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JANUARY 2016

Cover illustration Danny Allison

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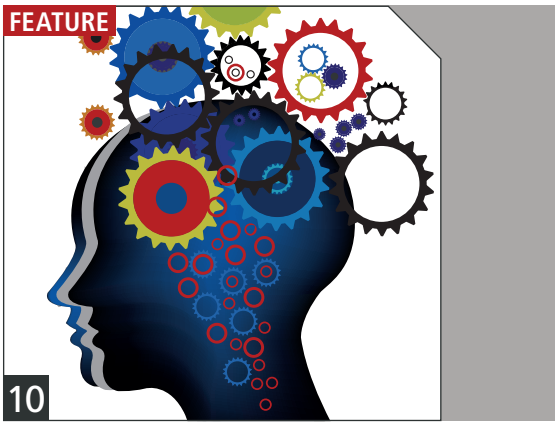
To contact the **Advertisement Office**: Tel: 020 7843 4729. To contact the **Editorial Office**: 64 Wimpole Street, London W1G 8YS. Tel: 020 7935 0875. Fax: 020 7487 5232. E-mail: bdjinpractice@bda.org. Web: www.bda.org/bdjinpracticeonline. Published for the **British Dental Association** by: Nature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

 ISSN 2057-3308.



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EMPLOYMENT LAW

Don't risk falling foul of this law

Most UK employers are not yet ready for the introduction of the national living wage, despite having just three months until it becomes a legal requirement, a government report has warned.

Business minister Nick Boles said that many organisations risk litigation because only 39% have told their staff about the upcoming changes and less than one-half (45%) have updated their payroll to take the increased rate into account.

From 1 April 2016, the hourly rate for those aged 25 and over will rise to £7.20, an 11% increase in the current mandatory pay rate.

Despite 63% of employers saying they knew who in their business should be receiving the new minimum wage, most of the organisations surveyed had not yet made preparations to implement the changes.

According to the survey by the Department for Business, Innovation and Skills (BIS), which polled around 1000 employers across the UK, 93% agreed that the national living wage was a good idea, with 88% predicting it would lead to higher productivity.

Four-fifths (83%) of respondents said the living wage would make staff more loyal to the organisation and 86% said the increased minimum rate would boost staff morale.

But despite these positive reactions to the new mandatory rate, many employers had still to prepare for its introduction to "properly reward their staff and avoid falling foul of the law," Boles said.

"The Government's new national living wage will provide a direct boost to over two-and-a-half million workers in the UK – rewarding and providing security for working people.

"I am urging businesses to get ready now to pay the new £7.20 rate from 1 April 2016."

Critics claim the increased costs on business could put up to 60,000 jobs at risk, but the Government's latest survey suggests employers are looking to other methods to help offset the increased wage bill. These are improving efficiency and productivity to help meet the cost increases, according to the professional body for human resources, the CIPD.

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More contract concerns

Two-thirds (68%) of dentists have said patients being unable to get the services they need is their greatest concern about the impact of the new NHS contract, according to research.

Viability of smaller practices is their second biggest fear, with more than one-half (59%) forecasting closures. An increase in private dentists (28%) ranks as the third.

Consolidation of practices, at 25% (*see also page 8*) and an increased demand for dental care professionals (23%) were identified as other concerns with the contract. Only 4% believe it will have no effect on the profession.

Head of marketing Alan Whiting at Wesleyan Group, which conducted the research, said: "The new contract is dentists' biggest concern about their profession, and its impact on patients is their biggest concern about the contract.

"But the contract will also have financial implications for dentists and their practices."

Three skills needed for growth

One in three small and micro-businesses has failed to grow in the past five years, according to research by the Association of Accounting Technicians (AAT).

To address this trend, many of them said they needed to have better marketing, PR and web skills (31%), citing these as the most important factors that would help them grow their businesses.

Other factors holding back growth, according to one in two of them (56%), were: a lack of capital to expand; too much red tape; and a lack of support from banks.

The study of 1000 small and micro-businesses found that 33% had failed to experience growth in revenue, while 31% had not seen an increase in profits since 2010.

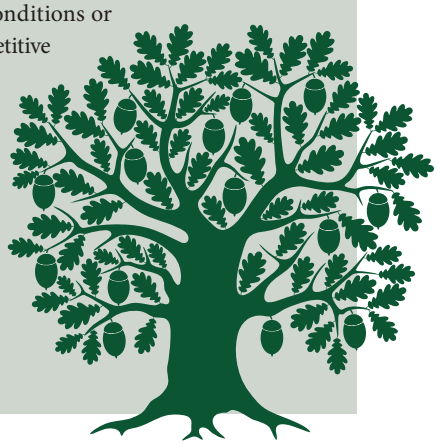
Despite this gloomy review, forecasts for growth are much more optimistic: 76% of small firms expect an increase in revenue and 78% predict profits will rise over the next five years.

But over one-half (58%) said they did not have a business plan to help them achieve this, although 10% said they wished they had one but did not know how to put one together.

"Having the necessary financial skills and a clearly defined business plan are essential tools to help firms expand successfully," chief executive of AAT Mark Farrar said.

"Growing your company can be one of the hardest stages in the life of a business but with the right skills it can be done. Growth can put pressure on cash flow, which is why many businesses fail when they're expanding.

"One of the most important things growing companies need is to ensure cash flow is effectively managed and the company has a robust, but agile, business plan. Whilst a strong sense of direction is important, it's also necessary to develop contingency plans should market conditions or the competitive landscape change."



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STAFF

Healthcare staff among most-bullied workers

Workplace bullying – especially of healthcare workers, among others – is on the rise, a study has found. But many staff are too afraid to talk about it.

Acas analysis of the latest representative surveys of workplaces, health and safety representatives and employees found that there are more incidences of bullying among public-sector minority ethnic workers; women in traditionally male-dominated occupations; workers with disabilities or long-term health problems; lesbian, gay, bisexual and transgender people; and workers in health care.

This analysis, *Seeking better solutions: tackling bullying and ill-treatment in Britain's workplaces*, also looked at calls by employers and employees to the Acas helpline (**below**).

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Acas chair Sir Brendan Barber said: "Our analysis reveals that bullying is on the rise in Britain and it is more likely to be found in organisations that have poor workplace climates where this type of behaviour can become institutionalised.

"Callers to our helpline have experienced some horrific incidents around bullying that have included humiliation, ostracism, verbal and physical abuse. But managers sometimes dismiss accusations around bullying as simply personality or management style clashes whilst others may recognise the problem but lack the confidence or skills to deal with it.

"Businesses should be taking workplace bullying very seriously as the annual economic impact of bullying-related absences, staff turnover and lost productivity is estimated to be almost £18 billion."

