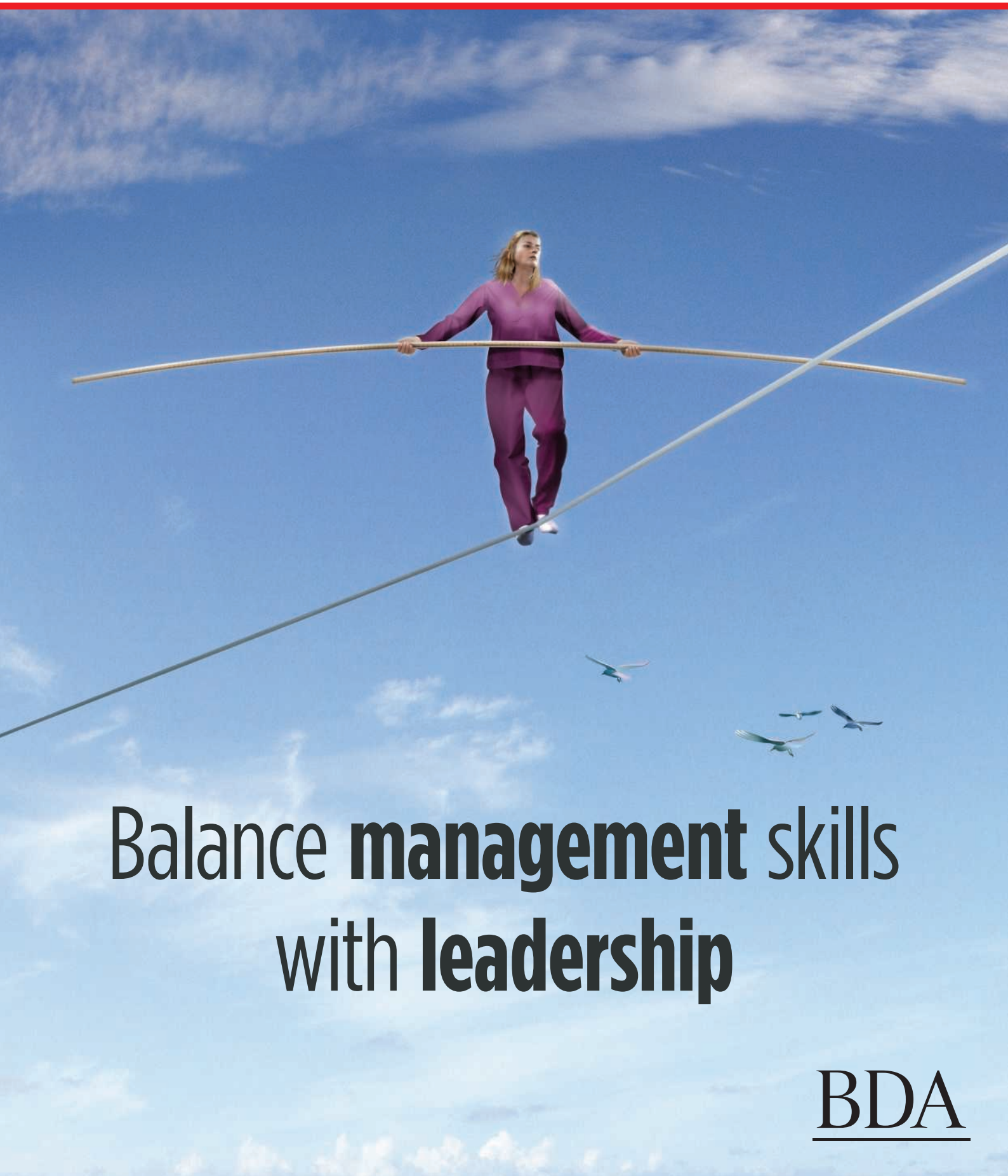
BDJ InPractice
September 2015



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BDJ InPractice

SEPTEMBER 2015

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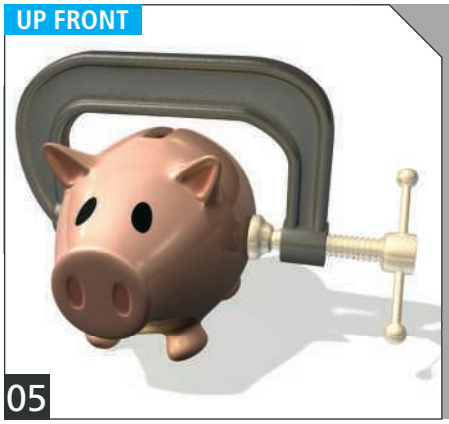

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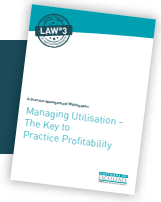

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Check your energy contract

SMALL TO MEDIUM-sized businesses (SMEs) are being rolled over and locked into energy contracts, according to a study.

It has found that 18.4% of businesses have been automatically rolled over onto a new contract without their permission and a further 16% do not know if they have been a victim of auto-renewal.

While Ofgem and some energy suppliers have taken steps towards making the business-energy market fairer, the practice of auto-renewal – where businesses are locked in to another fixed-term contract without their express permission – continues.

The SwitchMyBusiness.com research also showed that more than 30% of small businesses have been shunted onto a "deemed contract" (30.4%) with the same supplier at the end of a fixed contract, leaving them paying up to 80% more. A further 16.8% do not know if they have been put onto a deemed contract.

And most SMEs said they had problems understanding their energy contract (50.4%), highlighting and urgent need for more clarity, SwitchMyBusiness.com says.

Knowing how to switch supplier is vital if businesses are to avoid getting ripped off or paying more than they need to. But more than one-quarter of smaller to medium-sized businesses (25.6%) do not fully understand how to terminate their current business-energy contract, meaning as many as 1.3 million businesses are losing out on better energy deals.

"These findings prove that the UK's SMEs are still getting a raw deal," chief executive officer of SwitchMyBusiness.com Ivan McKeever said.

"Smaller to medium-sized businesses are in a uniquely challenging position: the business-energy market lacks the transparency that consumers now have and smaller businesses do not have the resources to liaise with lots of suppliers and negotiate a good deal."

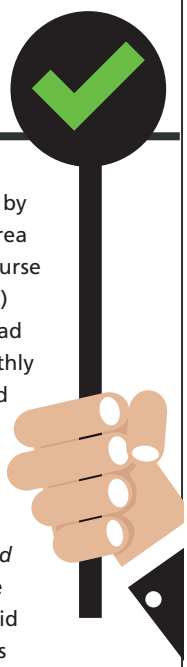
The study by SwitchMyBusiness.com comes in the wake of the Competition and Markets Authority (CMA) report that found that UK SMEs are unnecessarily losing £500 million a year on energy.

SwitchMyBusiness.com is calling on the Government to outlaw auto-renewal by reintroducing to Parliament the *Micro Businesses and Energy Contract Roll-Over Bill 2012–13* or by drafting a similar Bill.

It says there should also be a cap on how much more businesses on deemed contracts can be charged: Ofgem says that around 10% of smaller businesses are on such contracts at any one time and these cost an average of 80% more.

And it supports the CMA's recent observations that all suppliers should be required to make information easily accessible and switches more straightforward to ease the burden on busy businesses. ◆

Business-rates win



FOLLOWING SEVERAL MONTHS of challenges by the BDA against NHS area teams' refusal to reimburse business (non-domestic) rates to dentists who had paid their rates in monthly instalments and applied for reimbursement in a single payment (see www.bda.org/bdjinpractice *How to challenge a rates-refund refusal* June 2015, page 14) NHS England has said it agrees with the BDA's interpretation of the legislation.

NHS England has said it will tell dental-commissioning and finance colleagues in regional and local teams, and the Business Services Authority, how the legislation should be interpreted.

Dentists with outstanding payments as a result of disputed applications for reimbursement should receive confirmation that they will receive payment shortly. If they do not they should contact their area team to prompt a review of their application.

