Increases in patient complaints had placed strain upon of the finances and business model of the organisation. So could that car-crash consultation have been avoided?

Jason points to the failure to embrace radical thinking.

"There was little drive at the time to prevent complaints from occurring," he told *BDJ In Practice*.

"A regulator that only deals with complaints once they arrive is failing to protect the public fully."

Opportunities to share good practice and educate registrants were not explored. And the chance to prevent the harm that befalls both patients and practitioners from FTP hearings were missed, he says.

"I personally feel that radical change in the structure and processes of the GDC are required. This is the key to more effective outcomes for patients and the profession."

What then of the small steps to boost efficiency? In Jason's view the regulator had been too timid in its calls on government for *Section 60* orders to streamline its working processes. And that "deference" has disguised the absolute urgency of reforms that could have made a real difference.

Jason has enormous respect for many of his former fellow council members, even those with whom he strongly disagreed. And he takes personal responsibility for not winning the argument for big-bang reform.

"I failed to make my case to my fellow Council members," he says. He talks of his "naiveté" about the state of the GDC's organisation and finances when he stepped up, seeking change.

"I felt it was best to resign and attempt other ways to secure the change that I believe is the key to proportionate, efficient and effective future regulation."

Since his departure, the GDC duly voted on the ARF rise, and its consultation was found to be unlawful in the High Court. But the regulator has been able to escape refunding the increase in fees to registrants.

> "There was little drive to prevent complaints from occurring. A regulator that only deals with complaints once they arrive is failing to protect the public fully."

Jason describes the judicial review as an undeniable victory for the profession, but it's the next steps that are vitally important.

"Hopefully the BDA success will encourage the GDC to consider a radically different strategy," he says. "This is a chance for the regulator to make the break from business as usual."

An NHS-contract holder, running a mixed practice, he has worked at the coal face and in the lecture theatre, as well as operating out of two addresses on London's Wimpole Street. And in his roles in education and regulation has seen the best, and sometimes the worst, that the profession is capable of.

He doesn't believe that any of the healthcare professions, or their regulators, has really got to grips with what's driving the increase in patient complaints.

"If we are to try and prevent complaints from occurring, which should be the goal of a caring profession and an effective regulator, we need a sophisticated understanding of the causes of complaints," he says.

"Currently I don't think the profession has access to this information. If we do not understand a problem we cannot fix it."

Complaints, he says, are always real to the patient, and the time it takes to achieve resolution is the biggest barrier. He's clear that no matter what the facts are the patient's perceptions should be understood and empathised with.

Effective and efficient regulation is the goal. But, as Jason reminds us, "safe patients" and a "strong profession" are in no way mutually exclusive. Forget "gamekeepers and poachers": this was never a "zero sum game."

"I joined the GDC with a keen urge to help patients. A profession that respects and protects its patients will be the most successful in the future.

"The GDC has a primary duty to protect the public. The GDC has never worked for the profession. However, it should work with the profession," he says.

Following the judicial review, the BDA's new PEC member is unclear if bridges can be built with an "unchanged GDC", but we have to continue doing what's best for both patients and practitioners, he concluded. ◆

Rules for *Shared* Parental Leave

By Alan Pitcaithley, a 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 NHS regulations in Scotland and Northern Ireland

Parents will shortly be legally entitled to share statutory leave following the birth or adoption of a child. This "shared parental leave" will apply to eligible parents of babies due, or children placed for adoption, on or after 5 April 2015. It allows employees to break their absence from work into separate blocks and to share some of the leave with their spouse or partner. Potentially, eligible parents, in the first year of a child's birth or adoption, will be able to dip in and out of their job, taking time off to provide care for the child.

Sharing

The idea is to allow greater flexibility for new parents in setting their work-life balances in their child's first year.

This will have an impact on employers and there are, therefore, precise procedures to be followed.

The mother would normally be able to take up to 52 weeks' maternity leave. Shared parental leave allows a mother to turn her maternity leave into shared parental leave. The actual amount of shared parental leave available depends on how much maternity leave is taken.

Since a mother must take at least two weeks' compulsory maternity leave following the birth of their child, there could be up to 50 weeks of shared parental leave available. Any week or weeks of maternity leave taken by the mother before the birth of the child or after the two weeks of compulsory maternity leave reduces the shared parental leave available by a corresponding amount. The remaining amount of shared parental leave can be used by either the mother or her spouse or partner to take time off work to look after the child.

It is the mother's initial choice whether or not to opt for shared parental leave, but once that choice has been made the couple must agree when they should take leave. They may choose to take time off at the same time, consecutively or alternately. Whatever their decision, shared parental leave must be taken by the child's first birthday – any unused leave at that date would be lost.

> "The idea is to allow greater flexibility for new parents in setting their work-life balances in their child's first year."

Written notice

To use these rights, eligible parents (**right, top**) must give their employer proper written notice: in fact, three different notices.

First, the mother must give notice to end her maternity leave and change over to shared parental leave. Second, both parents must give their employers a *notice of entitlement* letter that sets out their basic eligibility (**right, bottom**). Finally, each must provide a *notice of leave* letter that specifies the actual dates that the employee wishes to take as shared parental leave. It should include the start date, end date and overall amount of leave to be taken, which must be in full weeks. Each notification fulfils a specific purpose but the employee could combine them all into one letter.

Time-limits are important. Eight weeks' notice must be given, both by the mother to switch over from maternity leave and by either parent before the start of a period of shared parental leave.

Continuity

A major change introduced by shared parental leave is the facility to divide leave into separate blocks, where a parent can return to work between blocks and go back on leave later on. Each block must, however, be made up of full weeks. This could cause difficulties for an employer, so how a practice responds to a *notice of leave* letter will depend on if the employee is asking for a continuous period of leave or a series of separate blocks.

If a continuous period of shared parental leave is requested, this request must be agreed. But if the employee asks for two or more separate blocks of leave – which would be interspersed by periods back in work – this is subject to the approval of the employer.

If you have an objective business or operational reason to refuse a request for leave to be taken in blocks you can. But you must respond in writing, setting out your reason within two weeks. In this situation, the employee's overall amount of requested leave defaults to a single period of leave to begin on the original start date for their intended first block of leave. You should ensure that your employee understands these default provisions because they can change the start date by amending their notice of leave or could withdraw their request altogether.

Being able to refuse a request for shared parental leave to be taken in separate blocks would seem to negate the employee's new right but an employee can submit three separate notice of leave letters within the

year. If each one asks for a continuous block of leave then, as currently understood, each of these three blocks of leave would have to be agreed. But this provision has given rise to the misconception that shared parental leave can only be taken in three distinct blocks. While this is the default situation where an employee gives you three separate *notice of leave* letters, they could in any of these requests ask for their leave to be split into many more parts. It is therefore theoretically possible that an employee could take 25 blocks of shared parental leave, working one week on and one week off up to the child's first birthday. This pattern of shared parental leave would require an employer's agreement but in some job roles could occur under the new arrangements.

Shared Parental Pay

Most mothers taking maternity leave will be entitled to Statutory Maternity Pay (SMP), which is available for up to 39 weeks. If an employee opts into shared parental leave then the Statutory Maternity Pay remaining becomes available as Shared Parental Pay (ShPP). This can be claimed by either partner while on shared parental leave. The eligibility for each partner is based on the same earnings criteria for Statutory Maternity Pay and Statutory Paternity Pay.

If both parents qualify for ShPP, they must decide who will receive it or how it will be divided. Each must inform their respective employers of how much ShPP each parent intends to take and when they expect to take ShPP. They must also include a declaration from the employee's partner confirming their agreement to the employee claiming their amount of ShPP. It is expected that this notice would be given at the same time as a *notice of leave* letter.

Another way to SPLIT it

The concept of Keeping-in-Touch (KIT) days that apply to maternity leave has been extended to shared parental leave. This allows an employee to attend work during a period of leave for training purposes or just to stay up to date with what is happening in their workplace.

Under shared parental leave these are known as Shared-Parental-Leave-In-Touch (SPLIT) days; and up to 20 SPLIT days are available overall to be shared by the parents. The employees should contact their employers to discuss the date or dates of SPLIT days that they wish to work, though there is no obligation on either party to agree to a specific date.

Sharing adoption leave

The right to opt into shared parental leave also applies to employees who are on adoption leave. From the end of a compulsory period of adoption leave, that is two weeks after the placement of the child, the adopter can opt into shared parental leave and share some of this with their partner or co-adopter. The same rules and procedures apply to giving notice, taking leave and claiming ShPP.

More details

Shared parental leave is new system and exactly how it will work for businesses, employers and employees remains to be seen. BDA Advice *Employees maternity and parental leave and pay* (see www.bda.org/advice) provides further information. ◆

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Who can share the leave?

A mother must:

- be an employee entitled to maternity leave or self-employed and entitled to maternity allowance; and
- have given notice to end her maternity leave and take shared parental leave.

A partner must:

- be the mother's spouse, civil partner or partner (who is a person in a long-term relationship with the mother and living with the mother and child), or the child's biological father (even if they are not in a stable relationship with the mother);
- share the primary parental responsibility for the child with the mother at the time of the birth; and
- be an employee, who is entitled to paternity leave.