Bullying and harassment is any unwanted behaviour that makes someone feel intimidated, degraded, humiliated or offended. The Acas helpline has received around 20,000 calls related to bullying and harassment over the past year with some callers reporting that workplace bullying caused them to self-harm or consider suicide.

"Anti-bullying workplace policies and managers with good people-management skills are essential to deal with the growing problem of bullying," Brendan Barber continued.

"Our study shows that encouraging a positive workplace climate is just as important as it allows people to have the confidence to report bullying when it occurs."

The study recommends that workplaces agree standards of acceptable and unacceptable behaviours and senior leaders act as role models for these standards. ◆

What Acas helpline found

- Barriers to people making complaints, such as the fear that trying to do something about unwanted behaviour might make the situation worse
- Ill-treatment from other staff often built up to the point where people dreaded going to work, their family and home life had been affected and many took leave to escape the workplace
- Inexperienced employers can feel they lack the skills to go through the complex grievance and disciplinary procedures that bullying allegations may involve
- Managers alerted to bullying allegations can favour simply moving staff around rather than investigating and dealing with underlying behaviours

Age gap fuelling workplace conflicts

Two-thirds (65%) of UK employees are experiencing intergenerational conflict at work, according to a survey.

For the first time in history, five generations of employees are working side by side, with consultants in their 80s serving alongside fresh talent in their teens. But the pan-European study by human capital management (HCM) firm ADP of 11,000 working adults found that the 65-year-age gap can lead to conflict in the workplace.

Generational conflict is primarily caused by: younger and older employees having different views about how things should be done (19%); older workers working for longer leaving less room for new talent (18%); and differing approaches to organisational values and corporate responsibility between the groups (18%).

Younger workers seem to be finding it more difficult to cope with age diversity. The study found that 16% of them believe their ageing management is out of touch with modern trends and a further 15% think older workers are resistant to change. But 94% of older workers believe that younger generations are armed with the skills to be successful in their roles and only 12% of employees say that older workers perceive younger talent entering leadership positions to be a threat.

Although 39% of employees are anxious about losing talent and knowledge as older workers retire, only one in ten businesses plans to employ retired employees as consultants.

"Diversity is one of the greatest assets to a business," HR director at ADP UK Annabel Jones said.

"While millennials bring new ways of working and a fresh set of skills to the workplace, older workers have rich and invaluable experience.

"It is concerning to see how much conflict the age gap can cause in UK businesses. Organisations must consider how they can mitigate these issues to enable them to engage with, and harness, the full potential of each age group." ◆

PAY

Work-life balance beats big bucks

Despite most people setting out to earn as much as possible from their jobs, nine in ten (91%) believe there is a point at which they would be happy to stick with their current salary rather than face a more hectic, stressful life after a pay rise.

This tipping point is an annual salary of around £37,000 – when the extra money isn't worth the sacrifice, responsibility and stress that comes with it, a study has found.

Almost two-thirds even admitted they have considered taking a pay cut or demotion to have a more fulfilling life and improve their work-life balance. And only one in ten believes money can buy happiness.

While the average Brit says they need to earn a minimum of £24,270 to be comfortable, anything over £37,396 has to be considered carefully to see if the cons are worth the extra cash. And, although some would be willing to accept the sacrifice, 88% would, or have, turned down a more senior job, or a pay rise, if these were likely to have an effect on their work-life balance.

Being financially rich ranked only the eighth most important area of life, the survey found. Having a happy family life is most important, followed by being healthy, having a good work-life balance and having a partner or being married. Further down come having a good circle of friends, being happy at work and having an active social life.

And 66% would prefer a job they loved, but which wasn't particularly well paid, than one they hated, but had a good salary.

"While money is one of the main reasons we go to work, it seems there is a limit on how much we are prepared to earn if it is going to affect our lives in other ways," senior brand manager for Anchor Cheddar, which commissioned the research of 2000 Brits, Lucie Illingworth said.

BOOK REVIEW

Delegation results in beneficial redundancies

The gift of time: how delegation can give you space to succeed
Gail Thomas
Capstone, 2015
ISBN: 978-0-857-08595-5
£12.99

Author Gail Thomas asks at the very beginning of this 260-page paperback: "A whole book on the subject of delegation?" Indeed, a book of this size devoted to this one single subject may appear somewhat fanatical, writes BDA Librarian **Roger Farbey**.

But there is more to delegation than a mere dictionary definition. Starting off with the benefits of delegation, Thomas suggests that, just as the job of parents is to make themselves "redundant" by making their offspring fully autonomous adults ready to fly the nest, delegation will ultimately result in "redundancy" at work, but in a beneficial way. It is a long-term goal: Smith delegates work to Jones who in turn delegates to Brown and eventually Smith retires leaving Jones to do Smith's work and Brown to do Jones's. So, delegation creates new jobs. But this is only one aspect of delegation.

The short-term benefits of delegation are quite different. Delegation offers opportunities for managers to explore the limits of their potential because they are not bogged down by the minutiae of their workload. It offers employees the chances to develop new skill-sets. It frees up time, which has a beneficial impact on morale and gives staff a new sense of empowerment.

These "soft benefits" of delegation are useful, but there are also "hard" (ie, financial) benefits, too: for example, the savings made on staff salaries as a result of reduction of tasks being carried out by over-qualified staff. Over 16 chapters, Thomas systematically covers all aspects of the subject: including, types of delegation, barriers to delegation, disastrous delegation and how to delegate. So, yes, a whole book on delegation, and justifiably so.

For more: www.bda.org/booknews

Pen and paper still tops

Most UK micro-enterprises are still being driven by pen and paper rather than cutting-edge technology, research has found.

Although 67% of the micro-businesses and sole traders surveyed use a smartphone for business, 63% still use pen and paper to manage their diary and almost one-fifth rely on just their memory to ensure they know where to be from day to day. Yet 20% said they had lost money in the month before the survey because of poor diary-keeping or communication.

The importance of a mobile to communicate with customers is, however, recognised. Over one-third said their phone was extremely important or vital to their business: only 16% believed they could operate without it. And 52% communicate with customers by text and 65% by mobile call, compared with 50% who use a landline.

The old way is still the most common approach to finding new customers: 86% of sole traders and small businesses still rely upon word of mouth for this. And almost one-half still use pen and paper to track their customers.

When it comes to taking payments, traditional methods are still popular. Despite plans to phase out cheques by 2018, 44% are still accepting these.

"The research findings show that the majority of sole traders still value the importance of writing when it comes to diary-keeping and customer management, founder of professional-services-marketplace Bidvine.com Sohrab Jahanbani said.