BDA Extra and Expert members who have been refused reimbursement of business rates can contact the BDA's NHS and Business Team for advice and support, by calling 020 7535 5864 or by emailing BusinessTeam@bda.org ◆

Dentists get massive **thumbs up**

NHS DENTISTS ARE rated very highly by their patients, government statistics show.

According to figures released by NHS England on the *Friends and Family Test (FFT)* from NHS England for the first three months of the FFT, 97% of patients consistently said they would recommend their practice's service and only 1% they would not. More than six out of ten dental practices that submitted details of their patients' ratings received 100% positive scores.

Chair of the BDA's General Dental Practice Committee Henrik Overgaard-Nielsen said: "These figures on patient feedback confirm what we know already from so many other sources that patients rate their NHS dental care highly."

Dentists should be proud of the 97%, the highest in the health service, he added. ◆

FREE LECTURES

Business **mini lectures** at Showcase

WITH RECENT RESEARCH by Lloyds Bank (*Healthcare Confidence Index 2015*) showing that nearly 70% of dentists want to expand their businesses within the next five years, business topics feature among Showcase's free mini lectures.

These include *Attract more private patients and increase profits*. Hosted by FooCo, this presentation includes techniques to reach more patients, gain competitive advantage and expand a private-client base. And through case studies and scenarios, Lloyds Bank will explain the most effective ways to raise finance in *Better understanding of how banks assess lending propositions*.

As well as the mini lectures there will also be on-stand lectures by exhibitors designed to tell visitors about new products and services.

Seating for the lectures is limited and all mini lectures are on a first-come, first-served basis.

BDIA Dental Showcase is on 22 to 24 at the NEC in Birmingham. To register for free entry, go to: www.dentalshowcase.com, call 01494 782873 or email register@dentalshowcase.com

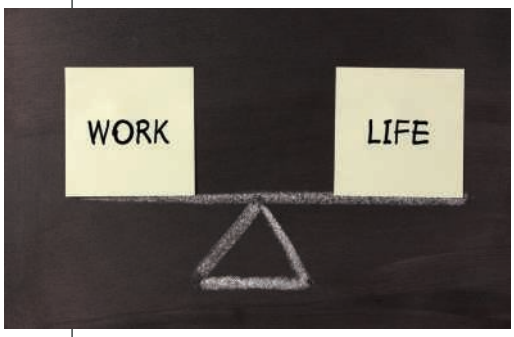
The Website also has full details of exhibitors and visitor information and an app to download. ◆

HAPPY EMPLOYEES

Respect work-life balance, NICE says

PROMOTING A CULTURE that improves the health and well-being of employees is good management and leads to healthy and productive workplaces.

This advice comes in guidance from The National Institute for Health and Care Excellence (NICE), which has called for employers and managers to do more to address the effect that poor working environments have on people's lives.



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Each year more than one-million working people in the UK experience a work-related illness, NICE says. This leads to around 27 million lost working days costing the economy an estimated £13.4 billion.

The reasons for poor workplace health are widespread and include long irregular hours, lack of control over work and discriminatory practices.

To address this, the guidance, *Workplace policy and management practices to improve the health and wellbeing of employees*, provides advice on how to develop the culture of an organisation to create a positive environment. It is aimed at employers, managers and employees and covers a range of areas from organisational commitment to the leadership style of line managers.

Mental well-being at work is a key topic highlighted. The guidance says that all those with a remit for workplace health should develop policies that support a culture that respects a work-life balance.

It says that, if possible and within the needs of the organisation, line managers should be flexible about work scheduling, giving employees control and flexibility over their own time.

Senior leaders should act as role models and proactively challenge behaviour that might adversely affect employees' health and well-being. Line managers should be given training to improve their awareness of health and well-being issues.

The guidance also calls for managers to adopt a positive style of management that encourages workers to be creative and to explore new opportunities that come their way.

NHS England chief executive Simon Stevens said: "Health-promoting workplaces are obviously good for millions of employees and ultimately for taxpayers too, so the time is right for all employers – including the NHS – to raise our game." ◆

UK now a smartphone society

SMARTPHONES HAVE OVERTAKEN laptops as the most popular device for getting online.

One-third (33%) of Internet users see their smartphone as the most important device for going online compared with 30% who are still sticking with their laptop, according to Ofcom's 2015 *Communications Market Report*.

The rise in smartphone surfing marks a clear shift since 2014, when just 22% turned to their phone first, and 40% preferred their laptop.

Smartphones have become the hub of our daily lives and are now in the pockets of two-thirds (66%) of UK adults, up from 39% in 2012. Nearly all (90%) 16-24 year olds own one; and ownership by 55-64 year olds has more than doubled since 2012, from 19% to 50%.

The surge is being driven by the increasing take-up of 4G mobile broadband, which provides faster online access, Ofcom believes. During 2014, 4G subscriptions leapt from 2.7 million to 23.6 million by the end of that year.

And people now spend almost twice as long online with smartphones than they do on laptops and personal computers. On average, mobile users spent nearly two hours online each day using a smartphone in March 2015 compared with just over an hour spent online by laptop and PC users.

At least one 4G mobile broadband service is now available to 89.5% of UK premises. Ofcom rules mean that 98% of premises will have an indoor 4G signal from at least one of the four operators by 2017. ◆

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LENDING SQUEEZE

Lending squeeze threatens practice growth

PLANNED CHANGES TO international banking rules could make it more difficult for SMEs to borrow money, the Federation of Small Businesses (FSB) has said.

The proposals from the Basel Committee on Banking Supervision, the group that sets global banking standards, would raise the amount of capital the banks are required to hold against certain loans. This, the FSB has said, could squeeze lending to SMEs.

In a joint letter, by it and four other SME champions to chancellor George Osborne, the FSB argues that banks might have significantly to increase the cost of lending to small businesses.

"The new rules won't just change who can borrow, they will also dictate who can lend," the letter says.

"New entrants and 'challenger' banks could be discouraged from certain types of lending due to these prohibitive extra costs. This is obviously bad for customer choice and market competition."

"We have come together to ask you to use the UK's considerable power and influence at the Basel Committee to ensure they rapidly rethink their approach in order to avoid yet more lending upheaval in the UK and potentially destabilising the borrowing prospects of some of our small firms and new mortgage borrowers."

Small-business banking remains worryingly concentrated with the big four banks controlling 85% of lending to SMEs, the FSB says.

This lending threat comes at a time when many practices are planning for growth. According to this year's *Lloyds Bank Commercial Banking Healthcare Confidence Index* survey, 78% are planning to expand at their current location or by branching out into more locations (www.bda.org/bdjinpracticeonline *Practices optimistic despite contract doubts* May 2015, page 3).

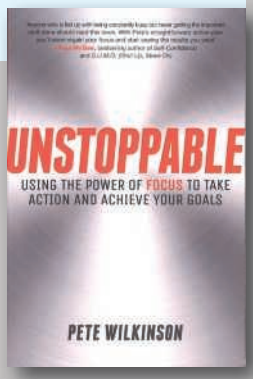
Growth plans are echoed by other small businesses. National chairman for the Federation of Small Businesses John Allan said: "Our research shows that small businesses are currently in a robust mood. Nearly two-thirds of those surveyed (65.3%) signalled a desire to grow, helping to sustain the economic recovery through 2015.

"But the Basel Committee proposals will make it harder for small firms to access funding and threaten to derail their ambitions for growth." ◆

BOOK REVIEW

1-3-5 action

Unstoppable – using the power of focus to take action and achieve your goals
Pete Wilkinson
Capstone, 2015
ISBN: 978-0-857-08582-5
£12.99



Endurance triathlete and business coach Pete Wilkinson lays down some solid arguments here as to how businesses can achieve their goals, writes BDA Librarian **Roger Farbey**. He rolls out his "1-3-5 Action Plan", which comprises 1 crystal-clear vision, 3 very specific core objectives and 5 goals.