A *notice of entitlement* letter must include the following

- The date that the child is expected or their actual date of birth
- The spouse's or partner's name
- The spouse's or partner's address and National Insurance number
- Confirmation that the spouse or partner shares childcare responsibility
- The amount of shared parental leave available overall for both parents
- The dates of any maternity leave that will be, or has been, taken
- The amount of shared parental leave that the employee intends to take
- The amount of shared parental leave their spouse or partner intends to take
- A personal declaration that the employee meets the eligibility criteria for shared parental leave and that all the information provided is accurate
- A signed declaration from the employee's spouse or partner that they meet the eligibility criteria for shared parental leave

Dealing with **suspected child abuse**

by Claire Bennett,

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

Direct and routine access to children and their families through the provision of dental services means dentists and the dental team can play a key role in child protection.

Responsibility for the welfare and safety of children is shared by the whole of society. Dentists and the dental team, however, have additional obligations to find out about and follow local procedures for child protection and to share any concerns they have about the safety of a child under their care with the appropriate agencies.

There is also a responsibility to ensure that a child is not at risk from other members of the profession.

To meet these responsibilities, you must ensure that you and your team can identify, assess and manage signs of abuse and neglect in vulnerable patients, particularly children.

It is important to know what you are looking out for. The NSPCC describes child abuse as: "Any action by another person – adult or child – that causes significant harm to a child. It can be physical, sexual or emotional, but just as often can be about a lack of love, care and attention." So, bear in mind the definitions of each type of abuse (see **right**).

Look for these signs

Signs and symptoms of abuse will not always be obvious and it is important to understand that it is not your responsibility to diagnose child abuse – only to share your concerns with the appropriate agencies. Children may present at the practice with all sorts of symptoms and conditions – medical and social as well as dental – which may raise suspicions. You have to decide if you have to act.

A child with physical injuries, emotional distress, behavioural problems or poor parent-child interactions may be suffering from some form of abuse. The National Institute for Health and Clinical Excellence (NICE) has published guidance for healthcare professionals, *When to suspect child maltreatment*, which gives a summary of the clinical features of maltreatment.

There may be tell-tale injuries. Signs of physical abuse could include bruising in the shape of a hand, scalding injuries or burns in the shape of a cigarette tip or an iron.

Oro-facial injuries occur in just over one-half of children diagnosed with physical abuse (52.4% according to Fonseca *et al*, *Pediatric Dentistry*, May/June 1992 **14:**3). But such injuries can arise entirely accidentally: children hurt themselves all the time through play, school fights or misadventure. So, the assessment of any physical injury involves evaluating the injury itself, its extent and any particular pattern of repeated injuries.

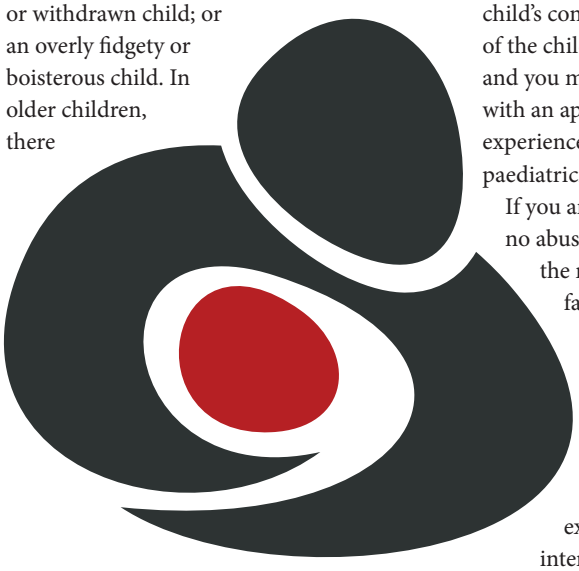
Take a history to understand how and why the injury happened and if what you see matches the explanation provided. Relate these finding to other observations: of the child's behaviour or child-parent interaction, for example.

This approach will help either to eradicate your concerns or to support them.

A two-year-old brought into clinic with trauma to their front teeth and gums might raise suspicion. But if the child's pregnant mother says the injury was caused when the toddler fell from their new bed (the child's crib being prepared for the imminent birth of the baby) when considered alongside the history and other behaviours it may be enough to satisfy you that there is no need for concern.

Emotional abuse may only be manifest through behavioural symptoms, although it can occur alongside other forms of abuse: for example, violence or neglect. Also, emotional signs may be the only signs that you see of sexual abuse.

Symptoms of emotional abuse may be apparent in child-parent interactions: for example, the parent may ignore the child, use inappropriate language in the child's presence, or have unrealistic expectations of how the child should behave when being treated. Other signs include a clinging or withdrawn child; or an overly fidgety or boisterous child. In older children, there may be signs of self-harm, substance abuse or delinquent behaviour.



When considering behavioural issues and possible abuse, compare or contrast the behaviour you see with what you might expect to see in a child who has dental anxiety or is just having a tantrum.

"Emotional abuse may only be manifest through behavioural symptoms, although it can occur alongside other forms of abuse: for example, violence or neglect. Also, emotional signs may be the only signs that you see of sexual abuse."

A neglected child may present to you with unmet dental needs and may, even, have failed to attend appointments previously. Other indicators of neglect include signs of malnourishment, soiled or inappropriate clothing for the time of year, attending for appointments unaccompanied by an adult, or not turning up to complete treatment.

But bear in mind some of these indicators may be symptoms of poverty or deprivation, not child neglect, and the family may benefit from official help. One dental practice concerned about a family with head lice realised that the mother was showing signs of not being able to cope and needed support.

Practice procedures

Seek an explanation for the presenting feature from both the parent, or carer, and the child. The child may make a direct disclosure of abuse or say something that further supports your concerns. Consider the child's comments alongside your assessment of the child and the history you have taken and you may need to discuss your concerns with an appropriate colleague: a more experienced dentist, senior dental nurse or paediatrician.

If you are satisfied that there has been no abuse or neglect you may provide the necessary dental care, supply the family with information about local support services, if appropriate, and arrange a dental follow up.

If you are still concerned, you should provide any urgent dental treatment needed. You should also talk to the child and parents to explain your position, tell them you intend referring them to local children's services and seek consent to making the referral. An exception to telling the parents you intend to refer and seeking consent is when you believe doing so may place the child at greater risk: for example, if there is an allegation of sexual abuse by a family member or organised abuse.

You must promptly contact the social services child-protection team at your local authority to report the situation. Ensure your clinical notes are detailed and accurate. You should keep a precise clinical record of exactly what you have observed and discussed. ◆

What is child abuse?

→ **Physical abuse**
– means causing physical harm to a child, which may involve hitting, shaking, throwing, poisoning, burning or scalding, drowning or suffocating. Physical harm may also be caused when a parent or carer fabricates or induces an illness (a behaviour called Münchausen's syndrome by proxy)

→ **Sexual abuse**
– involves forcing or persuading a child to take part in sexual activities. The activities may involve physical contact but also may involve non-contact activities: such as, sending sexually explicit text messages to a child. The child may, or may not, be aware of what is happening or understand it is wrong

→ **Emotional or psychological abuse**
– is the continuing emotional maltreatment or neglect of a child. Emotional abuse can involve deliberately trying to scare or humiliate a child or isolating or ignoring them

→ **Neglect**
– is a persistent failure to provide the right care and attention to a child's physical needs. This includes providing food and a safe environment; or meeting a child's emotional needs, including warmth, security and love

Direct access good in parts

by Henry Edwards, research analyst, British Dental Association

Recent research among practice owners suggests direct access is viewed as a curate's egg. The good parts are increased patient choice and a view that it would be good for patients' oral health. But these need to be weighed against concerns about missed diagnoses (especially of oral cancer) and the risk of patients being confused about the extent of care direct access can offer (see commentary **right**). And the jury is still out on its likely profitability for practices.

Restrictions on patients directly accessing treatments from therapists and hygienists were lifted by the General Dental Council (GDC) in 2013. At the moment it is only possible to work under direct access privately.

Prior to the restriction on direct access, research conducted by the BDA in 2012 showed that around two-thirds of practice owners indicated that they would object to direct access being provided at their practice (BDA 2012). In short, practice owners mostly felt that, at least at their own practice, patients should first undergo an examination by a dentist before seeing a hygienist or therapist.

In 2014 the BDA sought to build on this research and assess BDA members' experiences of direct access.

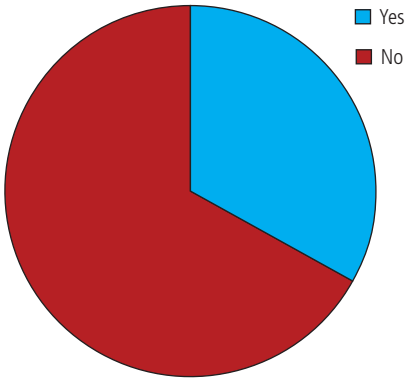
About the research

In the summer of 2014, a large-scale survey of practice owner BDA members across the UK working in general dental practice was conducted. The research aimed to: estimate the proportion of dentists providing direct access; assess the impact of direct access has on patient care; and identify difficulties in providing direct access. A total of 2283 BDA members were surveyed, with 895 valid responses. Respondents were selected across the UK and all four countries were well represented in the sample.

Research Findings

Practice owners were first asked if their patients were able to directly access treatment from a dental hygienist and/or therapist

Figure 1 Do you currently offer direct access?



without a prescription from a dentist (**above**). About one-third of practice owners said that direct access was available to their patients. Of those that did not offer direct access, almost half (48.6%) of them stated that they do not offer direct access because they do not employ either a hygienist or therapist, and a quarter (25.4%) stated that they do not agree with direct access.