"However, there has been some progress towards the use of technology: despite still using the mighty pen, 78% do use email to communicate with their customers.

"It is also clear that the mobile phone has become an integral part of even the smallest businesses. It shouldn't be a 'one size fits all' approach – through trial and error these businesses are learning which technologies provide benefit and, in some cases, when a more traditional system will do the job just as well."

Federating: your practice's future?

by Penny Whitehead,
the BDA's Head of Policy and Research

In 2015, the American Dental Association (ADA) published a seminal report on the future of dentistry in the USA, *A profession in transition: key forces reshaping the dental landscape*. The picture painted of dentistry in the USA has many parallels to the UK, including the growth of corporates, flat levels of turnover and rising costs. Increasing consumerism and the current generation being much less likely than preceding ones to seek regular dental care are also helping to change the dentistry landscape.

We have seen these trends clearly in the UK with NHS fees failing to keep pace with rising practice expenses and an oversupply of providers in many areas, leading to increased competition for patients. Coupled with this is the pressure from the NHS in England for integration of services in primary care and too few commissioners to manage thousands of individual NHS contracts. In medicine, doctors are responding to these pressures by forming federations, with mixed results, (**see page 8**) to provide NHS services in co-operation with other GPs and primary-care providers. Would this be a good idea for dental practices, particularly small ones?

Co-operation between practices is always more likely to be successful where partners do so because they believe they can work together, rather than being forced to, for example by NHS contracting bodies. The time may therefore be right for some dental practices to begin thinking about the pros and cons from their own perspectives.

Through means of an appropriate legal "vehicle", be that a form of co-operative, limited liability company or partnership variant, individual dentists operating as small businesses can band together under one "umbrella" to present a single face to suppliers, customers, commissioners, regulators and potential business partners.

An appropriate umbrella body allows participating members to take advantage of, to a greater or lesser extent, benefits that would otherwise be denied them.

> "The trend towards larger, consolidated multi-site practices will continue, driven by changes in practice patterns of new dentists, a drive for efficiency, and increased competition for patients. The pressure to reduce costs will also drive innovation, including exploring alternative care delivery models." *American Dental Association 2015*

Economies of scale

Bargaining with suppliers as a collective body when buying equipment and services to achieve an overall preferential rate: for example, laboratory work, consumables, IT services, accountants and equipment. Shared equipment is also possible, such as an orthopantomogram.

Shared staffing

Employing staff: for example, practice managers and dental therapists and dental hygienists through the umbrella body, thereby sharing the burden of salaries and allowing for more effective and flexible allocation of staff time and resource.

Increased brand identity/customer face

Through operating as part of a co-operative body, each of which is promoting a shared identity, members can potentially benefit from an exponential increase in their joint brand identity and reach out to a far wider customer base.

Increased confidence

With more dental practitioners operating from one established, identifiable and branded body tendering as a single entity, potential business partners may have greater confidence in the reliability and robustness of the group as a potential contractor as opposed to smaller independent providers. For NHS tendering, reduction of risk to the NHS commissioner is an important criterion for success.

Easier contract management

At present, NHS contracts have to be managed individually. However, given the reduction in commissioning and contract-management support for dentistry, it is highly likely that NHS England will offer providers with multiple practice locations (for example, 20) a lead contact for contract management. Federating will allow the federation to manage these contracts more easily. It is also possible to sub-contract units of dental activity (UDAs) among contracts within the federated group.

Pooled expertise and experience

The combined experience, expertise and ideas of the group are available to all members, whether from a clinical- or business-development perspective.

Shared capacity

A co-operative grouping that includes a provision to share workload such as UDA commitments within a defined geographical area as well as business expenses has far greater flexibility to ensure performance of contractual obligations than does an individual contractor.

Limited liability

Depending on the legal "vehicle" used to set up the co-operative, affiliates (members of the group) may benefit from limited liability. This can, of course, be perceived a disadvantage in co-operating with other dental practitioners.

Informal arrangements

Federations of dental practices could take many forms, both formal and informal. Informally, practices could work together to share business intelligence, provide mutual support and take part in peer-review and audit activities.

Practices could buddy with each other to cover Christmas, religious holidays and periods of holiday leave. They could participate together in peer review and audit which, as a by-product, will provide clinical support and so reduce stress, and share the cost of in-practice training such as CPD.

From a business perspective, practices could share intelligence about local and national issues that may affect the practices involved and build support networks for practice staff.

Legal vehicles

Having a legal vehicle (a company, limited-liability partnership or perhaps a community-interest company) will have advantages and could bring benefits such as reduced CQC registration fees. Trust would be needed among the practice owners, however, and legal and financial advice in drawing up an agreement would be vital. It is equally vital that affiliates of the co-operative, in whatever form it takes, sign up to an agreed dispute-resolution process before going into business together. This could be a form of alternative dispute resolution, such as mediation or arbitration, or a judicial dispute resolution under the auspices of a pre-defined jurisdiction: for example, that of England and Wales.

Potential affiliates

There is a lot to consider in federating and an important issue is identifying potential affiliate practices. The purpose of co-operation in terms of this process is that "the whole is greater than the sum of its parts". Think about how your business, with its individual strengths, might complement another practice and where your weaknesses can be lessened.

Business compatibility

Consider if it is to your advantage to co-operate with a potential affiliate. Unless a smaller concern brings with it a definable benefit, or you can sell your particular strengths to a larger concern, it may be sensible and realistic to think about affiliating with practices similar to your own in terms of size and resources.

Personal compatibility

Depending upon the legal route you adopt in working in co-operation, you may end up in partnership with other practitioners or acting as one of a number of directors. So, the other practitioners could effectively have a significant amount of control over the fortunes of *your* business. On this basis, mutual respect and trust are vital factors in the decision-making processes.

The BDA has advice for members on working co-operatively: go to www.bda.org ◆

COMMENTARY

Learning from medicine

by Andrew Lockhart-Mirams, (Senior Partner) at Lockharts Solicitors. Andrew can be contacted directly at csd@lockharts.co.uk

In general medical practices the move towards federating and the formation of provider entities has gone through a number of stages. Stage 1 can best be seen as including the early development of federations and provider entities where the work was led by enthusiastic entrepreneurs across some, but not all, parts of the country. There were two main models here. One was where practices combined to secure contracts for what are generally described as "enhanced services", commissioned either by Clinical Commissioning Groups (CCGs) or local authorities. The other was where federations worked on a much larger scale, often winning contracts for extended access, walk-in centres or urgent care.

Stage 2 is probably best understood as the stage where other groups of practices saw what was happening to those at Stage 1 and thought that they should "get in on the act". While most Stage-1 formations have been pressing ahead, many of the Stage-2 formations have faltered along the way and are really producing very little. There seems to be a number of reasons for this and, apart from lack of entrepreneurial leadership, include, lack of time to put into the project and, in quite a number of cases, some form of mistrust among the practices who might participate.