The third of four parts covers four key skills needed to realise the vision. These are leadership, personal organisation, relationship building, and, finally, what he calls "key strength development". This third part contains some useful and interesting ideas: for example, with leadership Wilkinson suggests a four-tier method of communicating with staff – weekly, monthly, quarterly and annually – with the meetings traversing from informal quick chats to a formal yearly appraisal.

The final part of the book looks to the future by reviewing past performance in seven key areas: including, a review of business and staff performance; the company's message to its customers; and what actions need to be taken.

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

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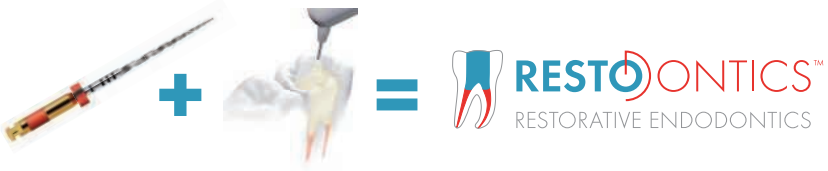

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*The combination of good coronal restoration and good endodontics had the highest absence of periradicular inflammation of 91.4%. H.A. RAY & M. TROPE (1995) Periapical status of endodontically treated teeth in relation to the technical quality of the root filling and the coronal restoration. International Endodontic Journal (1995) 28, 12-18.

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GDC should heed PSA report

by Peter Ward,
BDA Chief Executive

This time last year the BDA was submitting its evidence to the General Dental Council's (GDC's) consultation on its enormous annual retention fee (ARF) rise. It seems such a long time ago: what's happened in the year since?

We had the judicial review, of course, at the end of 2014, with the GDC being found to have acted unlawfully, but still allowed to introduce its proposed increase. There was also an adjournment debate in Parliament hosted by Sir Paul Beresford and, thanks to pressure from the BDA and dentists, in March the GDC was held to account for the first time in Parliament by the Health Select Committee.

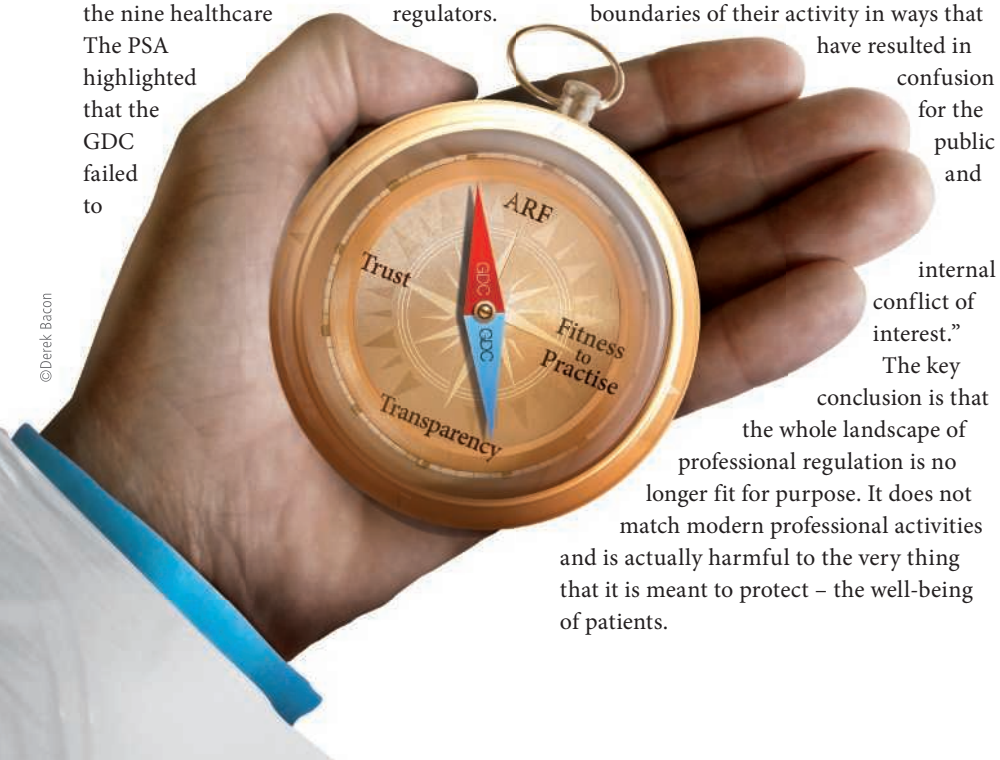
External scrutiny and criticism has also continued, with the regulators' regulator, the Professional Standards Authority (PSA), once again highlighting in June continuing and significant failings in dental regulation. The GDC came bottom of the league in the PSA's assessment of the performance of the nine healthcare regulators. The PSA highlighted that the GDC failed to meet a total of seven of its standards of good regulation. On fitness to practise, the GDC fully met only one of the 10 standards and failed to meet six others, representing what the PSA describes as a significant decline in its performance compared with an assessment it carried out in 2013/14.

More recently, the PSA has produced a really interesting report called *Rethinking regulation* (http://bit.ly/ps-rethinkregs). Published just last month, it pulls no punches. It doesn't focus solely on our regulator but raises broader concerns, concluding that: "Health and care regulation is incoherent and expensive and there is little evidence for its effectiveness."

It comes to the conclusion that the nine regulators of health and social care are all doing things differently, with different interpretations of their remits. But one common theme is underperformance.

It seeks to remind regulators about their core purpose – that "their concern is not quality improvement but quality control." This very much chimes with the BDA's view – that the GDC has plenty to improve in its core functions before it considers where it can extend its reach.

The report continues: "Too often we have seen examples of regulatory mission creep, where regulators have sought to expand the boundaries of their activity in ways that have resulted in confusion for the public and internal conflict of interest."



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The key conclusion is that the whole landscape of professional regulation is no longer fit for purpose. It does not match modern professional activities and is actually harmful to the very thing that it is meant to protect – the well-being of patients.

"We must seek to understand what motivates individuals, teams and organisations to succeed, not attempt to frighten them to resentful compliance," the report says.

> "The BDA is determined not to let up in its efforts to ensure that we get the regulation our profession deserves. We are continuing to shine a spotlight on GDC poor practise and to advance the cause for a better way ahead."