Those who offered direct access at their main practice were then asked a series of questions relating to the experience of direct access in their practice: specifically, the profitability, patient oral health and patient choice (see page 16).

> "Those who offered direct access at their main practice were then asked a series of questions relating to the experience of direct access in their practice: specifically, the profitability, patient oral health and patient choice."

With practices under continued financial strain the financial viability of direct access is a concern. Participants were first asked for their level of agreement with the statement "direct access is profitable for my practice". A third of participants (33.5%) agreed with the statement, however, the majority of participants (49.2%) were still unsure as to the profitability of direct access. There was some variability in these findings across the UK with respondents in Scotland the least likely to find direct access profitable compared with the other countries.

Continued on page 16

COMMENTARY

Patients will need clear messages

by Stephen Hancocks

Stephen is editor-in-chief of both *BDJ* and *BDJ In Practice*

Much has been written about the professionals' views of direct access (DA) as well as what the Office of Fair Trading and the General Dental Council believe patients should think about it. But what do we actually know about patients' views?

Since DA has only been allowed for a relatively short time, and because there are few instances of it there is little research either to support it or otherwise from the patient's viewpoint. But for a practice thinking of introducing DA, some previously published research provides clues to the elements that need to be considered.

A study carried out in Sheffield in 2012 and published in the *BDJ* (**Dyer TA, Owens J, Robinson PG.** What matters to patients when their care is delegated to dental therapists? *Br Dent J* 2013; **214:** E17) identified three key themes.

Patients reported positive views and experiences of care provided by dental hygienists/therapists.

Trust is a key element and is built on the communication skills and attitude of the dental team and continuity of care.

There were negative experiences in cases where communication was poor and continuity of care was lacking.

Although the results are not directly comparable to the situation of DA, there are enough similarities to draw some general inferences. And they certainly highlight the main questions patients have about being treated by a dental care professional (DCP) rather than a dentist, with whom they will be more familiar as their traditional provider of oral care.

The study focused on services provided by dually trained hygienist/therapists, the rationale for whose training has been embedded in increased patient access and the efficiency of the delivery of dental services. Using qualitative methods, the study interviewed, in their homes, adults whose treatment had taken place at local practices but been delegated to dental therapists.

Three issues arose. Patients took what the study called a "consumerist approach". They said they didn't mind being treated by a therapist but thought the price for this should be lower because it wasn't being done by a dentist. On further reflection, however, and following the explanation that the therapist was just as well trained to do the treatment as was the dentist, patients were more prepared to accept price parity. This highlights that the key to patient acceptance is effective communication.

Secondly, patients were concerned about the continuity of care. They wanted to know how seeing a DCP for one aspect of their dental care would affect their future care; if they would see the dentist next time; and how the division of care would work.

The third issue revolved around what a dental therapist was and their place in the hierarchy of the dental team. They asked if the therapist was a "mini-dentist" and how what they are allowed to practise related to the practice of other dental-team members.

This confusion was also identified in an earlier, wider, study by two of the same authors. There it was found that the public was generally not well informed and did not understand the extents of practice of the different team members (**Dyer TA, Robinson PG.** Exploring the social acceptability of skill-mix in dentistry. *Int Dent J* 2008; **58:** 173-180).

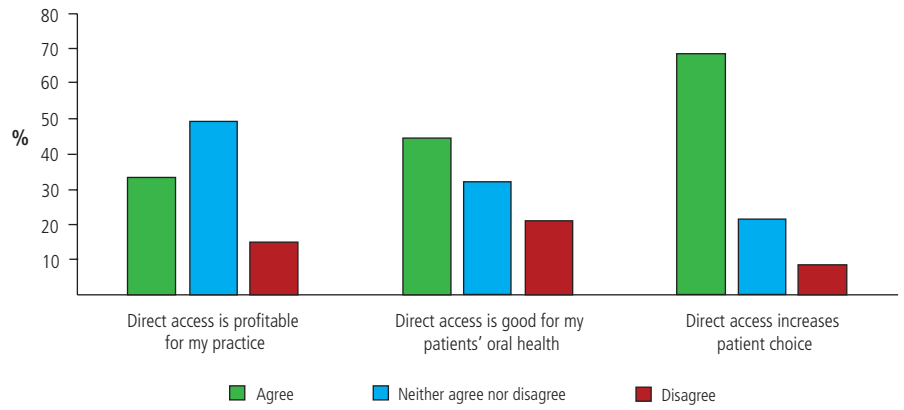
So a practice thinking of introducing DA would need to address three key issues.

It would need to communicate clearly to patients why this development was happening.

It would need to explain the benefits of DA to the patient in terms of care, continuing of care and cost.

And it would need to provide background information about the training and scope of practice of the various members of the dental team. ◆

Figure 2 How far do you agree or disagree with the following statements? (%)



Previous research (BDA 2012) demonstrated dentists' concern as to the impact that direct access may have on their patients' oral health. Participants were asked how far they agree or disagree with the statement "direct access is good for my patients' oral health". Over two-fifths of participants stated that they believed that direct access is good for the oral health of their patients, with only one-fifth disagreeing with the statement.

The Office of Fair Trading's investigation into dentistry expressed concerns over patient choice, of which direct access was one of the outcomes (OFT 2012). To elicit practice owners' opinions on whether direct access was achieving increased choice, participants were asked how far they agreed or disagreed with the statement "Direct access increases patient choice". Over two-thirds (68.6%) of participants agreed with this statement. Those participants with the highest level of NHS commitment were most likely to disagree with the statement.

Despite these initial findings, when asked, a third of practice owners (who currently offered direct access) harboured some concerns about offering direct access. Those that expressed concern were prompted to explain these further. These responses were analysed and grouped into themes (**left**).

The overwhelming theme that emerged from participants' comments was a concern that increasing levels of direct access would lead to numerous missed diagnoses. For example, one participant noted that "Direct access does not allow a proper oral examination to take place. Patients who just attend when in pain miss out on a full clinical exam – missing future problems, cancer etc."

Another respondent said that "However good my hygienist is, things may get missed."

Several participants were especially concerned about "possible missed opportunity to diagnose oral cancer".

> "The overwhelming theme that emerged from participants' comments was a concern that increasing levels of direct access would lead to numerous missed diagnoses. For example, one participant noted that "Direct access does not allow a proper oral examination to take place."

Main concerns with direct access

- Concerned about missed diagnoses
- Falling patient care
- Patients having a false sense of security
- DCPs not fully trained, especially in more complex issues
- Lack of dentist involvement
- Treatment not included in treatment plan
- Patients do not understand the system

Respondents' concern with direct access went beyond missed diagnosis, but some felt that if a patient only saw a hygienist or therapist, it may give patients a false "sense of security" and thus a lowering of patient care. For example, one participant stated that "patients may think oral health is being maintained by visiting the hygienist", while another said that "patients will use it to bypass regular check-ups thinking the hygienist will do this for them."

Other concerns about the repercussions of neglect or a failing duty of care, differences in training and specialities of dentists and DCPs and confusing patients with differing treatment plans and option were also noted.

Discussion

The findings presented above have demonstrated a mixed view on direct access. Overall experiences were varied in regards to the profitability of direct access, however, there were some strong concerns about its impact on patients' oral health and potential for missed diagnoses.

The BDA has echoed some of the concerns highlighted in these findings[1]. Specifically, the BDA are concerned about whether direct access undermines best practice in patient care.

The BDA supports the concept of a multi-disciplinary dental team, with the dentist as the leader of that team, providing the initial diagnosis and treatment plan and co-ordination of the care pathway, taking overall responsibility for patient care, helping the patient through their treatment journey. More information and advice on direct access can be found at: www.bda.org/directaccess.

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1 https://www.bda.org/dentists/policy-campaigns/research/dir-acc

COMMENTARY

Time for independent, patient-centred research

by Judith Husband,
chair of the BDA's Education, Ethics and the Dental Team Working Group

The highly contentious decision by the General Dental Council (GDC) to lift the restrictions on patients accessing care by dental care professionals (DCPs) took place amid heated debate and conflicting options throughout our profession.

At that time, the British Dental Association (BDA) criticised the GDC's decision-making on this issue: it was difficult to scrutinise the way it was made and not be disappointed. The evidence base presented may not have demonstrated harm to patients, but it certainly failed to demonstrate clearly how the change would protect them or improve care. This concern has clearly remained and is a theme running through the BDA's research of practice owners.

Unprecedented speed

The underlying motivation for the relaxation of the regulations, and the unprecedented speed of its introduction, also raised many questions back in 2013. This was a complex issue with some significant long-term implications, both for patient care and for our profession.

Workforce planning for dentists was promised but is long overdue (except for within Scotland) and at this time there had been no real inroads into mapping or planning DCP training, working practices or numbers. For those of us who attended the GDC session and witnessed the decision being made, it was hard to be anything other than deeply unimpressed by the meagre debate by the Council that preceded it.

The political and economic landscape leading to the decision must also be considered. Reflecting on the historical perspective and precursor to the change we must bear in mind the Office of Fair Trading's 2012 report into dentistry. This was deeply flawed but a very significant event for dentistry in the UK. It looked at dental care and treated it as a commodity: sadly, in more recent times, we have seen this view reinforced by the current chair of the GDC.

Drive towards commercialisation

It could be argued that this unremitting drive towards commercialisation of our profession can be traced back to this decision in particular, which has been reinforced by the shift of our regulator towards referring to "customers" rather than patients and to a "dental sector" rather than a profession.