Stage 3 brought about a measure of revival and, in many parts of the country, was led by CCGs wanting to promote the use of federated working, mainly because it would be far preferable for them to contract with one entity rather than 10, 20 or 30 separate practices. Possibly, however, this stage is also beginning to peter out and we are now moving to the next, and possibly final, stage.

Stage 4 is where a number of CCGs are recognising the inertia that has dogged Stages 2 and 3 and are beginning to encourage the merger of practices rather than the separate formation of a provider entity. But it has always been the case that a practice merger that is really going to work is formed because the partners believe they can work together and not because they are pushed into it by CCG pressure.

Clearly, it is inappropriate for CCG funding to be spent supporting one provider entity when there may be other entities who, at a later stage, will want to challenge for contracts, but it is perfectly acceptable for CCGs to hold events where all practices in their area learn about the pros and cons of federating and/or merging.

> "There may be similar opportunities for general dental practitioners but, if they choose to work in small federations, it is unlikely they will be able to secure any of the more profitable work in urgent care or extended access."

Undoubtedly some of the more commercially focused federations have succeeded, particularly where they have been able to win extended-access contracts under the Prime Minister's Challenge Fund. But if the federation is only securing a relatively small volume of enhanced-service work, sub-contracted into each practice, and which is not pensionable, this does little more than balance the practice books and the income gained at the start has to be set off against the set-up costs, procurement costs and the annual running and maintenance costs.

There may be similar opportunities for general dental practitioners but, if they choose to work in small federations, it is unlikely they will be able to secure any of the more profitable work in urgent care or extended access. Possibly the way forward is for them to work with the larger, more progressive, federations to provide a one-stop-shop.

Where enhanced-service work is done by practices on a sub-contract basis there is little, if any, profit in the operation for the federation itself because all the income is passed through the provider company to the sub-contractors after the payment of the company's expenses. Certainly, this form of working does not give rise to a capital share value. If, however, contracts for large-scale working can be won the operation has a much more commercial flavour, with the company paying the staff to perform the work and hoping to make a profit in each trading year. If GDPs were able to link into share ownership in one of these enterprises there could be dividends or capital gains to the investment. ◆

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Follow Acas guide to show fairness

by James Dawson,
Head of Advice Publications at the BDA. James is responsible for the Association's guidance documents for members in general practice on legal matters including associate contracts, staff employment and data protection

Guidance on how to investigate workplace incidents has recently been published by Acas. *Conducting workplace investigations* covers the steps to take to gather the facts before formally beginning disciplinary proceedings or responding to a grievance.

If you are faced with a workplace incident that could develop into a disciplinary matter or lead to an employee raising a grievance, then sticking to the Acas guidance is a sure way to show that you are handling it fairly. If events lead to an employment tribunal, the case could be decided on if, in the circumstances, you are judged to have acted reasonably or unreasonably towards the employee.

If you can show how you followed guidance, such as that produced by Acas, it helps demonstrate that you have been objective and reasonable. And some latitude is given for small businesses, like many dental practices, because they do not have the resources to carry out an investigation in the way a large business that has a human-resources (HR) department could. The model BDA procedures distil Acas's guidance into step-by-step guides. If you are an Expert member see www.bda.org/ExpertSolutions for copies of the BDA's template disciplinary and grievance procedures and model letters.

The Acas guidance provides information on the role of the investigator: identifying the information that needs to be gathered and who needs to be interviewed; conducting interviews; and collating the information so a decision can be taken about next steps.

The investigator

Basically, the person doing the investigation has to find out the facts. You have to look for evidence that either supports or contradicts the allegation. Ideally, the investigator should not have been involved in the original incident. And they should not be the same person as the one who will make any necessary disciplinary decisions.

This is easier to do in larger employers and the Acas guidance recognises this. Smaller employers are advised to try to create as much separation as possible between those directly involved in the incident, the investigator and the decision-maker. If this is not possible you need to be rigorous in showing that your procedures have been followed objectively. If the allegation is serious it may be worth bringing in an outsider, such as another local dentist, small business owner or (for a fee presumably) the practice accountant or solicitor.

The information

Think about what you need to find out. Identify sources of information and how to get it. A good start will be to check the practice policies and procedures that are relevant to the issue in hand. Other sources of information could include practice records.

Closed-circuit television (CCTV) footage could be checked. If the system is operated by someone else – cameras covering the street outside the practice, for example – then you may need to make a formal request to the operator and seek consent from anyone appearing in the images.

Asking to search an individual's possessions can only be done in rare circumstances. You must have a legitimate justification for doing so, tell the person what these are, and allow them to be present while you do so. The employee may refuse if they believe such a search is too intrusive and this cannot automatically be taken to imply guilt. If a criminal matter is suspected then it may be better to involve the police.

Generally, the most important investigation will be talking to the people who were directly involved in the incident – including the employee who may be disciplined or the employee who raised the grievance – and anyone else – staff, associates or patients – who witnessed the incident. Once you have identified people who may be able to give relevant information about the incident, decide the best order in which to speak to them. There is no set rule about which would be the best order but make sure you speak to everyone. Some may give you information that you want to talk to the others about, so you may need to go back to people.

The interviews

Investigatory meetings should be conducted privately. These are not formal meetings but it is still a good idea to allow the witness to bring a companion if they want. For employees, this normally would be a work colleague or a trade-union official but you can consider friends or family if this would be appropriate.

Plan the questions that need to be asked to get the information you want to find out. The common approach is to ask open questions first to invite a full response in the person's own words. Only move onto closed questions on specific points to seek clarification once they have given you the overall picture. And avoid asking a series of questions all at once: this only causes confusion and could mislead the witness. For advice on interviewing witnesses, see www.bda.org/bdjinpracticeonline *Dealing with a reluctant witness* July 2015, pages 16-17.

Take your own notes of the meeting. Write down the date, time and place of the meeting; who was present; and what was said, including if the witness refused to provide some information. Ask the witness to sign these notes. Give them time to check through to make sure they are happy it is an accurate record. Because the notes are their evidence you should generally allow them to make amendments before signing them. If you believe that the changes contradict what was discussed at the meeting, then add a footnote to that effect. If they refuse to sign at all, try to discuss their reasons and allay their concerns. If they still refuse to sign, make a note of this fact on the statement, with any reasons that were given for not signing.

Sometimes you may accept statements written by witnesses whom you have not interviewed. This may be appropriate if the witness is not an employee, for example a patient or a supplier and you are relying on their voluntary co-operation; if the statement covers straightforward facts; or if a witness is ill.