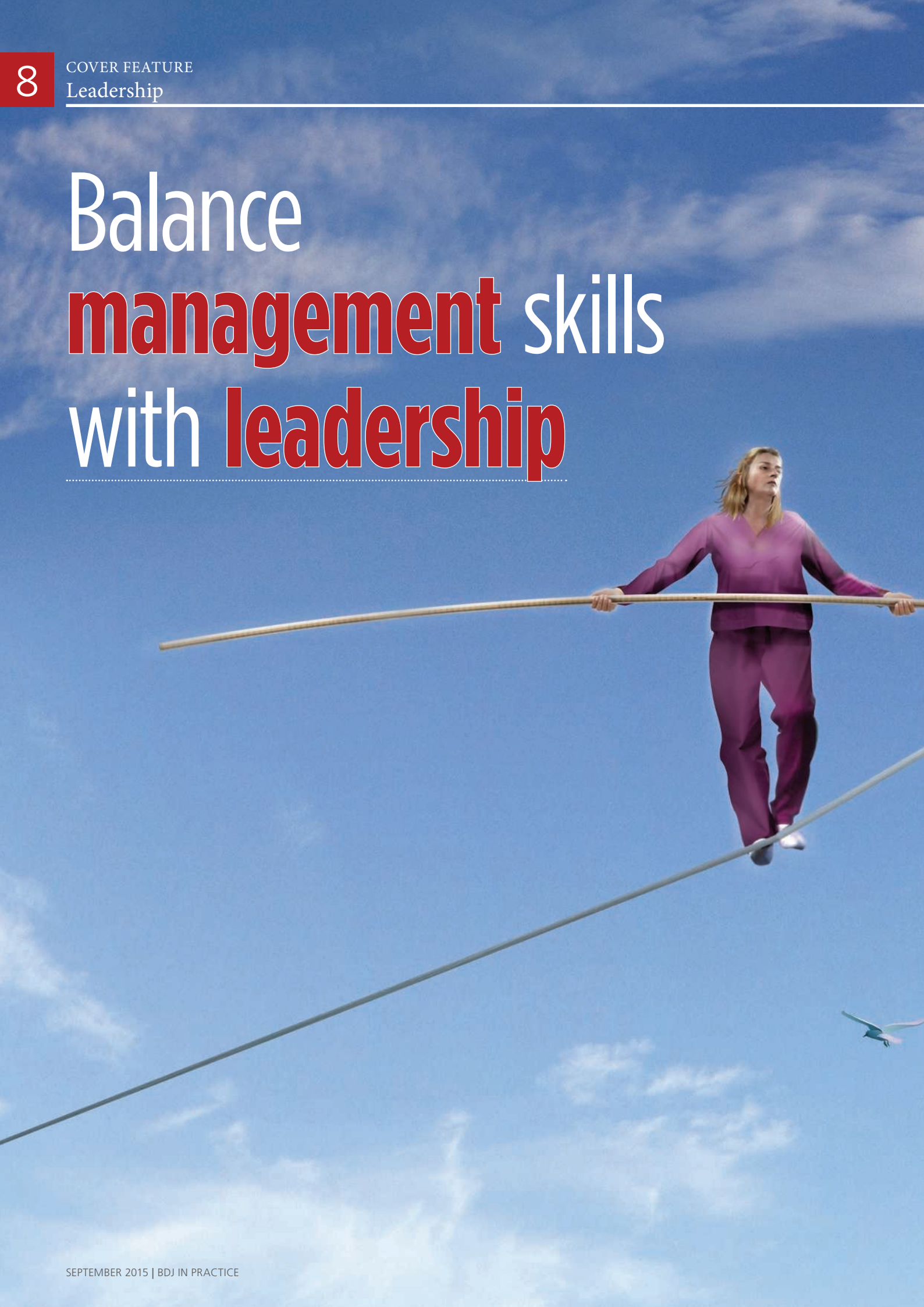
The PSA calls upon policymakers to undertake a radical rethink and design intelligent and coherent systems that do what they should. It is vital that we take this document seriously and keep this debate going.

The BDA is determined not to let up in its efforts to ensure that we get the regulation our profession deserves. We are continuing to shine a spotlight on GDC poor practise and to advance the cause for a better way ahead. This year we have been in contact with, and met, ministers, parliamentarians, other professional bodies both inside and outside dentistry, the PSA, and the GDC.

The Council meets next month, when it will discuss its approach to fees for 2016 and, importantly, its corporate strategy for the next three years. What we have seen so far of that document offers little comfort that the GDC has learnt its lesson as it continues to try to extend its reach. I have already written to the Council to urge it to focus on getting its core responsibilities right and to pay heed to the PSA'S well-chosen words.

So, you can see, the debate about the future of regulation is alive and well, and your BDA continues to fight your corner. Please continue to engage with us and support us, and watch this space for what happens next. ◆

Balance management skills with leadership



by Bob Hughes,

CEO of global leadership and coaching organisation the Forton Group. Before co-founding the Forton Group, Bob's career included senior management at British Telecom, where he was responsible for over 200 staff. He then ran the talent and employee engagement programme at Network Rail. Bob is also a non-executive director at government-backed-initiative *Engage for Success*. Email: bob.hughes@thefortongroup.com

Which are more important, management or leadership skills? The answer is: successful businesspeople need both. But which you should make most use of depends on circumstances and your role.

Management is about how resources are managed to achieve goals. Leadership is about taking ownership and responsibility. Leaders set direction and communicate goals. They inspire and motivate people to achieve.

Combined, these have greater power and real impact than each alone: for the team and for the organisation.

Everyone can be a better leader and manager – and there are four key elements to achieving this (see **next page, top right**).

Attitude means "dropping the ego". Leadership isn't about your hierarchy, position, or status. It's about success. And it's about enabling your team members to be successful, too. We can grow the next generation of loyal managers and leaders as a result, sometimes referred to as succession planning.

Delegation is a key way to involve others. People learn from new challenges and your life is a lot easier when you let go of needing to be the one alone who has all the answers. When you develop people well, you can trust team members to solve problems.

Inspiration is very much a leadership skill. And it is vital if we are going to both motivate ourselves and others.

And all three above should lead to successful actions: what we do and how we do it better.

To illustrate why it is so important to have both managerial and leadership skill-sets, here are the top-five challenges businesses face most often and how each skill-set can be used to solve these.

1 Poor performance by an individual

Solving poor performance is a classic example of why businesspeople need to develop both their leadership and management skills.

Although this is a management issue, its solution often lies more in the leadership skill-set. It is easy to fall into the trap of thinking there is something wrong with the person when the real problem is there is something wrong with the task they are being asked to perform. A management response might be to put the person into the "poor-performance process", setting and monitoring weekly targets. One consequence of this is that we will always be looking for failure and will miss the good points.

A leader, however, will check both their and the staff member's understanding of the situation to ensure that the staff member really does have the skills needed to deliver the required performance or understands how to deliver it in the right way.

A good leader will also look at the wider factors. Has this person always delivered in this way? Has something changed recently? Addressing those underlying factors is a key leadership tool.

The qualities a good leader would use in this situation are listening and asking questions. They would check for understanding by asking, *and listening to,* what the staff member has to say. If we genuinely ask questions from a basis of understanding, and then demonstrate belief in the staff member's willingness to improve, we can build trust and peoples' confidence in their own abilities.

2 Poor performance across the team

If the team is not working well together and performance has suffered across the whole team, leadership skills are more likely to provide the solution.

A manager would set and monitor targets more tightly. They might take the team out for a team-building event, like go-carting, thinking that is the way to improve team morale: getting them to bond at a single "rewarding" event. There is nothing wrong with regular social events – but one person's preferred activity may not be another's.

Leading a team is about understanding each individual as well as the team dynamic. A leader works to understand everyone's skills strengths and motivations – as individuals and as a team. They create an inspiring vision that the team can get behind. Crucially, they communicate why that vision is important.

3 Solving a silo mentality

When people work in silos and do not communicate well the risk is they will neither understand nor appreciate the importance of the bigger picture.

A manager would believe that they just have to communicate *more* – setting out rules or processes more clearly, by notes and emails, or by holding "cascade briefings" further to clarify processes and tell people what to do.

A leader would demonstrate the importance of *better* communication by listening more and encouraging more interaction within and between teams. Asking open questions and really listening to the answers is vital to good communications. It is also important to remember that communications are more than two-way in today's social-media environment.

4 High-performer conundrum

At first glance, it might seem to be good to have one high-performing individual within a team but this can, sometimes, be disruptive.

A manager would reward and encourage them because of their contribution. They may see this person as the "hero" in the team rather than realising that they are the source of disruption and discontent. Even if they do recognise this, the manager might conclude that the high-performance outweighs the disruption.

> "At the heart of the leadership versus management debate is a fundamental behavioural misattribution. When something goes wrong, the manager believes someone is to blame. There is the assumption that people have personality flaws that need fixing."

A leader would recognise the poor impact on the wider team and consider some radical options. The first is to support the high performer to improve their social skills, especially their emotional intelligence. Improved social skills enable people to improve their working relationships with others.

The good leader is also willing to consider the possibility of moving that person on, either within or outside their organisation – for the overall benefit of the whole team.

5 Unreasonable demands from "the top"

The problem of unreasonable demands from "the top" is more likely to be encountered within salaried NHS dentistry, academia, or larger dental practices. But practices also have mini-teams (dentist/nurse partnerships) or the group that runs the reception, for example, both of which have a leader and senior management above them.

In response, a typical manager either complies by setting tighter targets or responds by what is called "shroud waving". Shroud waving is a way of pointing out the worst-case scenario in dire terms to secure more resources. The effects of such scenarios may be valid but the likelihood of them happening is often low. Shroud waving is the workplace equivalent of emotional blackmail.