> "For those of us who attended the GDC session and witnessed the decision being made, it was hard to be anything other than deeply unimpressed by the meagre debate by the Council that preceded it."

The hasty implementation of the decision left significant issues outstanding about how dental teams would work within this model of patient care. Confusion and concern quickly came to light with some significant limitations of this much-heralded freedom of choice. The day-to-day of prescribing and reporting on radiographs, local anaesthetics and Duraphat still needed either a Patient Group Directive or direct intervention from a dentist.

Putting aside our philosophical differences, a pan-professional group hosted by the BDA came together in November 2013. This included the British Association of Dental Nurses, the British Association of Dental Therapists, the British Association of Clinical Dental Technology, the British Dental Association, the British Society of Dental Hygiene and Therapy, and the Faculty of General Dental Practice and indemnity organisations.

This meeting clearly demonstrated that patients sat at the heart of our profession: all members of the team recognised that to protect them and ensure the highest level of dental care we needed to work together. Our regulator had swiftly implemented sweeping changes but sadly left us with significant gaps and questions.

In November 2013, the BDA said there were many areas still requiring further guidance that were common to all groups; NHS regulations and the variations in legislation among the devolved nations, prescribing and reporting on radiographs, and consent and referrals within the dental team to ensure efficient and safe care for patients.

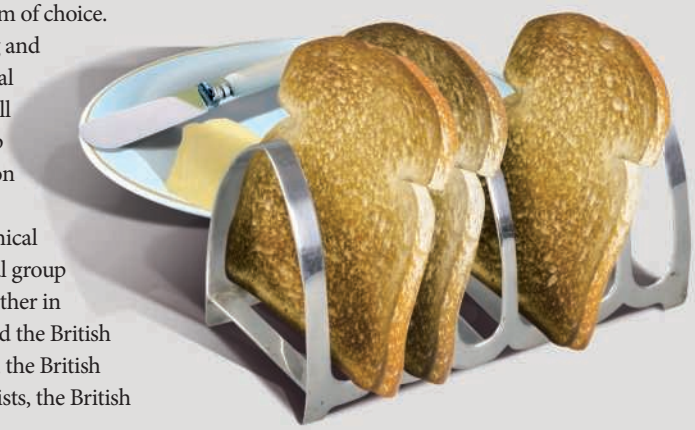
Significant issues remain

These concerns are echoed in the BDA's research published here: and, sadly, the significant issues remain. Dental teams who have embraced the new working options have had to tread carefully and rely on their professional organisations for advice and support.

It is no surprise that direct access implementation has been slow with so little guidance and clarity from those who forced this upon our profession.

The GDC made a commitment at the time of implementation to review their decision and undertake further research into the effects of direct access.

We can only hope that this is honoured and robustly undertaken from an independent, patient-centred perspective – free from political or personal agenda. ◆



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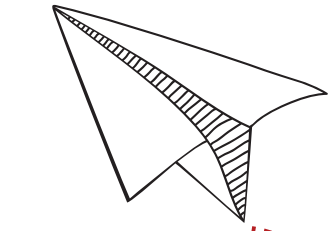

Romance your way to a job

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

Beginning a relationship is not always easy, whether it is a personal or commercial one. But there are some simple rules to help. A personalised approach is useful. Standing up in a room full of potential suitors and shouting "does anyone want to go out with me?" is unlikely to be as successful as approaching someone you particularly like and showing why you are interested in them in particular.

Getting a good job at a good practice is not so different.

First, it is important to choose the practice carefully. You may just want a job but you could end up being unhappy with a job at the wrong practice just as you would be with the wrong life partner. Think about where you want to be geographically. Think about your values as a dentist. Where do you want your career to go? Do you want a nine-to-five job, do you want to specialise, do you want to move into management, or do you want to become a practice owner? Are money and lifestyle important or are you driven by the ideological principles of the NHS.

So, think about what type of practice will give you what you are looking for. Once you have decided this you stand a better chance of finding a suitable one.

Dental practices have information on their websites and information about NHS practices is available on the *NHS Choices* website and on the Care Quality Commission (CQC) website. You may be able to see what the practice looks like from Google Streetview (but beware the photographs may be out of date). Personal recommendations are useful. Read the advertisement for the post carefully. If it is asking for a particular skillset, there is little point in applying if you do not have that skillset. If you do, stress you meet their requirements in your application.

Romance the practice you are applying to. They may receive hundreds of applications and you need to set yourself

apart from the crowd. An email saying simply "please find attached my CV" will not work nearly as well as a letter, on good quality paper, explaining why you have applied to that particular practice. For example, you may get their attention by saying: "I am impressed by your desire to provide a friendly service and by the feedback on the *NHS Choices* website showing that your patients have appreciated this."

Ensure you highlight your unique selling points. Your past jobs can work for and against you. Experience in hospitals could be interpreted to mean that you are good at dealing with difficult patients; or it could mean you will not be as fast as someone who has more experience in general dental practice. There will be an element of luck about which interpretation a reader places on your application.

Your personal interests could be important, too. The fact that you toured Europe on a motorcycle could catch a practice owner's eye if they, too, like riding motorbikes.

In all dealings with the practice, whether by phone or in writing, ensure you are friendly and professional. One practice simply hung up on a candidate when he answered the phone with a gruff: "What!" Show enthusiasm for the position.

"Your personal interests could be important, too. The fact that you toured Europe on a motorcycle could catch a practice owner's eye if they, too, like riding motorbikes."

Prepare for the interview. Carefully read the practice website to find out as much as you can about it. Be ready to answer standard questions like: "Why do you want to join this practice?" It would not endear you to a potential suitor if you simply say you would like to date them because, conveniently, they live in your street. Similarly, it would not help your case to major on the convenience of the practice location. You need to make a potential suitor or interviewer feel they are special.

Ask good questions. This shows you are keen to ensure the practice is as good as it says it is. And candidates who ask good questions are viewed more positively because they are showing they want to be as careful about finding the right practice to join as the practice is about finding the right dentist.

By all means negotiate over any terms they offer but do so respectfully and politely. Explain why you want the changes and how it may affect the practice. Be careful if negotiating on pay if you are early on in your career: practice owners will probably have a number of other applicants who will be grateful to accept what they offering.

Relationships need constant work and communication. Once you have found your ideal job, make sure you keep your relationship with the practice owner and staff on good terms. Talk if you have concerns. Listen if they have.

Some of the tips in this article are based on contributions from dentists and practice owners who attended a BDA-hosted panel session at last-year's Conference. A similar event is being held at the 2015 British Dental Conference and Exhibition (see **right, top**). This is your chance to ask questions of the sort of people who will decide whether or not to read your CV, offer you an interview, and offer you a job. ◆

Help to develop your career

This year's conference is packed with sessions exist to help you chart the next steps in your career.

Choosing the right career path for you

Thurs 7 May 10.15-11.30

James Goldman, the Head of the BDA's Employment and General Practice Team, leads an interactive session on making the transition from associate to practice owner. Hear from, and speak to, an experienced panel to find out what they have done to move up in the dental world.

Learning objectives:

- Understanding the range of opportunities available for associates
- Working out which path is right for you
- How to move in your chosen direction

Setting up in practice

Thurs 7 May 14.30-15.45

Whether you are considering buying an existing practice or opening a new one, you will need to equip yourself with the essential knowledge and skills to avoid potential pitfalls. Freddie Edwards-Rost, a practice management consultant in the BDA's Business Team, shows that making a success of a new business takes more than entrepreneurial flair. It involves a great deal of planning, management skills and commitment, as well as knowing when to seek appropriate professional advice. The presentation, suitable for both those thinking about setting up, and those who have just set up, in practice, will take you through the fundamental steps of the process and will highlight the possible challenges you may face on the road to achieving a successful enterprise.

Learning objectives:

- Have an understanding of making the right decisions in the planning stages, including choosing the right location and premises
- Be aware of the various business-structure options available
- Gain an insight of NHS commissioning and bidding for NHS dental contracts
- Understand the importance of having financial backing in place to succeed
- Be aware of your obligations as an employer and employment requirements

Making the most of your career in dentistry

Friday 8 May, 11.45-12.45

During this session Nick Lane will explore the advantages of a career in general practice, drawing on personal experience and lessons learned in his first 12 years. He hopes to convince you of the many merits of general practice, the importance of post-graduate training and the role the Faculty of General Practice can play in shaping your career.