The next steps

On finishing the investigation you need to review what you have found. Consider the agreed facts, the facts that are disputed and what claims are unsubstantiated.
A conclusion on how to proceed with the disciplinary or grievance matter will have to be reached as a result.
If you are in a large enough organisation the investigator should put all of this in a written report.

You can find BDA Advice *Disciplinary procedures and dismissal* and *Grievance procedures* at www.bda.org/advice and for the Acas guidance, *Conducting workplace investigations*, go to: www.acas.org.uk ◆

Holiday-leave entitlement following maternity leave

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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

An employee returning from maternity leave may come back to you part time. This may, in turn, raise issues about their holiday entitlement going forward. Those can be difficult to resolve easily because the employee may have accrued holiday both before they went on maternity leave and during that leave. And she may want to take annual leave immediately after her maternity leave, delaying her return to work by a few weeks.

Basic leave formula

Employers have to work out how much leave has accrued and when this leave can be taken. You need to approach this issue mathematically.

The basic legal rule is that employees are entitled to at least 5.6 weeks' paid leave each year. This is an strange number because it includes bank holidays and it is intended to give a full-time employee who works five days a week a minimum of four weeks' holiday plus the eight bank-holiday days each year (five days a week *multiplied* by 5.6 weeks a year *equals* 28 days' leave a year). Use this formula to work out the proportional entitlement for part-time workers: for example, someone working three days a week would receive three days *multiplied* by 5.6 weeks a year, which *equals* 16.8 days' leave a year.

The entitlement to 5.6 weeks' paid holiday is regardless of any sickness absence during any particular day or week and is regardless of any maternity or other family leave during any particular day or week. So, a woman taking a full year's maternity leave will still accrue all of her holiday entitlement. Her maternity leave, however, is likely to straddle two leave years, so some of her holiday entitlement may have to be carried over to the next year.

Carrying leave over

Leave does not normally carry over from one year to the next (you use it or lose it)

and there is no specific law covering the situation in cases of maternity. But the judgments in various court cases suggest there may be a right for new mothers to carry over their accrued holiday.

If a woman does not have the chance to take her annual leave before she goes on maternity leave, it would therefore be unwise not to let her take that annual leave in the following year. In any case, many women will use their annual-leave entitlement at the beginning or end of their maternity leave to extend either the beginning or end of their time off. Discuss maternity plans with your employee and discuss how they can use their holiday. That way, any problems can be spotted early and managed. A template, *Model maternity leave plan for employee* is available at www.bda.org/ExpertSolutions for BDA Expert members.

Calculating leave going forward

An employee who cuts her hours by going part time when she returns from maternity leave reduces her holiday entitlement proportionally going forward. But her holiday accrues at the old rate up to the date of her return. Accrued leave cannot be reduced *pro rata*: the employee's reduced hours affect only her future accrual of holiday entitlement. You must, therefore, assess an employee's outstanding leave entitlement when she returns from leave. Discuss this with the employee and be ready to explain your calculations to her if she queries them.

The returning employee could have a large amount of accrued leave to take, which may run to many working weeks – especially if she has carried over holiday from the previous year and has reduced her hours. In the example given (**right**) the employee returning on 1 October for three days a week has approximately 39 working days until the year-end but 25.2 accrued days of leave to take during that time. Ask her to suggest the best time for her to take this leave.

As with most employment-law issues communication is the key. ◆

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Worked example

If a practice's leave year runs from January to December and it offers 28 days' paid leave to full-time employees and a woman returns from maternity leave on 1 October, cutting her hours from five days a week to three days a week means her leave works out as follows.

Months	Proportion of the year	Annual entitlement for full-time worker (based on 5.6 weeks a year)	Full time or part time	Days that accrue
January to September	9/12 x	28 days x	5/5 =	21
October to December	3/12 x	28 days x	3/5 =	4.2
Total leave for the year				**25.2**

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Be up to date with medical-emergen

by Daniel McAlonan,

a Chartered Safety & Health Practitioner and the Head of Compliance at the BDA, who helps members on all aspects of health & safety law, infection-control requirements, practice inspections and compliance with professional regulations

An updated version of its free iResus app – a tool with which healthcare professionals can access the latest algorithms, such as basic life-support checklists or step-by-step resuscitation guides from its 2015 guidelines – has been release by the Resuscitation Council (UK). It can be installed on any iOS (Apple) or Android tablet and mobile device and downloaded from the Apple App Store or Google play and can be used to help the dental team in dealing with a medical emergency. Once downloaded, the app does not need an Internet connection to work as all the information is hosted on the device. It is not available for the Windows-phone operating system

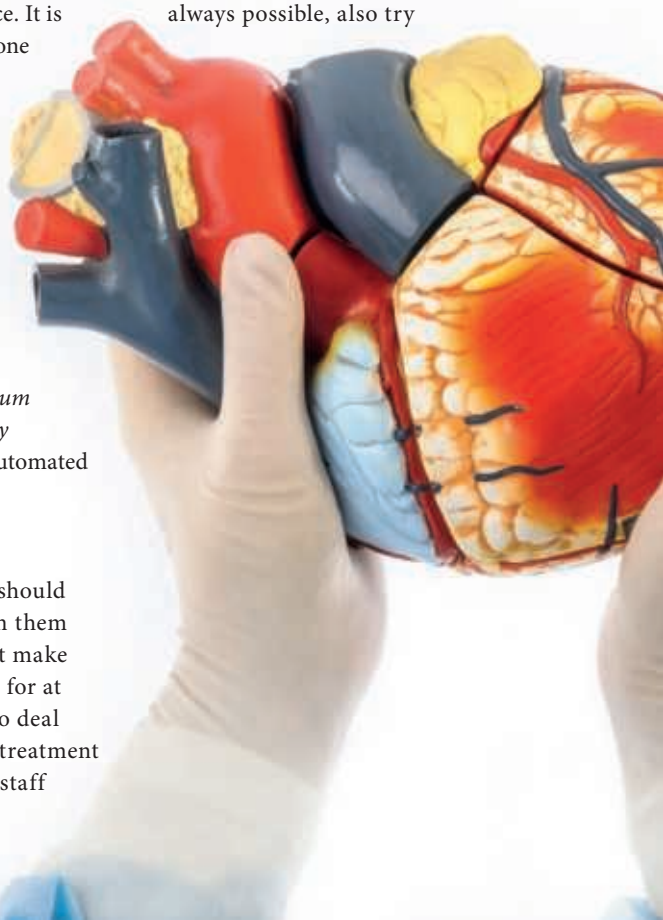
The Resuscitation Council (UK)'s guidance on medical emergencies and its training updates must be followed by General Dental Council (GDC) registrants. Its guidance for primary dental care is now made up of *Quality standards for cardiopulmonary resuscitation practice and training* and a *Minimum equipment list for cardiopulmonary resuscitation* (which includes an automated external defibrillator).