A leader would tap into the knowledge of the team to look for radical alternatives to the way they currently work so they can deliver what is being "demanded". They would offer alternatives, explain any constraints, and say what is possible given the situation. When all options have been explored, if the demands genuinely are "unreasonable", the leader should show resilience in their communications with senior management.

It is down to behavioural misattribution

At the heart of the leadership versus management debate is a fundamental behavioural misattribution. When something goes wrong, the manager believes someone is to blame. There is the assumption that people have personality flaws that need fixing. Leaders, however, understand that we are more often than not subject to particular circumstances and that the environment in which we work has an impact.

Most people come to work with the intention of doing a good job. Obstacles that threaten this arise because of circumstances – not human frailty. And it is the job of the good manager and leader to clear those obstacles out of their team members' paths so the team – and the organisation – can succeed. ◆

Four key elements

- Attitude: our flexibility, how we think, and how we gather information
- Relationships: how we involve others
- Inspiration: how we motivate ourselves and others
- Actions: what we do and how we improve our activities

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Dealing with theft at work

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

Theft in the workplace is not unheard of. Usually an employer has a lot of evidence to justify their suspicions that a particular employee has been stealing: sometimes they literally catch the employee with their hand in the till. But a recent Court of Appeal case (*Stuart v London City Airport Ltd*) stressed that a proper procedure should be followed even in these situations.

This court said that when an employee is accused of stealing there must be a reasonable investigation and a fair process. There can be no shortcuts despite the serious nature of the situation. In fact, it concluded that fairness in these circumstances demanded that the employer look carefully into the situation and come to an objective judgement. For practices, such a scenario also raises ethical issues about if you should report the matter formally to the police or General Dental Council (**far right**).

Summary does not mean immediate

It comes as a great shock to an employer to discover that an employee has been stealing from them: they will also feel that all trust and confidence in the individual has been lost in a heartbeat. Someone with whom the employer may have worked side by side for years has suddenly become a person they want out of the practice as quickly as possible.

Theft undoubtedly justifies summary dismissal but only once you are sure of the facts and the employee has had an opportunity to respond. This is what Court of Appeal re-emphasised in its judgment. Dismissal can be summary, in that there is no need to have issued previous warnings. But this does not mean immediate. You must investigate and arrange a disciplinary meeting to consider the allegations. Despite the seriousness of the situation an employer could lose at an employment tribunal if they just fired the employee on the spot.

Suspension does not mean guilt

The accused employee could be suspended so they are not in the workplace while the investigation and the disciplinary process is done. But suspending an employee just means that you believe it would be beneficial to the investigation and less stressful for both sides if they were not at the practice. It does not mean that they are automatically viewed to have been in the wrong or that you believe they are guilty.

To do this correctly, you need to tell the employee: not only verbally, but also in writing. Your written disciplinary procedure should (like the template available to BDA Expert members) include the provision for employees to be suspended. Say in the letter that they will receive full pay for the duration

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> "Where theft is suspected you have to be especially scrupulous. It is very important to take detailed notes for each person interviewed."

of the suspension, that suspension does not imply blame, and that the employee will be required to attend an investigatory meeting as part of the disciplinary process. It is advisable always to seek legal advice about whether or not to suspend an employee.

Investigating is essential

Establishing the facts, as best you can, is absolutely essential. Gather together all information possible from practice records and by talking to everyone who was involved in the events in question. You need to decide if there is enough evidence to substantiate the allegation that the employee has stolen from you or someone else at the practice. For details of the investigations process and the taking of witness statements, see www.bda.org/bdjinpracticeonline *Dealing with a reluctant witness* July 2015, pages 16-17.

Where theft is suspected you have to be especially scrupulous. It is very important to take detailed notes for each person interviewed. Sometimes they may be willing to write their own statement. Ensure that after each meeting the interviewee reads through the notes. It is always best practice to give copies of the notes to the interviewee as soon as possible and ask them, if they are willing, to sign your copy.

If possible, the investigation should be done by someone not directly involved with the original incident. In small businesses, such as many dental practices, it can be difficult to achieve such separation. But you should try do this so you can demonstrate that the whole matter is being handled objectively and without prejudging the issue.

One of the key witnesses is the suspect. But an investigation meeting with them is not a formal disciplinary interview so the employee has no legal entitlement to bring a representative. Should your employee ask for representation it can be denied, but it may be better, in the interests of openness, to agree. You should have someone else present to take detailed minutes and to act as a witness, perhaps another senior-team member, the practice accountant or its lawyer.

Assess before acting

Once you have gathered all the information needed, collate it into a report. This report should include everything you, as the investigator, has found. The report should include the allegation or incident details as first given to you. It should then detail the investigation. Say what was said and by whom. Be specific, include dates and times. Drawing up a timeline of events will help you assess the information gathered and to visualise the incident a little better. You can even compare the timelines of the different versions of the event, which might reveal discrepancies in the stories. Say what is definitely known to have happened and detail the issues that are disputed.

> "Be specific, include dates and times.Drawing up a timeline of events will help you assess the information gathered and to visualise the incident a little better."

On the basis of all the information gathered you must decide what action is needed. This can be either that no further action is needed, in which case the matter has been dealt with and you should inform all relevant parties in writing; or that disciplinary action is needed.

It may seem unnecessary to conduct a detailed or thorough investigation when the facts appear clear or, indeed, when the employee has admitted to an allegation. But the *Stuart v London City Airport Ltd* case has demonstrated that you must be seen to act fairly. Check www.bda.org/advice for more information in BDA Advice *Disciplinary procedures and dismissal*. You must also seek independent advice if you suspect theft within the practice. BDA Extra and Expert members can contact BDA Practice Support on practicesupport@bda.org or 020 7563 4574. ◆

The police and the GDC

- Theft is a criminal offence as well as a disciplinary matter but the issue of when, or if, to involve the police is a delicate one. There is a strong argument that the time to consider reporting the incident to the police is after you have concluded your disciplinary process, including any appeal process, and reached a conclusion that there was a theft, that a particular employee was responsible, and that they should be dismissed. Before this stage you do not know for sure what has gone on and so it is arguably premature to take the matter to the police. Another reason is that a formal police investigation may prevent you from going through the disciplinary process, with you then left unable to sack the culprit.
- Alternatively, contacting the police as soon as you have suspicions could help you get enough evidence to dismiss the culprit. If you do not have enough evidence to confirm your suspicions, the formal criminal investigation may be able to discover more.
- Employers need to consider each situation case by case and get independent advice on the best approach to take.
- You must also consider reporting a registered dental professional (dentist or dental care professional) who is dismissed for theft to the General Dental Council (GDC) for professional misconduct. According to GDC *Standards for the dental team*, matters should be reported to the GDC: "If you think that the public and patients need to be protected [owing to] issues of … dishonesty, serious crime or illegal practice." Therefore, the need to report depends on the severity of the case. Thefts involving large sums, with a malicious intent to deceive or defraud, or which occur over some time, may be considered worse than a one-off opportunistic case for which genuine sorrow has been shown.
- The same criteria would apply when deciding if the matter needs reporting to the police. If it has been reported to the police, then the registrant needs to declare it themselves.

Take three steps to support CPD

by David Harris,
a solicitor specialising in helping members on contractual and legal issues in their work

Continuing professional development is a chance for dental practices and associates to support each other. Practices can support their associate dentists by discussing objectives, identifying available courses or seminars, and providing study leave. And internal training provides an excellent opportunity for team building. Associates will be able to provide more value to the practice if they see their development and career supported by the practice.

Doing continuing professional development (CPD) and training is the responsibility of the individual professional but a dental practice has an interest in ensuring its dentists are trained and have up-to-date skills and knowledge. And keeping up to date makes good business sense, too. If a dentist at the practice develops new skills and qualifications it could offer new services to patients.