Learning objectives:

- Find out more about a career in general dental practice – could it be the route for you?
- Learn about the Faculty of General Dental Practice, its courses and how it could benefit you
- MJDF vs MFDS – how can these qualifications enhance your career?
- Discover what life is really like in general dental practice, including the salary and benefits you can expect

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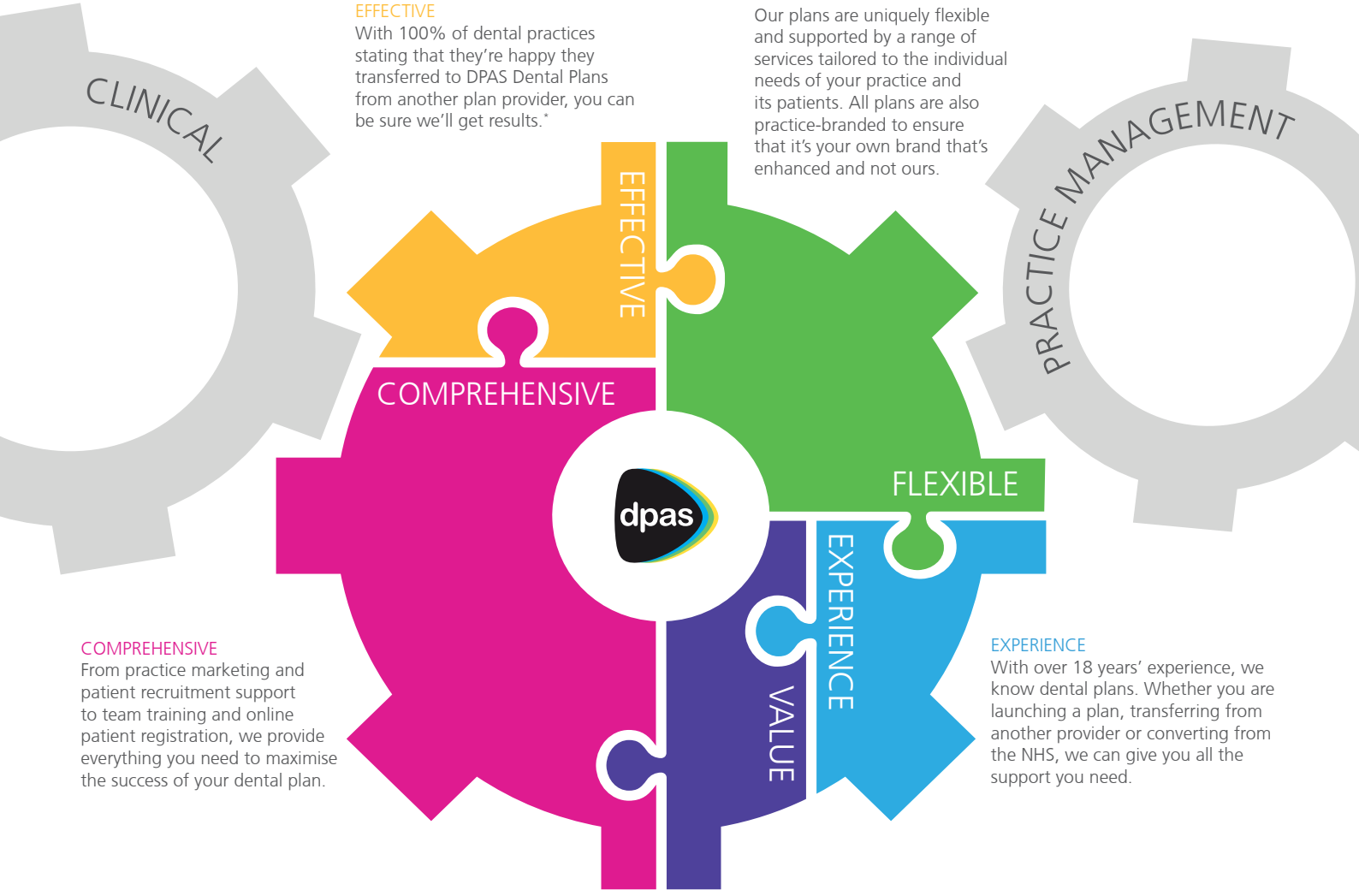

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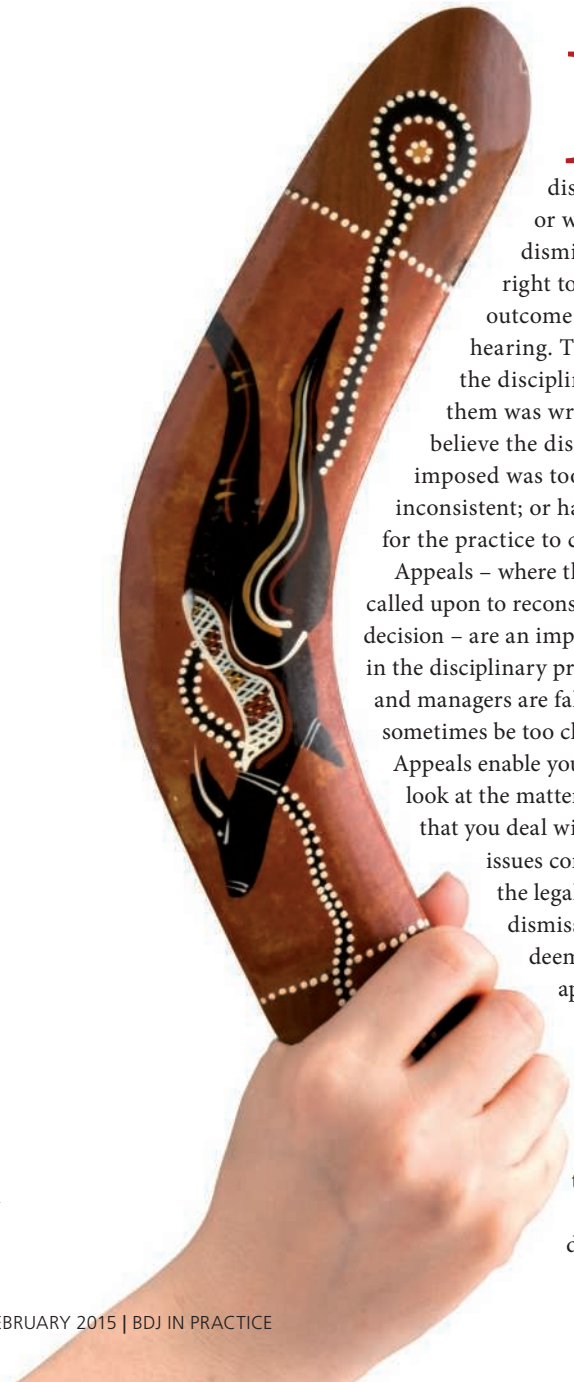
*DPAS Customer Satisfaction Survey 2014

What to do when you get it wrong

by 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



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Employees who have received a formal disciplinary warning, or who have been dismissed, have the right to appeal against the outcome of the disciplinary hearing. They may: think that the disciplinary action against them was wrong or unjust; believe the disciplinary sanction imposed was too severe or was inconsistent; or have new information for the practice to consider.

Appeals – where the practice will be called upon to reconsider its disciplinary decision – are an important safety valve in the disciplinary process. Employers and managers are fallible and can sometimes be too close to the issue. Appeals enable you to take a step back, look at the matter again, and show that you deal with disciplinary issues conscientiously. And the legal side is clear – a dismissal is likely to be deemed unfair if no appeal was allowed.

But an appeal hearing is not a just re-run of the disciplinary meeting. It has three new functions (**right**) and depending upon the reasons the employee gives for making the appeal there could be a number of things you should do.

A disciplinary decision could be challenged on the basis that it was unreasonable to conclude on the information available that the employee committed the act of misconduct in question. So, you may need to look to see if all relevant information was considered at the initial disciplinary meeting.

You may need to double check there were sufficient grounds to justify the decision.

This is not a question of whether or not another person hearing the appeal would have made the same decision. It is a question of whether or not the original decision was reasonable: one that makes sense on all the information available.

> "Employers and managers are fallible and can sometimes be too close to the issue. Appeals enable you to take a step back, look at the matter again, and show that you deal with disciplinary issues conscientiously."

Three functions of an appeal

- → To review whether or not a reasonable decision was made
- → To review whether or not a fair procedure was followed
- → To consider any new information, new material or new arguments

Why an employee might appeal

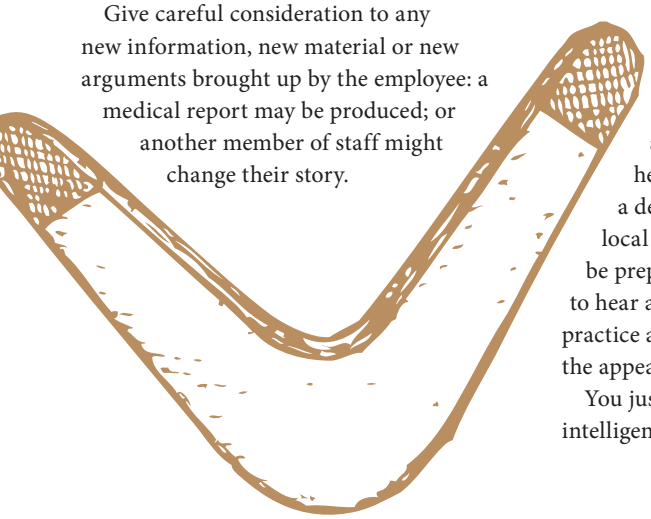
- They may think the disciplinary action was wrong or unjust
- They may believe the sanction was too severe or was inconsistent
- They may have new information for the practice to consider

Initial checklist

- Check that all relevant information was considered at the initial disciplinary meeting
- Check that there were sufficient grounds to justify the original decision
- Check that the employee was given proper notices and all relevant information
- Check that the investigation into the matter was sound
- Check that the employee was told they could appeal, how they could do so, and the timescale in which to do so

And you need to check the employee was given proper notices with all the relevant information in enough time. Make sure the practice followed its written disciplinary procedure. Check that the investigation into the matter was sound and that the practice spoke to all the right people (see www.bda.org/bdanewsonline *Be fair – and be seen to be fair*, November 2013, page 12). If there were problems with the procedure, the appeal can be a chance to fix the error.

Give careful consideration to any new information, new material or new arguments brought up by the employee: a medical report may be produced; or another member of staff might change their story.