At least two

All members of the dental team should know the requirements placed on them by the GDC. All registrants must make sure that there are arrangements for at least two people to be available to deal with medical emergencies when treatment takes place. And all members of staff must know their role if there is a medical emergency.

Members of staff who might be involved in dealing with a medical emergency must be trained and prepared to do so at any time. They must practise together regularly in a simulated emergency so they know exactly what to do.

Registrants must be able to deal with a medical emergency during a home visit for treatment. It will be for each registrant to decide which emergency drugs and equipment to take with them and to be able to justify their decision if it was called into question. Although not always possible, also try



cy guidelines

> "All members of the dental team should know the requirements placed on them by the GDC. All registrants must make sure that there are arrangements for at least two people to be available to deal with medical emergencies when treatment takes place."

to ensure that two registrants attend any domiciliary visit. All registrants should also know the view of their dental defence organisation on this matter.

The GDC also highly recommends that registrants cover medical emergencies as part of their minimum verifiable continuing professional development (CPD) requirement. This should be at least 10 hours in every CPD cycle – with a minimum of two hours each year.

The resuscitation standards expected when conscious sedation techniques are used are covered in the existing guidance from the Academy of Medical Royal Colleges, *Safe sedation practice for healthcare procedures*. Scotland's National Dental Advisory Committee (NDAC) has published guidance for dental settings entitled *Emergency drugs and equipment in primary dental care*. Both can be viewed at www.bda.org/medicalemergencies

Other medical emergencies

For information on medical emergencies other than cardiorespiratory arrest, the Resuscitation Council (UK) directs the profession to guidance published in the *British National Formulary* (*BNF*). The BDA has recently issued its own publication on medical emergencies, reproducing with permission the advice from both the Resuscitation Council (UK) and the *BNF*.

And two quick-reference, medical-emergency posters are available. These were developed by the BDA in association with Walsall Healthcare NHS Trust. Copies can be downloaded from www.bda.org/medicalemergencies These posters were also distributed to all BDA members with the 11 September 2015 *British Dental Journal*.

Emergency-medicines rules

Some emergency drugs, such as prescription-only medicines (POM), are subject to restrictions imposed by medicines legislation. While dentists are allowed to buy any appropriate medicine, this legislation does not allow dental care professionals to buy or procure POMs such as midazolam, although it is included in the recommended emergency drugs list in the *BNF*. Generally, controlled drugs such as midazolam can only be administered by a dentist or on the prescription of a dentist. The administration of these drugs by a hygienist or therapist can, however, be covered by a Patient Group Direction (PGD). This is because hygienists and therapists working independently must have the recommended list of emergency drugs available in the practice. Prescription-only and pharmacy medicines for emergency use can only be legally obtained if ordered by a dentist but the PGD means they can be held and administered by hygienists and therapists without a dentist on the premises. Guidance on establishing PGDs is available at www.bda.org/advice in BDA Advice *Prescribing and medicines management*.

Drug storage

All drugs should be stored according to their manufacturers' recommendations. The Care Quality Commission (CQC) has asked some practices in England about the storage of glucagon. As the hormone that helps to raise blood-glucose levels, a glucagon injection can be used to treat episodes of severe hypoglycaemia if the patient is either unable to treat themselves or treatment by mouth has been unsuccessful.

The most commonly available form of glucagon injection is the GlucaGen HypoKit 1mg, which ideally should be stored in a refrigerator at 2 to 8°C, but must not be frozen. When stored in a refrigerator the manufacturer's shelf-life is 36 months.

The GlucaGen HypoKit can also be stored outside a refrigerator at a temperature of not more than 25°C for 18 months provided the expiry date is not exceeded during that time. It should be stored in its original packaging to protect it from light. ◆

The Do's and Don'ts of managing NHS activity

by Victoria Michell,
a practice management consultant in the Business and NHS Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and other general-practice matters

At this time of year general dental practitioners in England or Wales may want to close their books to new NHS appointments because they have already reached their contracted units of dental activity (UDA) target for the year. But even if you are over capacity, in almost every situation you cannot close your book (even though the *NHS Choices* website gives you the option to advertise that you are not accepting new patients).

Under-commissioning for dental services is not a new phenomenon and neither is the strain of managing NHS activity consistently throughout the financial year. Practices have long faced the challenge of new patients asking for appointments for a service that is fundamentally oversubscribed. With no further funding allocation to dentistry on the horizon, it is more important than ever that practices with an oversubscribed service manage their appointment books in line with their contractual obligations.

First come, first served

Since 2006, there has been no patient registration (previously you could manage your capacity by managing your patient lists). Your obligation is to offer NHS appointments on, essentially, a first-come, first-served basis. This obligation needs to be balanced with your allocated NHS activity. To avoid performing your activity too quickly, or being left with a surplus to perform come March, you will need to ensure you spread your allocation throughout the year.

Your first available routine NHS appointment may not be your first available appointment. Many practices manage their NHS activity by allocating one-twelfth of their annual activity to each month and arranging appointments in line with this. Managing the activity in this way allows some flexibility from month to month and avoids leaving the practice with too little activity or too much activity at year-end. But bear in mind your obligations to patients who are under a current continuing course of treatment (**left**).

Your contractual obligation essentially means that a patient who has never attended your surgery before should be offered the same appointment opportunity as someone who came to see you last year. There should be no favouring of recent patients over new patients, infrequent attenders or former patients. The rationale for this is to allow an open playing-field for patients wanting NHS dental care. Everyone, theoretically, should be able to have NHS dental care provided an NHS practice has available UDA capacity.

> "If you are likely to run out of UDA activity before the year-end, act quickly. Contact your local NHS England team to ask if they have any additional activity they could offer you. If none is available, will need to begin actively managing your activity. "

Off-target at the year-end

If you are approaching year-end with excess or not enough activity the sooner you deal with the problem the better.

If you are likely to run out of UDA activity before the year-end, act quickly. Contact your local NHS England team to ask if they have any additional activity they could offer you. If none is available,

Managing your NHS activity

- Set yourself monthly units of dental activity (UDA) allocations so you can plan to address increases or decreases in demand to keep to your contractual target
- Monitor your UDA performance each month to ensure you are achieving your monthly target.
- If you have performers at your practice, monitor their performance targets and take into account their holiday absences to ensure they are on track to meet your UDA target
- If you are not on target, raise concerns early within your practice and, if needs be, with NHS England
- If you delegate the management of your contract to your practice staff, ensure you check this regularly so you are always aware of the performance position

will need to begin actively managing your activity.