Practice owners who engage associates to perform NHS work also have a responsibility to ensure that their associates fully understand the *NHS Regulations* and their requirements for claiming and treating under the NHS. Failing to do so leaves an owner vulnerable to financial clawback and contract breaches. So, by taking an interest in the CPD done by the associates, a practice owner can safeguard that claims are made appropriately under their contract. There are a number of suggested ways that dental practices can help with the professional development of associate dentists.

1 Plan CPD together

Make sure all team members know what they have to do. CPD is anything that can advance the professional development of a dentist. It encompasses both maintaining skills and knowledge and learning new scientific developments, treatments and skills. While this gives scope to cover a wide range of topics, the General Dental Council (GDC) has set down certain core and recommended subjects and numbers of hours it expects its registrants to undertake (**right**).

To ensure the associate is on top of their requirements and to find out if they need any help from the practice, CPD should be part of regular catch-up meetings between associate and practice owner. Discuss the whole CPD process: from planning what to do; how to clear time to do it; and reviewing the courses or other learning that has been done. Even something as simple as talking with colleagues can be a useful way to gain new skills, insights and training. And

find training that supports an associate's wider goals: for example, owning a practice or training in a specific subject area that gives the associate more qualifications and competences. Practice owners can also consider their associates' development plans when they make plans for future practice services.

Recording is as much of a professional obligation as the planning and doing of CPD. Anecdotally, a major challenge here is not the act of recording but remembering to record. Discussions between associate and practice owner can help prompt an associate to update their CPD record.

Technology can help with CPD recording. The BDA's *CPD Hub* allows all members to earn, record and manage CPD through one free online service. They can record all of their CPD, wherever they earn it: go to http://cpd.bda.org. Individual CPD records should be kept for five years after the end of each CPD cycle. It is also in the interest of the practice to ensure that team members are complying with recommended GDC subjects because this will be relevant to inspections: for example, by the Care Quality Commission (CQC) in England.

2 Agree study leave for CPD

CPD is offered by a large range of providers, including the BDA Conference, and associates will probably have to ask the practice to accommodate their taking time out for CPD and study leave, preferably as part of their contract. The BDA's template associate contracts (which are available to all members at www.bda.org/associates) gives a straightforward wording for this: "The Associate shall be entitled to take [*the agreed number of*] days' study leave for continuing education in any calendar year."

Three is suggested as an appropriate number of study days. The 75 hours of verifiable CPD required over the five-year CPD cycle is an average of 15 hours a year. A full-day course or seminar will probably provide at least five hours of verifiable CPD (after registration time and breaks). So, three days of study leave would be needed to make the 15-hour average. Of course, many training events provide more verifiable CPD hours.

But this is just the minimum CPD requirement. Individual dentists may want to do more to enhance their professional development so there should be flexibility in handling study leave for associates. Additional courses over and above the agreed study-leave allowance could be agreed on a one-off basis if the associate can show the advantage more study will bring to their performance or to the services offered by the practice. And because verifiable CPD is assessed over a five-year cycle, the 75 hours do not have to be split equally across each year.

Agree how much notice has to be given by the associate to take study leave. The practicalities of taking leave should be understood by both parties. If the practice is generally booking patients up to one month ahead, it is reasonable for the associate to give one month's notice to attend a course. It is not reasonable for the practice to have to cancel patients because the associate decides to attend a last-minute course.

> "But the practice owner and associate need to discuss how in-house training meets the associate's CPD objectives and not allow it to monopolise the associate's CPD hours."

Some dental practices may expect associates to undertake training during their general annual leave. This is not recommended because it fails to distinguish between the reasons for holiday and study leave. By having a contractual term on study leave, the practice overtly shows that it supports associates in maintaining professional standards.

3 Think about in-house CPD

Practices may decide to arrange training for the whole team, including associates. The core or recommended CPD subjects are often suitable for internal training because everyone has to do them. Real-life situations concerning handling complaints, medical emergencies or child protection involve the whole practice so training to prepare for them as a team could bring immeasurable benefits. A practice-wide training event also helps team building.

But the practice owner and associate need to discuss how in-house training meets the associate's CPD objectives and not allow it to monopolise the associate's CPD hours.

Non-verifiable CPD can be accrued from reading professional journals: for example the *BDJ* and *BDJ In Practice*. The *BDJ*'s online programme provides up to 48 hours of verifiable CPD each year; and *BDJ In Practice* provides up to 12 hours. Both publications have the CPD questions available for six months following publication. ◆

CPD requirements

- All dentists must complete 250 hours over a five-year period
- At least 75 hours of these must be verifiable

Core subjects are

- Medical emergencies – at least 10 verifiable hours a cycle, the cardiopulmonary resuscitation (CPR) element to be done annually
- Disinfection and decontamination – at least five verifiable hours a cycle
- Radiography and radiation protection – at least five verifiable hours a cycle
- Other recommended subjects include
  - complaints handling
  - legal and ethical issues
  - oral cancer – early detection
  - safeguarding children and young people
  - safeguarding vulnerable adults
- Recommended subjects can be done as either verifiable or non-verifiable CPD and have no recommended hours attached to them
- Detailed guidance on CPD can be found in BDA Advice *Continuing professional development, clinical governance, clinical audit and peer review* (available online at www.bda.org/advice)
- The GDC plans to change these requirements. At present it is expected that they will change at the beginning of 2017, subject to piloting new proposals in 2016. Any updates on this will appear in *BDJ In Practice*.

When a **hunch** is not enough

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

Hunches have no place in decisions following the disciplinary hearings of employees. You have to reach conclusions on whether or not there was misconduct; whether or not the employee did what was alleged; and whether or not they have provided a satisfactory excuse or reason. It would be easy to feel daunted and unable to conclude matters as you grapple with your inner voice, which asks: how strongly do I have to hold the view that the employee is guilty of the misconduct alleged; how much evidence is needed to reach that decision; and does the misconduct justify dismissal or merely a formal warning? The way round this problem is to think things over objectively and with common sense.

Legal standard of proof

In deciding employment-law issues you just have to conclude that something is more likely to have occurred than not. Or that one explanation for an event is more likely than another. This standard of proof (common in all civil cases) is known as *the balance of probabilities*. Employers are not required to have proof of a fact that places it *beyond reasonable doubt* – the more stringent standard of proof familiar from criminal cases. But a decision whether or not to dismiss an employee for theft at work is based on the balance of probabilities

while a criminal court would require the higher standard of proof.

After a disciplinary meeting, the employer must decide if they believe that the employee committed the act of misconduct or not. Any belief of the employee's guilt must be genuine, be based on objective grounds, and follow a reasonable investigation.

Gather enough evidence

You have to be sure that there is enough information to provide reasonable grounds to believe the employee to be guilty. Your practice should have gathered these by carrying out an appropriate investigation. Investigations must be thorough and even-handed; and all relevant issues should be explored. For details of the investigations process and the taking of witness statements, see www.bda.org/bdjinpracticeonline *Dealing with a reluctant witness* July 2015, pages 16-17.

> "You need to show that your belief in the employee's guilt is genuine and that you have sufficient reason for reaching that conclusion. This can be a difficult when there is an absence of compelling evidence or there is conflicting evidence."

Have a reasonable belief

To test if you have come to a reasonable decision, ask yourself if you would be happy to explain it to a stranger without feeling awkward or embarrassed. Would someone else find your reasoning to be logical? You need to show that your belief in the employee's guilt is genuine and that you have sufficient reason for reaching that conclusion. This can be a difficult when there is an absence of compelling evidence or there is conflicting evidence, but remember the legal test is based on the balance of probabilities.

Consider an appropriate penalty

Where a practice decides misconduct has occurred, it must decide what sanction to apply. It should give careful consideration to a number of factors before reaching its decision, particularly if that decision could be to dismiss the employee. If there is a challenge to the fairness of the practice's decision it may have to persuade a tribunal that its decision to dismiss was reasonable in all the circumstances of the case.

Factors to weigh up include if the employee's explanation of their conduct provides any mitigating circumstances and their previous disciplinary record. You must also show consistency of treatment among employees.