Letter must mention appeal

The letter telling an employee of their disciplinary sanction or dismissal must have clearly said that they can appeal internally against that decision. It should have told them that they must put their appeal in writing to the employer and generally have given them around two working weeks from receiving the letter in which to prepare and submit their appeal.

Meeting should be face to face

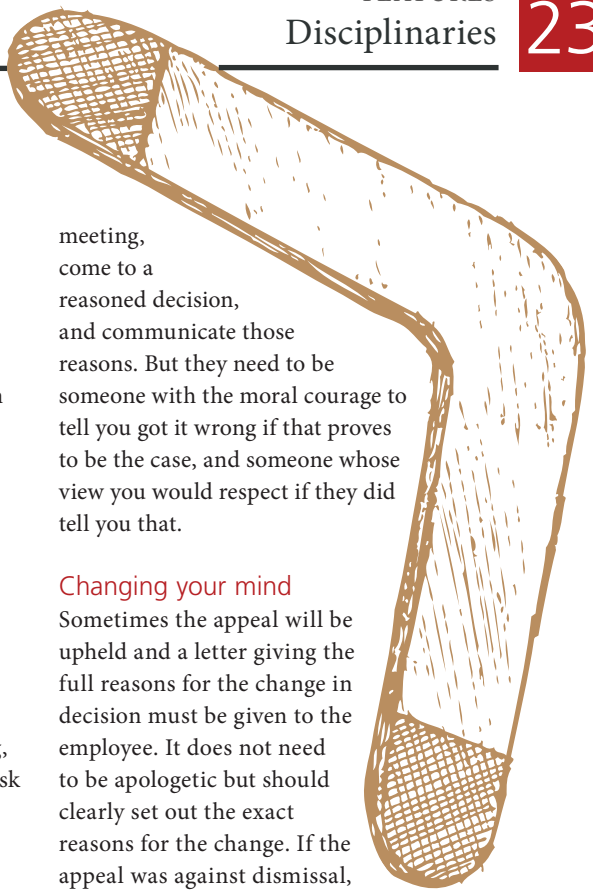
The appeal should be considered at a face-to-face meeting (with the employee bringing a companion, if they want, see www.bda.org/bdanewsonline *Tell companions their role from the outset*, July 2013, pages 6-7). On rare occasions where an employee is unwilling or too incapacitated to attend an appeal hearing, the appeal can be considered on paper. Ask for full grounds for the appeal in writing from the employee with all evidence and statements in support.

> "Sometimes the appeal will be upheld and a letter giving the full reasons for the change in decision must be given to the employee. It does not need to be apologetic but should clearly set out the exact reasons for the change."

Try to get someone other than the person who conducted the disciplinary hearing to consider the appeal. This is a good way to demonstrate that you deal with these issues fairly and impartially. But in small businesses, such as practices, doing this is not always easy: there may not be that many people involved in disciplinary processes.

In a partnership, one partner could handle disciplinary matters and the other any appeals. Or the practice may need to ask an associate or someone external to hear an appeal. The latter could be a dentist from another practice or a local small-business owner, who would be prepared to give a couple of hours to hear an appeal. Or you could pay your practice accountant or solicitor to consider the appeal.

You just need someone who can intelligently assess the facts, chair a meeting, come to a reasoned decision, and communicate those reasons. But they need to be someone with the moral courage to tell you got it wrong if that proves to be the case, and someone whose view you would respect if they did tell you that.



Changing your mind

Sometimes the appeal will be upheld and a letter giving the full reasons for the change in decision must be given to the employee. It does not need to be apologetic but should clearly set out the exact reasons for the change. If the appeal was against dismissal, the dismissal is effectively erased from history and the member of staff is still employed. They will need to be paid their normal pay for the period of their dismissal.

Awkward? Yes. But, we have all had awkward situations. A little discussion can help. The employee may just be pleased to have their job back or to have a warning erased and be grateful their boss understands that a mistake was made.

But most appeals will be rejected and the original sanction will be upheld. Here, the person hearing the appeal should write to the employee and explain why the appeal has been rejected. If it goes to a tribunal, the judge will simply want to know that the process has been fair; that there has been an appeal; and that the decision-makers have made sensible decisions. ◆

Key message

Most appeals will be rejected and the original sanction will be upheld. The person hearing the appeal should write to the employee and explain why the appeal has been rejected. If it goes to a tribunal, the judge will simply want to know that the process has been fair; that there has been an appeal; and that the decision-makers have made sensible decisions

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To view the Winter Lectures visit:
www.bda.org/winterlecture

Exclusive and FREE for BDA members

Compiling cash-flow forecasts

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

Small-business surveys by the Department for Business Innovation and Skills (BIS) have consistently shown that cash-flow problems are an obstacle to success in about one in ten small businesses (*BIS Analysis Paper Number 2*, December 2013). And many of the other factors cited as hurdles to success – the economy in general, taxation and obtaining finance – can also be related to a business's cash flow.

Cash-flow forecasting is seen by leading banks, accountants and lenders as playing an essential role in the business-planning and management processes. Your accounts will show actual cash flow but you need to have previously forecast what is going to happen each financial year so you can predict peaks and troughs in your cash balance. This awareness allows you to anticipate how much money the business will need to have available at each point in the year. If it shows months when cash flow will be poor you could be unable to meet your immediate costs. Knowing that early allows you to act now to overcome that problem.

Spreadsheet

Your accounting software may include a template for cash flow. There is also a model available in *BDA Expert*. At its simplest, this document is a spreadsheet that automatically totals the figures that you input (**page 26, top right**) and is an organised way of predicting the cash coming into your business and the cash leaving your business.

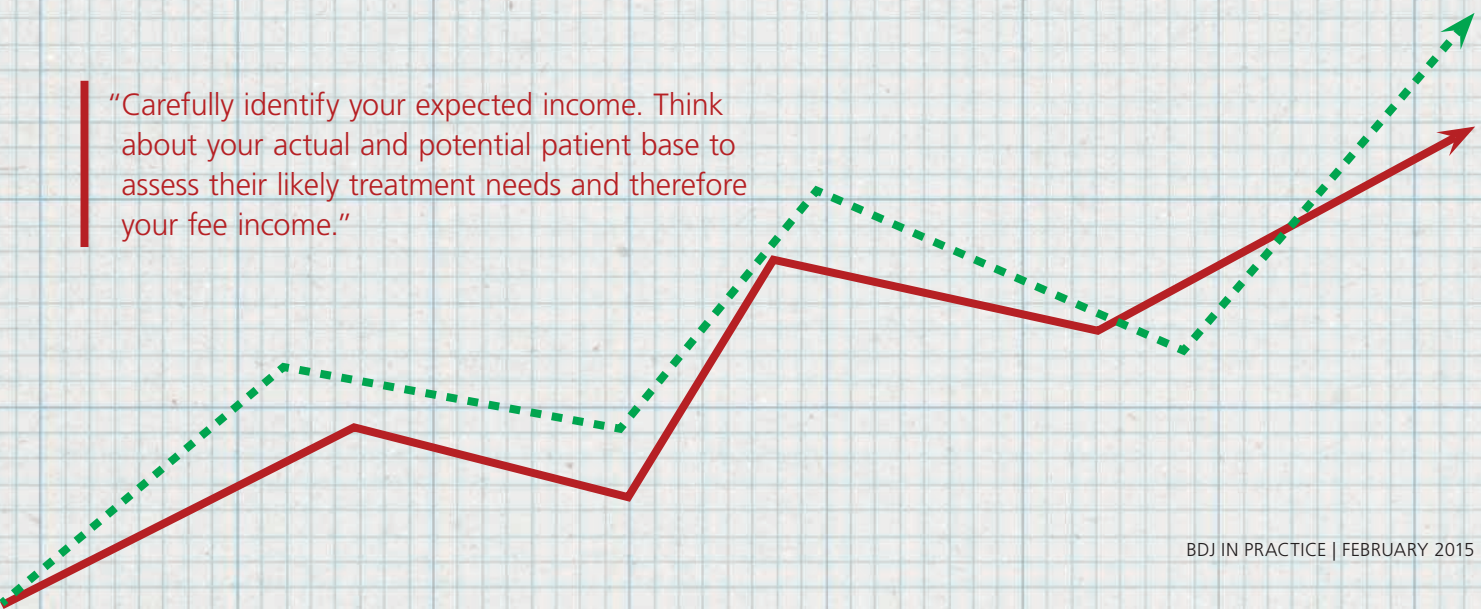
To be of use you need to populate each box of your cash-flow forecast as accurately as possible. How you do this will differ depending on if you are an established business, with historic financial records that give you an indication of monthly and annual trends, or a start-up.

Your forecast must not be guess work. You must have objective reasons for each entry that you make. So, meticulous research is important (see www.bda.org/advice *Business planning and managing change*). Break items down into all their component parts. For example, review the items included in the costs of consumables and materials and work out how much of each item you will use month by month and when you are likely to need to re-order particular items.

Carefully identify your expected income. Think about your actual and potential patient base to assess their likely treatment needs and therefore your fee income.

You should break this down as much as possible. For example, where an NHS patient needs numerous crowns or filings,

"Carefully identify your expected income. Think about your actual and potential patient base to assess their likely treatment needs and therefore your fee income."



> "When putting together the information, you need to identify your overall costs: you need to include the cost of all the activities you will undertake to deliver each individual service."

the units of dental activity (UDA) system of payment in England and Wales does not recognise the greater workload. You should also factor in unforeseen circumstances such as: patients failing to attend, emergencies running over, staff absence, or equipment failure. Never presume you will run at full capacity all the time, that you will sell all the dental products you have in stock, or that you will be paid promptly by patients.