Remember, your obligation is to offer the next available NHS appointment to anyone wanting NHS treatment, to finish courses of treatment within a timely manner, be available during contractual opening hours and to treat urgent patients. You cannot "close your books".

This does not mean you need to over-perform but you must offer your next available appointment, which might be some time in the future or even in the next financial year. You could calculate the number of available UDAs and therefore the appointments available for each remaining week of the contract year. These obligations are balanced successfully during the last few months of the year by many practices.

With underperformance, bear in mind the 4% tolerance level. But this will mean doing more work next year to catch up with the shortfall, which must be made up within three months, on top of your regular UDA target. In any case, you should contact NHS England or your health board at the earliest opportunity. If you give them enough time they may agree temporarily to reduce your contractual target to allow you to avoid a breach notice. Or they might give the excess activity to another local practice, which is running out of UDA activity.

Alternatively, think if there are ways to catch-up on activity, through taking on an additional performer or extending your hours. If this is not possible, then calculate how much the underperformance may cost and negotiate with NHS England or your health board about how to handle the situation.

The BDA's Advice Team is on hand to discuss with BDA Extra and Expert members any issues they may have on how to manage contract activity in either of these instances: email PracticeSupport@bda.org or telephone 020 7563 4574. ◆

Scotland and Northern Ireland

Practices providing General Dental Services (GDS) services in Scotland and Northern Ireland do not have the contract-activity concerns that can affect practices in England or Wales. In both countries, a dentist must offer NHS treatment to their registered NHS patients to: "To secure and maintain their oral health." The gateway to treatment is, therefore, the acceptance of the patient under a continuing-care arrangement (adults) or a capitation arrangement (children).

There is no overall obligation to accept a patient and it is generally possible to refuse on capacity or business grounds. Of course, a patient cannot be refused on illegal discriminatory grounds, such as race or gender. Nor can they be refused following an examination on the grounds of poor oral health. You can, however, have a policy to accept only children or patients who are exempt from NHS charges.

Once a patient has been accepted onto a continuing-care or capitation arrangement they must be offered an appointment and provided with appropriate care. These arrangements can be ended, however: with three months' notice; if the patient registers elsewhere; if repeated missed appointments or non-payment of fees have led to an irrevocable breakdown in the dentist-patient relationship; or, in Northern Ireland, if the patient has not attended for 24 months. Further information is available online at www.bda.org/advice in BDA Advice *General Dental Services in Scotland* and *General Dental Services in Northern Ireland.*

Tips for successful orthodontic

by Victoria Michell,
a practice management consultant in the Business and NHS Team. Victoria advises members on all aspects of NHS general dental regulations and agreements and other general-practice matters

NHS orthodontic contracts in England and Wales are likely to be recommissioned soon. Usually time limited since the inception, in 2006, of the current NHS system, most orthodontic contracts have been rolled over and extended several times. But because of competition rules, it is anticipated that the NHS will decide that it should launch a widespread recommissioning process.

This alarm has been sounded before. As recently as the spring of 2015, it was widely anticipated that some areas of the country would see the mass tendering of orthodontic contracts. However, many were again extended for up to three years. Nevertheless, it is now more likely that after that latest round of extensions to orthodontic contracts the next tranche will be put out to tender.

Process could take months

Tendering is now a common way for public authorities to procure services, including dental services. Tender documents are, however, difficult to respond to and are often three times the size of a university dissertation. So, the BDA advises you to get ready in advance, ideally long before the process is up and running. Now is the time to prepare your practice for tendering because, given the workload, even when you have prepared in advance for the tender it will still take over your daily life (and often that of your practice manager) for the duration of the process. And the process can last up to nine months: from receipt of the first tender documents to the contract-award stage. Here are three areas out of many that you can turn your mind to now to begin your preparations.

Show a top-quality service

Demonstrating that you are already providing a top-quality service can be a key factor in successfully re-bidding for a contract. One way to determine if you are providing a good-quality service is using surveys to find out what your patients and general dental practitioners think of your overall service and where they think you can make improvements. A history of satisfaction surveys and a paper trail of actions taken off the back of the surveys will look positive in the eyes of the commissioners.

Provide value for money

The commissioners will be looking for value for money when they commission the new service, which means they want a

Consultancy and workshops

The BDA offers a consultancy service and workshops to help members prepare their practice for tendering. The next workshops are scheduled for 19 and 25 February at the BDA offices in London. The more work that can be done now to front load the process the better the tender will go. Contact the BDA Business Team on BusinessTeam@bda.org or 020 7563 4574 to find out more.

tendering

high-quality service for the least amount of money. As a benchmark, over the past five years, some contracts have been awarded at £45 to £51 a unit of orthodontic activity (UOA). If your current UOA rate is significantly above this, you will need to look closely at your profit margin and

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business accounts. Calculate what your minimum UOA figure needs to be for you to run an excellent service while giving the practice a safety buffer and profit margin.

If this exercise tells you that you need to make cost savings, work out if you could take on more activity for a lower UOA rate and maintain your business. Talk to your accountant about the costs of running your service to provide a competitive tender. Or, if you are a BDA Extra or BDA Expert member, speak to the BDA Business Team on BusinessTeam@bda.org or 020 7563 4574 for further advice on how to put together a strong bid.

Prove you are eco-friendly

Tender documents commonly ask questions that look at environmental issues. Some practices ignore this section but, to give yourself an edge, make sure you have given it real consideration and that your practice is as eco-friendly as possible.

You could provide details of your waste disposal and if you recycle as much of your (non-clinical) waste as possible. Highlight if you are close to local public-transport links and if you encourage your patients to travel by means other than cars. Say if you have a bike shed, if you operate a cycle-to-work scheme, or a carpool for your staff. List any supplies that you are sourcing locally to support local trade and reduce the impact (and cost) of transportation.

One final tip – get your practice team involved in the process. They will see your business from another angle, be engaged with your patients and see pitfalls and strengths that may prove very useful when you are preparing your practice to bid. ◆

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CONTRA-INDICATIONS AND PRECAUTIONS FOR USE: Hypersensitivity to any local anaesthetic agent or any component of SEPTANEST. Do not use SEPTANEST in patients who have experienced bronchospasms after administration of products containing sulphites, patients with deficiency in plasma cholinesterase activity,patients receiving MAOI or tricyclic anti-depressants,patients in whom general anaesthesia might be required to complete the procedure and in children under 4 years of age.