Usually, misconduct will justify only a formal warning. Dismissal will only be justifiable if the employee has previously received a final warning that is still in force or has committed gross misconduct. To be gross misconduct the employee's action has to be something that totally destroys your confidence in them: like theft or a breach of patient confidentiality.

Even with gross misconduct you must also consider if a lesser sanction than dismissal (such as a final warning or demotion) is more appropriate. The Employment Appeals Tribunal recently found in the case of *Brito-Babapulle v Ealing Hospital NHS Trust* that a tribunal had erred when it held that dismissal would always fall within the range of reasonable responses in cases of gross misconduct. Although dismissal may be "almost inevitable" once there has been a finding of gross misconduct, the Employment Appeals Tribunal held that there may be mitigating factors that suggest dismissal is not, in fact, a reasonable response.

Document the decision

You must give the employee your disciplinary decision in writing (template letters are available to BDA Expert members).

Also, keep the notes made at the disciplinary meeting to show what was discussed and to help explain how you have reached your decision. There is little point in a practice going through a comprehensive decision-making process if it is unable later to prove it has done so.

For BDA Advice *Disciplinary procedures and dismissal*, go to www.bda.org/advice. BDA Extra and Expert members can contact BDA Practice Support on practicesupport@bda.org or 020 7563 4574. ◆

by James Dawson,
Head of Advice Publications in the Practice Support Team 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

Ins and outs of the *Fit for Work* scheme

With the Government's new *Fit for Work* scheme currently being rolled out across England, Scotland and Wales a practice should update its sickness-absence policy to refer to it. *Fit for Work* provides free occupational-health assessments for any employee who has been off work through illness for at least four consecutive weeks. The assessment leads to a *Return to Work Plan*, which contains recommendations aimed at helping the employee to get back to work sooner than might otherwise be the case. It is hoped that by providing a relatively early intervention, *Fit for Work* can manage an employee's expectations about how their condition will affect their fitness for work. There is also a general-advice helpline 0800 032 6235 (0800 019 2211 in Scotland) for guidance to both employees and employers.

> "*Fit for Work* is designed to work alongside, not replace, existing occupational-health services. But the scheme provides an additional tool for employees and employers to use when handling illness."

Fit for Work could be of great benefit to employees and their employer: reference in the sickness-absence policy should explain how both staff and the practice can use it. Make sure your policy refers to not only the availability of the *Fit for Work* scheme, but also its advice website and helpline. Outline the circumstances in which the practice might consider referring an absent employee for a *Fit for Work* assessment. Explain that when carrying out an occupational-health assessment, *Fit for Work* may need to speak to the practice about the employee's role, workload and working environment, so say that the practice would discuss these matters with a *Fit for Work* occupational therapist if the practice was contacted.

The practice might be sent a copy of an employee's *Return to Work Plan* so include in the policy how you will deal with the plan. It is not feasible blindly to commit to implementing every recommendation in every plan that you might receive, so stress that you will give careful consideration to any recommendations contained in a plan and that you will discuss these with the employee. If the practice is sent a *Return to Work Plan* this overrides the need to obtain a medical certificate ("fit-note") from the employee's doctor, so mention this in the part of your policy that deals with providing evidence of incapacity for work.

Occupational-health referrals

Referrals for a free occupational-health assessment can be made once an employee has been off sick for four weeks. Either the employee's doctor (GP) or their employer can make a referral. Note, however, that employer referrals are being rolled out area by area throughout 2015. Check www.fitforwork.org to see if your area is covered.

GPs can refer earlier if it is clear that the employee will be absent for at least four weeks. Later referrals, after the four-week mark, can also be made by either the GP or the employer provided a referral has not already been made.

Whatever the precise timeframe, referrals should only be made where the employee has a reasonable chance of making, at least, a phased return to work. However, only one referral can be made within any 12 months: if both the employer and the employee's GP have made a referral to the *Fit for Work* scheme the cases will be combined.

Employees have to consent to the occupational-health referral. Hopefully, they will agree because the process is aimed at actively managing their sickness and helping them recover. But the referring GP or employer has to make sure that the employee understands the *Fit for Work* process and that they have given clear consent.

The occupational-health assessment

After being referred to *Fit for Work*, employees will be contacted by an occupational-health professional within two working days. This person will be their case manager and they will conduct the assessment. They will seek to arrange a convenient time for the assessment to take place.

Assessments will normally be conducted over the telephone, although, if the assessor believes it necessary, a face-to-face assessment might be arranged. This would happen within a further five working days. The employee's reasonable travel expenses for attending a face-to-face assessment will be reimbursed.

Whether carrying out a telephone or face-to-face assessment, the assessor will take a holistic approach to the patient. They will consider the employee's current condition and overall health, working environment and other personal or social issues that may be affecting them. *Fit for Work* has called this a bio-psycho-social approach. The assessor will ask about the effect that the employee's condition has on different aspects of their job. The case manager (*Fit for Work* assessor) will try to identify all the potential obstacles that could be stopping the employee from returning to work. If necessary, the assessor can consult specialists in musculoskeletal or mental-health conditions.

The case manager might also contact the employer or line manager to discuss work factors and adjustments that may help the employee return to work. This is so the assessor can get a better understanding of the working arrangements and any potential problems that the employee has in the workplace. The employee's consent is needed for their employer to be contacted.

After conducting the assessment, the *Fit for Work* assessor will draw up a *Return to Work Plan*.

Using the *Return to Work Plan*

The *Return to Work Plan*, devised by the *Fit for Work* assessor, will be derived from the discussion the assessor has had with the employee. It will include the assessment, advice and the recommendations that were agreed. The plan should address each obstacle that has been identified as stopping the employee from returning to work.

To help the employee back into work, the plan provides practical advice and steps that can be taken by the employee, employer or the employee's GP. It is useful, therefore, if the plan can be forwarded to the employer and the employee's GP, although this requires the employee's consent.

Following the *Return to Work Plan's* recommendations is generally voluntary but the reports are a constructive way to help an ill employee back into the workplace so it is expected that all parties will find them useful. Following some recommendations will be more appropriate for either the employee, their employer or

their GP, depending on the nature of the recommendation. And employers should note that some of the recommendations might help them comply with obligations under the *Equality Act*, especially the disability-discrimination rules (see *Reasonable adjustments* in BDA Advice *Sickness absence* online at www.bda.org/advice). Another reason for everyone to give serious consideration to a plan is because, if disputes later arise over an employee's ability to continue working, looking at whether or not the plan has been followed, and if not then why not, and by whom, may be important in assessing the reasonableness of any decisions taken by the employer (see *Long-term absence* in BDA Advice *Sickness absence* online at www.bda.org/advice).

Return to Work Plans can be used as evidence of sickness absence and so replace the need to provide medical certificates.

Plan will be followed up

At a pre-arranged time, the case manager will contact the employee to see how the plan is going. Where a return-to-work date has been planned, the assessor will also contact the employee shortly after that date to check how things have gone. A further assessment may be arranged if the case manager decides one is necessary: for example, if the employee has not returned to work as anticipated. The *Return to Work Plan* may also be revised to reflect any changes that are needed.

Where recommendations in the *Return to Work Plan* have not been implemented, the *Fit for Work* assessor may, with the employee's consent, contact the employer. This could be to ensure that the recommendations in the plan, especially any that would have to be implemented by the employer, have been fully understood. The case manager may liaise between employee and employer to facilitate the implementation of any action points from the plan.

Generally, the assessor will discharge the employee once they have returned to work. Cases will also be discharged if no return to work has been possible after three months.

Fit for Work may later contact employers or employees for feedback on their service.

Health advice available

The *Fit for Work* service also provides work-related health advice to employers and employees through its website www.fitforwork.org and a telephone helpline on 0800 032 6235 (0800 019 2211 in Scotland). The advice is available to help support employees when illness is affecting their job. The advice provided could cover information on the type of adjustments that might help them stay in, or return to, work.