Practice receipts on your forecast could also include other sources of money, such as bank loans, personal investments, business grants, sales of dental products, lecturing or writing fees, and rental income from letting or hiring out surgery space.

It all adds up

When putting together the information, you need to identify your overall costs: you need to include the cost of all the activities you will undertake to deliver each individual service. For example, imagine you are planning a mass marketing campaign. The advertising agency would need full details of your requirements from you. You should not just turn up and say I want 500 leaflets because that would be poor business management. The agency would want you to specify the size of the leaflet, whether to print on both sides, the range of colour, gloss or matt finish, and the quality of the paper. With this amount of detail, the agency would be able to give you an accurate quote for this specific job. You need to adopt a similar approach when costing the services you provide by listing what you will need under each item of expenditure.

Pinpoint, too, unavoidable expenditure such as insurance premiums, essential equipment-safety checks and tax-due dates.

If it is your first year you will also need to include start-up costs and any cash investments that are needed to get you off the ground. Look to future years and factor in inflation, staff-wage rises, training courses, the depreciation of equipment, and practice improvements and refurbishments. Review past trends to help you predict future trends in these costs.

Compare predictions with actuality

Monitor your financial performance against your estimates on a continuing month-by-month basis. You will need to look into the reason for any major variation and if this trend will continue. Adjust your estimates for future months to ensure that there will be no shocks as a result. And use the experience in devising your cash-flow forecast for the next financial year.

The BIS annual small business surveys have asked businesses what they considered to be the main causes of cash-flow difficulties (**right, bottom**). These factors are relevant to your business today – you can use them to help you plan your cash-flow forecast to ensure that you take into account these potential barriers to success.

When producing your cash-flow forecast you must, as with all your financial affairs, consult a specialist in this field to ensure your individual financial needs are met. The guidance in BDA Advice, *Financial management*, at www.bda.org/advice can help you in your discussions with your accountant. ◆

Cash-flow elements

A completed cash-flow forecast table usually has the income and expenditure down one axis and the months across the other. Incomings may include, among other things: NHS payments, private fees, sales of dental products, loans taken out and other investments into the practice.

Outgoings may include, among other things: your mortgage or rent, building repairs, utility bills, staff wages and other costs, equipment purchases or depreciation, equipment repairs, materials, laboratory costs, waste collection, marketing costs, accountancy and legal fees and tax.

A cash-flow forecast is nothing more than a table containing your financial information. It details what money you have targeted to come into the business each month, what money will leave the business each month, what cash injections will be needed and what the opening and closing balance of each month will be.

Using an electronic spreadsheet will be more useful because it also automatically adds up the figures to give you a yearly total of income, expenditure and cash-flow balance.

Causes of cash-flow difficulties

- → Income fluctuates while outgoings were steady
- → Late payment from individual customers
- → Late payment from other businesses
- → High level of working capital needed
- → Timing of tax payments
- → Individual customers expect credit
- → Outgoings fluctuate while income is steady
- → Early payment required by suppliers
- → High levels of investment required
- → Difficult or costly to get credit from suppliers

Source: BIS Small business surveys

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As an experienced practice owner, Paul likes to run a tight ship. However, at 55 and with April 2015 approaching, he felt a little out of his depth, and sought specialist advice to help navigate the new pension rules.

Having complete freedom, and access to his hard earned money, gives him a wealth of options. But to take advantage of the opportunity and avoid the threats, he now understands the importance of seeking advice.

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Pronamel® meeting discusses the use of BEWE for the assessment and management of Acid Wear in practice

On June 9 2014, GSK Consumer Healthcare, the manufacturers of Pronamel®, held a meeting of dental professionals from NHS and private practice, as well as academics. The meeting discussed ground-breaking data from a recent ESCARCEL study, which was sponsored by GSK. This study revealed that 29.4% of young European adults aged 18-35 years already have moderate tooth wear (**Bartlett DW *et al***. *J Dent* 2013; **41**: 1007-1013).

To help dental professionals in the crucial early diagnosis of tooth wear, the meeting suggested the use of the Basic Erosive Wear Examination (BEWE), which facilitates consistent measurement and recording of tooth wear in practice and offers useful management guidelines.

The duration over which acid is consumed and method of consumption must be considered in risk management.

The BEWE is featured in the Department of Health's 2014 *Delivering Better Oral Health* toolkit as a method for the prevention of Acid Wear.

For more information on Acid Wear and using the BEWE to identify and manage the condition in practice, visit www.gsk-dentalprofessionals.co.uk

Revolutionise your practice

We all want an easier life, especially when it comes to work. As the dental profession benefits from a wide range of technological advancements it means there are many methods available to be able to do this.

Although digital imaging systems do incur an initial outlay, the effect they can have on your working life can be of huge benefit to you and the rest of the dental team. MyRay produces a range of systems to suit any needs, such as the Hyperion X9, which incorporates a modular concept enabling you to start with 2D panoramic imaging and upgrade to its 3-in-1 solution when needed.

The MyRay range also boasts intraoral x-ray units offering you precision positioning and imaging every time. The ergonomic unit offers wireless convenience and image clarity meaning that taking radiographs is simple and fast.

For more information go to www.my-ray.co.uk or call 08707 52221.

Even more options

Now with even more options than ever before, the Carl Zeiss OPMI pico from NuView represents the cutting-edge of dental microscopy technology, with a five-step magnification changer that delivers brilliant images in crisp, clear detail.

It features LED illumination. This virtually maintenance-free lighting source provides consistently distributed, high-intensity, true-to-colour, light that lets you see and explore details as plain as day.

Varioskop optics are designed to reduce neck strain and back problems. When equipped with a Varioskop objective lens, OPMI pico enables you conveniently to adjust the focal length without leaving your preferred working position.

And full HD video camera with streaming to LAN and recording allows users conveniently to document procedures in high-definition image quality, for co-observation, patient consultations and conference presentations.

For more information email info@nuview-ltd.com visit www.nuview.co or call 01453 872266.

Your data in your hands

Leading provider of outstanding practice management software Carestream Dental brings you the new CS R4+ feature, Springboard. It focuses on four key areas.

Occupancy: you can easily identify available appointment slots and analyse patterns to maximise your chair occupancy.

Treatment: you can find patients with proposed treatment plans who haven't arranged to take them further and contact them to book appointments.

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And you can gain complete control over the continued care of your patients with a clear visual display of current data. You can manage re-care settings and send reminders to patients for appointments automatically, whether they prefer post or text messages.

For more information, visit www.carestreamdental.co.uk

Promoting profitability

Too many practices have their most expensive overhead (their staff) spending too much time trying to drive down their least expensive overhead (consumables), according to Henry Schein Dental head of Business IQ Andy Sloan.

But while keeping control of costs is important for any business, practices should not lose sight of the need to seek ways for the business to grow, he says.

Business IQ is a just-launched, free service for Henry Schein customers designed to help them do this. Its aim is to help practices understand how to develop more-efficient business process, improve communication and gives tips, advice and guidance on a range of topics.

Some stem from Henry Schein's own portfolio of products and services, such as its **EX**act practice-management software and its education programme, the Academy of Excellence.

Others are third-party services that customers can access at a discounted rate. These include Milkshake Dental Marketing, which can build and run websites; and Finance4Patients, which can give practices quick patient-finance decisions to help convert patient interest to treatment.

For more information go to: www.henryscheinbusinessiq.co.uk

Innovative x-ray devices

Clark Dental has launched its NOMAD® Pro 2 hand-held x-ray system.

Boasting a newly designed battery handset with infrared connectors, and an innovative charging cradle that improves durability and performance, the NOMAD Pro 2 is lightweight, rechargeable and can go anywhere.

The user interface has been re-engineered for ease of use and intuitive operation. Your whole dental team will appreciate how quickly and easily the settings can be changed to meet the needs of any situation.

For practices seeking a single solution to cover multiple treatment rooms, or looking for the flexibility to expand into more surgeries at a later date, the NOMAD Pro 2 is ideal. Its hand-held, portable design allows you to move from room to room, eliminating the need for multiple units.

Recruit DCP staff for free online

British Dental Association (BDA) members can now advertise their dental care professional (DCP) roles for free online at bdjjobs.com, the BDJ's dental jobs and classified listings website. Qualifying DCP roles include dental nurses, practice managers, dental technicians, and receptionists, but exclude dental hygienists and dental therapists.

The starting price for DCP advertisements are normally £107.50 + VAT, so this represents a great opportunity to promote your DCP vacancies to the 29,051 (WebTrends data 2014) dental professionals that, each month, visit bdjjobs.com, which is also cited as the most used online resource for dental job searching (QA Research, *Dentists' ICT Use*, 2011).

To make a booking or for more information contact the BDJ Jobs sales team at e-mail: bdj@nature.com or on +44 (0)20 7843 4729.

Budget brush convinces professionals

A survey of the cheapest brush in the Sonicare range among 5468 dentists, dental hygienists and therapists has found that over 90% would continue to use this brush and over 80% would also recommend it to patients, putting it within the purchasing range of most patients, Philips says.

Specifically, over 95% rated cleaning and gum health as "good to excellent"; ease of use was rated "good to excellent" by over 90% of participants; stain removal increased steadily over the four weeks of the trial with 84% rating it as "good to excellent"; and "good to excellent ratings for comfort rose during the trial to 91%.