SPECIAL WARNINGS: SEPTANEST should be used with caution in patients with hepatic disease, thyrotoxicosis, cardiovascular disease, abnormalities of cardiac conduction, epilepsy, and in diabetic patients. Intra-vascular injection is strictly contra-indicated. Resuscitative equipment, anti-convulsant medicines and other resuscitative drugs should be available for immediate use. The product should only be used in pregnancy when the benefits are considered to outweigh the risks. Breast feeding should be avoided for 48 hours after use of SEPTANEST.

ABILITY TO DRIVE AND USE MACHINES: No demonstrated effects upon motor coordination, however subjects who suffer adverse effects should not drive or use machines until symptoms have resolved.

INTERACTIONS: SEPTANEST should be administered with caution to any patient receiving drugs with sympathomimetic properties or with agents whose therapeutic actions may be antagonised by adrenaline. Articaine should be given with caution in patients receiving an antiarrhythmic agent.

UNDESIRABLE EFFECTS: Hypersensitivity, overdosage or intra-vascular injection may result in excitatory or depressant manifestations of the CNS, depressant cardio-vascular reactions, respiratory and allergic reactions. . Patients with peripheral or hypertensive vascular disease may develop ischemic injury or necrosis.

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Sales-and-marketing-consultants Pitch Factory has launched an online business-accelerator service for small and medium-sized enterprises (SMEs) called Factoria Plus.

It is designed to help SMEs develop and grow faster by providing them with technology, access to expertise, and information to support three key tasks.

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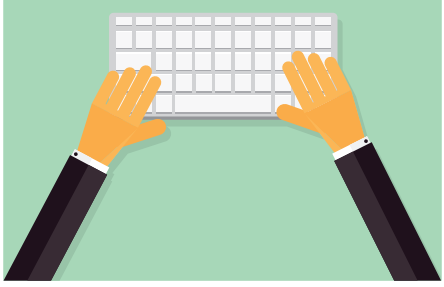
"Factoria Plus provides businesses with a winning combination. The latest technology for producing high-quality sales and marketing materials, and expert help to help them develop and grow whenever they need it," managing director of Pitch Factory Tony Treacy said.

"Factoria Plus will enable SMEs and larger companies to jump to the next stage in their development cost-effectively."

For further information contact: email: tony.treacy@pitchfactory.com or call 07904 155618.



Upgraded Voyager chair

The new Voyager III is a significant upgrade from the previous model. Improvements include better vacuum air-flow, the chair base and delivery arm have been redesigned, and the chair's ergonomics and comfort have been improved. It also comes with a touchless sensor as standard.

As with the previous model, the Voyager III can be moved from left to right-handed use in a couple of simple steps. Moreover, the clever Below-The-Patient engineering ensures that neither left nor right-handed use is compromised.

The ultra-slim backrest will eliminate any physical stresses that can be experienced with some treatment centres. The operator console is easy to clean, easy to position and rotate, and is height adjustable. The twin-articulating headrest and smooth, near silent operation will help patients to feel relaxed, while the compact, rotating armrests will ensure ease or access from either side.

Having the operator console located below the patient ensures it can be positioned out of site until needed. This allows for all the clean and preparation to be done out of the patient's view and is more efficient in terms of time and space.

For more visit www.belmontdental.co.uk or call 020 7515 0333.

Stock up with salt for winter

Workplace-equipment-supplier Slingsby is urging all businesses and organisations to stock up early with salt in preparation for winter, and to avoid inferior products that often fail to melt snow and ice.

Slingsby supplies winter products from snow shovels to grit bins and has a state-of-the-art salt-distribution and bagging plant to offer next-day delivery throughout the UK on all quantities of salt and rock salt, ranging from 25kg to several tonnes.

"Every year workplaces are caught out because they wait until bad weather hits before thinking about their salt stocks and then find themselves caught up in an inevitable rush to buy it," Slingsby group sales and marketing director Lee Wright said.

"Salt is easy to store and keeps for a long time so it makes sense to stock up with it early.

"Workplaces should also be aware that salt quality can vary greatly when it comes to melting snow and ice. Salt should meet BS 3247: 1991, which means it contains less than 4% moisture and can be spread easily and effectively.

"There are also two main salt products that are used for de-icing purposes consisting of white salt and brown rock salt. White salt is clean to handle and leaves no residue whereas rock salt contains mudstone so, while it's not as pure as white salt, it goes a long way making it perfect for large sites."

For further information go to www.slingsby.com

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Dr Bola Soyombo
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Dr O Onabolu
On Specialist List: Yes, Periodontics

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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
Matthew Brennand-Roper BDS MClinDent (Pros) MJDF RCSEng MFDS RCSEd MPros RCSEd
Interests: Fixed and Removable Prosthodontics, Dental Implants
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 Robert Philpott BDS MFDS MClinDent MRD (RCSEd)
Interests: Endodontics
On Specialist List: Yes, Endodontics
Dr Penny Hodge BDS Edin 1982, PhD Glasg 1999
Interests: Periodontology
On Specialist List: Yes, Periodontics
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
Prof Lars Sennerby DDS, PhD (Visiting Professor)
Interests: Implant Dentistry, Biomaterials, Bone Biology
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
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

259506

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Email: info@blackhillsclinic.com
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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
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

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South East

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

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

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

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

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

263521

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37 Wood Lane, Sonning Common, Berkshire/Oxfordshire, RG4 9SJ
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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

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On Specialist List: Yes, Restorative Dentistry and Periodontology

257674

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257244

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

258051

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

266913

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

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

270171

DENTAL SPECIALISTS MK
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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

North West

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

261006

North

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

261782

East Anglia

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Email: enquiries@devonshirehousedental.co.uk

Specialist Referral and Education Centre

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

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

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

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

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

Specialist Orthodontist:
Dirk Bister

269120

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A 31 January 2016
B 1 April 2016
C 30 April 2016
D 30 June 2016

Q2: Which of the following is a "hard" benefit of delegation?

A Offers staff the chance to develop new skill-sets
B Has a beneficial impact on staff morale
C Gives staff a new sense of empowerment
D Allows salary savings by reducing tasks being done by over-qualified staff

Q3: If a practice offers 28 days' paid leave a year (January to December) to full-time employees, how much leave will a woman who, on returning from maternity leave on 1 October cuts her hours from five days a week to three days a week, accrue?

A 5.6 days
B 16.8 days
C 25.2 days
D 39 days

Q4: What is the shelf-life of a GlucaGen HypoKit 1mg when it is stored in a refrigerator?

A One month
B 12 months
C 18 months
D 36 months

Q5: Which of the following statements is true of salt used for de-icing?

A Salt that meets BS 3247: 1991 contains less than 4% moisture
B White salt contains mudstone
C White salt is perfect for large sites
D Brown rock salt leaves no residue

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