Users were particularly impressed by the comfort of the brush, which appeared to increase with use.

To find out more go to www.philips-tsp.co.uk/sonicare

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

Miss Karen Juggins BDS (Hons) MFDS RCS (Eng), MSc, MOrth RCS (Eng), FDS (Orth) RCS (Eng)
Interests: Specialist Orthodontics **On Specialist List:** Yes

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

236739

PARK ROAD DENTAL PRACTICE
www.parkroaddentalpractice.co.uk

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

Interests: Periodontics, Orthodontics, Implants

Dr Ayodele Soyombo
On Specialist List: Yes, Orthodontics

Dr Bola Soyombo
On Specialist List: Yes, Periodontics

Dr O Onabolu
On Specialist List: Yes, Periodontics

209439

South West

THE CIRCUS DENTAL PRACTICE
www.circusdentalpractice.co.uk

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

239371

North West

T CLINIC
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Professor Paul Tipton B.D.S, MSc., D.G.D.P, RCS
Specialist in Prosthodontics

T Clinic, Barton Arcade, St. Ann's Square, Manchester M3 2BH
Tel: 0161 348 7844

T Clinic, 22 Harley Street, London W1G 9PL
Tel: 0161 348 7846

Email: louises@tiptontraining.co.uk
Interests: Prothodontics, Dental Implants, Restorative Dentistry, Cosmetic/Aesthetic Dentistry, Full Dentures and Smile Design
On Specialist List: Yes, Prothodontics

246343

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

235125

Scotland

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Mr Paul Stone BDS (Hons) Lpool, FDS, RCS Ed.
Interests: Implant surgery, oral surgery, conscious sedation, bone grafting and sinus lifts. **On Specialist List:** Yes, Oral surgery
Mrs Adela Laverick BDS (Hons) Lond, FDS RCS Eng, MSc Lond
Interests: Fixed & removable prosthodontics, dental implants **On Specialist List:** Yes, Prosthodontics
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
Dr Brian Stevenson BDS PhD FDS (Rest. Dent.) RCSEd MFDS RCSEd FHEA
Interests: Fixed and removable prosthodontics, endodontics and dental implants **On Specialist List:** Yes, Restorative Dentistry and Endodontics
Mr Graeme Lillywhite BDS MFDS MSc MRD FDS (RCS Ed)
Interests: Restorative Dentistry, fixed prosthodontics, dental implants
On Specialist List: Yes, Restorative Dentistry and Prosthodontics
Mr Chris Allan BDS, FDS, RCPS, MRD RCPS Glas
Interests: Fixed & removable prosthodontics, dental implants **On Specialist List:** Yes, Restorative Dentistry
Mrs Julie Kilgariff BDS MFDS RCS MRD RCS (Endodontics)
Interests: Endodontics **On Specialist List:** Yes, Endodontics
Mr Donald Thomson BDS(Hons)Edin, FDS RCS Edin, DDR RCR
Interests: Cone beam CT imaging **On Specialist List:** Yes, Dental and Maxillofacial Radiology

209189

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Edinburgh Dental Specialists , 178 Rose Street , Edinburgh EH2 4BA
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Dr Kevin Lochhead BDS LOND, MFGDP (RCSEng)
Interests: Fixed and Removable Prosthodontics, Dental Implants
On Specialist List: Yes, Prosthodontics
Dr Pier Luigi Coli DDS, PhD
Interests: Fixed and Removable Prosthodontics, Dental Implants, Periodontics **On Specialist List:** Yes, Prosthodontics and Periodontics
Dr Fran Veldhuizen BDS, MFDS RCS(Ed), M Clin Dent, MRD RCS(Ed)
Interests: Fixed and Removable Prosthodontics
On Specialist List: Yes, Prosthodontics
Dr Carol M E Tait BDS, BDS Hons. MSc, MFDS RCSEd, MRD RCSEng
Interests: Endodontics **On Specialist List:** Yes, Endodontics
Dr Gillian Ainsworth BDS Sheff 1996 FDS RCPS Glasg MSc Edin MSurgDent RCS (Ed)
Interests: Oral Surgery, Implant Surgery, Sedation
On Specialist List: Yes, Oral Surgery
Mr Martin Paley BDS, MB ChB, FFDRCSI, FRCSEd, FRCSEd(OMFS)
Interests: Oral and Maxillofacial Surgery, Dental Implant Surgery, Head and Neck Surgical Oncology
On Specialist List: Yes, Oral and Maxillofacial Surgery
Dr Penny Hodge BDS Edin 1982, PhD Glasg 1999
Interests: Periodontology
On Specialist List: Yes, Periodontics
Prof Lars Sennerby DDS, PhD
Interests: Implant Dentistry, Biomaterials, Bone Biology
Dr Neil Heath DCR(R), BDS, MSc, MFDSRCS, DDRRCR
Interests: Specialist interest in CBCT interpretation and Ultrasound scanning in diagnosis of head and neck pathology.
Specialist List: Yes, Dental and Maxillofacial Radiology
Dr Donald Thomson BDS (Edin), FDS RCSEd, FDS RCPSG, DDR RCR Interests: Cone Beam CT Imaging
Specialist List: Yes, Dental and Maxillofacial Radiology

247539

South East

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

253003

CRESCENT LODGE DENTAL PRACTICE

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Fax: 020 7720 8782
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Specialist Periodontist: Dr Stella Kourkouta DipDS, MMedsci MR RCS FDS RCS Eng
Specialist in Oral Sugery: Dr Fabrizio Rapisarda DDS

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255225

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28 Harley Place London W1G 8LZ
Tel: 0207 580 2366
Email: harryshiersdentistry@gmail.com

Dr Harry Shiers BDS (Lon). MSc. (Implant dentistry) (Eng) MGDS. RCS. (Eng) MFDS. RCPS. (Glasg)

Orthodontist Dr Sarah Sadek, BDS (Hons.), B.Sc (Hons.), MFDS RCS (Ed.), M.Sc, M.Orth RCS (Ed.)

(Accredited Specialist in Orthodontics).

Interests: Restorative dentistry, Implant dentistry, Cosmetic dentistry, Preventative dentistry, Orthodontics, Periodontics, Peadodontics

On Specialist List: Yes, Orthodontics, Periodontics.

252578

DENTAL SPECIALISTS MK

www.dentalspecialistmk.com

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

209440

DENTAL SPECIALISTS ST ALBANS

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

239826

ANDRÉ C HATTINGH

www.ach-periodontology.co.uk

6 Dartford Road, Sevenoaks, Kent, TN13 3TQ
Tel: 01732 471 555
Email: achattingh@btconnect.com
Interests: Dental Implants and Periodontics
On Specialist List: Yes, Periodontics

206654

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

230732

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Aspects Dental and Referral
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On Specialist List: Yes
All referrals welcome.

257224

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37 Wood Lane, Sonning Common, Berkshire/Oxfordshire, RG4 9SJ
Tel: 0118 972 2626
Email: info@woodlanedentistry.co.uk

Claudia Wellmann BDS(Hons)(Wales) MFDS RCSEng MSc (Hons)(Perio)

Vikram Chugani BDS (Wales) MFDS RCSEd MSc (UCL)

Jessica Lee BDS (Wales) MFDS RCSEng DipDentSed

Referrals accepted for Periodontology, Endodontics, Implants, Restorative Dentistry, Oral Surgery and Dental Sedation.

On Specialist List: Yes, Restorative Dentistry and Periodontology

257674

North

TRINITY HOUSE ORTHODONTICS

www.trinityhouse-orthodontics.co.uk

Mr Dirk Schuth BDS, FDSRCPS, FDS, RCS (Ed), MOrth RCS (Eng+Edin) MDentSci (Leeds)
Borough Road, Wakefield WF1 3AZ
Tel: 01924 369696

Trinity House Orthodontics
46 Shambles Street, Barnsley S70 2SH
Tel: 01226 770010
Email: thortho@btconnect.com
Interests: Orthodontics – Adult & children, NHS & Private
On Specialist List: Yes, Orthodontics

217672

THE YORKSHIRE CLINIC

www.mydentalspecialist.co.uk

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

212838

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

255221

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Dr. Sharif Khan BDS (Edin.), M.CLIN.DENT. (Lond.)
Interests: Cosmetic & Implant Dentistry, Advanced Prosthodontics

Dr Meera Aggarwal BChD (Leeds)
Interests: Periodontology

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247094

East Anglia

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Email: reception@grantadental.co.uk
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On Specialist List: No

237823

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A 39 weeks
B 40 weeks
C 50 weeks
D 52 weeks

Q2: Up to how many Shared-Parental-Leave-In-Touch (SPLIT) days are available to be shared between the parents?

A 5
B 10
C 15
D 20

Q3: Which of the following is not necessarily a characteristic you should look for when choosing someone from outside the practice to chair an appeal hearing?

A They should be a dentist
B They should be able intelligently to assess the facts
C They should be able to come to a reasoned decision
D They should have the moral courage to tell you if you got your initial decision wrong

Q4: Which of the following have been identified by Department of Business Innovation and Skills (BIS) surveys as causes of cash-flow difficulties: a – income fluctuates while outgoings are steady; b—outgoings fluctuate while income is steady; c – early payment required by suppliers?

A a and b only
B a and c only
C b and c only
D a, b and c

Q5: What proportion of small businesses have suffered because of flooding, drought or snow over the past three years?

A One-third
B One-half
C Two-thirds
D Three-quarters

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