Tax exemption on treatment costs

A tax exemption is available to employers to help them fund medical treatments that can help their employees return to work. Up to £500 an employee a year is available to fund interventions recommended by a healthcare professional, either in the *Return to Work Plan* or by the employer's own occupational-health assessment. This means that any treatment provided up to the maximum amount will not be liable to tax as a benefit-in-kind to the employee. Before funding any treatments, however, employers should consult an independent financial adviser.

Approach designed to work in parallel

Fit for Work is designed to work alongside, not replace, existing occupational-health services. But the scheme provides an additional tool for employees and employers to use when handling illness. If employees can get back into the workplace sooner than they would without such help, it has therapeutic affects for them and can reduce costs to business that employee absences cause. Through a free assessment, at an early stage in absence and a set of recommendations in the *Return to Work Plan*, the Government has said that it sees the scheme as providing assistance and support to employees and employers.

Further information is available from www.fitforwork.org or from www.fitforworkscotland.scot in Scotland.

The BDA Advice *Sickness absence* (see www.bda.org/advice) has been updated and a new template *Model sickness and injury absence policy* is available for BDA Expert members. ◆

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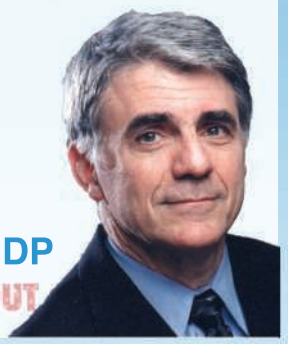

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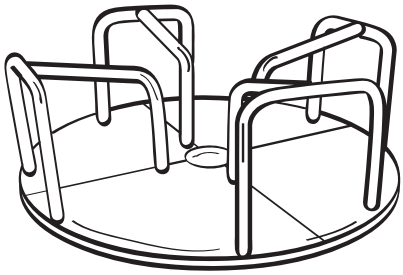
Discounts swings and roundabouts

by John Ling,

the Advice Manager (BDA Expert) at the BDA. He has the Professional Postgraduate Diploma in Marketing from The Chartered Institute of Marketing and is a Chartered Marketer



People love a bargain. Famous New York department store Penney's found that only one in every 500 products it sold was at full price. It moved out of the discount game but has now returned, according to a report (*The dirty secret of Black Friday discounts*, in the *Wall Street Journal* of 25 November 2103). Discounts have become common across the retail and hospitality sectors. People have become so used to discounts and special offers that many delay purchases until they are discounted. If people increasingly expect discounts, and competitors are offering them, it can be hard to stay competitive without offering them yourself. But do discounts work in dentistry?

Swings

For existing private dental practices, discounts can be very effective at attracting new customers or encouraging patients to try or take up treatment options. For example, some people may have thought about having cosmetic treatments such as tooth whitening but have been put off by the price. A discount may encourage them to give it a try and they may love the results so much that they are happy to undergo treatment again, even at the full price. Or, once they have experienced the quality of care that you provide, they may be reassured enough to opt for other treatments that you have diagnosed as clinically appropriate.

For a new private dental practice, a discount campaign can help raise awareness of the practice and tell people what treatments the practice has to offer.

In both cases you must act within the advertising rules laid down by the Advertising Standards Authority and the General Dental Council (**right**).

By generating more patients and more sales, discounts can be a win-win for both the practice and patients.

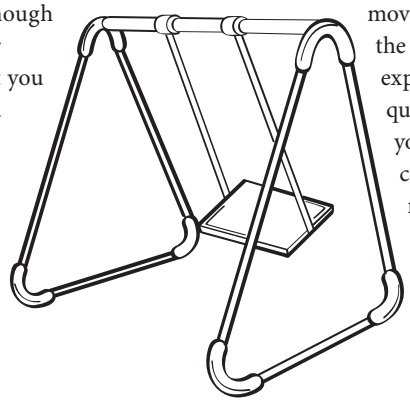
Roundabouts

So, what's not to like about discounting? Actually, there is quite a lot.

To entice people to take up your offer, you may need to give substantial discounts. But substantial discounts mean you have to "sell" many more treatments to make up for the drop in unit profitability. By simple arithmetic, if you offer a 50% discount, to achieve the same amount of revenue you have to sell twice as much. You have to judge if your chosen level of discount will generate a viable level of increase in sales.

Successful discounting is a delicate balance between bringing in new sales and losing money on sales that you might have made anyway. If it has simply brought forward sales that you would have made anyway, it is not tremendously worth while – unless it brings in many new patients who stay with you for years.

Another danger of discounting is that it moves the focus away from the quality of the treatments you provide, the patient experience you provide, and your high-quality care, on to just the price. If you compete purely on price, and a competitor undercuts you, you have nowhere else to go but to lower your prices further, reducing your profits still further.



Keep within the rules

Consumer law prohibits misleading customers – you cannot trick them into making a purchase. So, discounts and price comparisons must reflect the most recent price and you should have offered goods or services at that price for at least 28 days in a row. Nor can the comparison be with a higher price from more than six months ago.

Promotions also have to comply with the general rules on being "legal, decent, honest and truthful". The GDC also states that you must provide patients with "balanced, factual information which enables them to make an informed choice about their treatment."

Discounts can also change patient expectations of what they should be paying for their treatments: "If my dentist can offer a scale and polish at a 50% discount, why am I usually charged twice this amount?"

And, as many retail shops have found, discounting creates the problem of your being forced into a cycle of perpetual discounts: patients hold back on treatments until you offer a discount and fewer and fewer people become willing to pay full price. Before you know it you are offering discounts nearly all the time.

Overall, offering a discount on some treatments can be a great way to attract new patients or boost the take-up of particular types of care. But bear in mind your professional duty to offer clinically appropriate care, your need to stay profitable, and the risk of being drawn into a cycle of perpetual discounts. ◆

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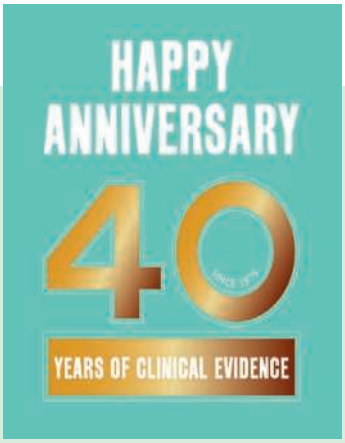
It works by reducing the absorption of addictive nicotine and other damaging chemicals found in tobacco smoke in two ways. Swishing with NICORINSE before smoking leaves a fine coating inside the mouth that reduces absorption; and swishing after smoking washes away nicotine and toxins left in the mouth.

It is also designed to help to eliminate smokers' breath and reduce the risk of yellowing teeth.

The mouthwash was created in North America by a practising dentist, Dr John Nesbitt, in partnership with a chemist, Dr William Farone.

There are two flavours of NICORINSE: peppermint, called *Icy Blue* (blue bottle); and spearmint, called *Fresh Mint* (green bottle). The mouthwash costs £11.95 for a 250ml bottle and can be bought online at: http://nicorinse.co.uk/product/nicorinse

Corsodyl® celebrates 40 years of clinical evidence for chlorhexidine digluconate



GSK, manufacturer of Corsodyl® mouthwash, is celebrating the anniversary of the first clinical evidence for dental application of the chlorhexidine digluconate formulation.

Corsodyl® can be recommended for a range of dental-treatment needs including:

- treating gingivitis[1-3];
- supporting oral health in compromised patients – where toothbrushing cannot be adequately employed;
- supporting effective gum healing after surgery;
- helping to resolve denture stomatitis[4]; and
- helping to aid to healing in acute candidiasis.

This is why Corsodyl® remains the most recommended medicated mouthwash by dental experts in the UK[5].

Corsodyl® mouthwash has a proven heritage in treating gum problems. Chlorhexidine digluconate is a double-positive-charged molecule enabling it to bind to negatively charged surfaces including teeth, mucous membranes and bacteria. Once on the surface, chlorhexidine repels bacteria by creating a protective shield over the teeth and gums. This substantivity means chlorhexidine is available for up to 12 hours post-rinsing for round-the-clock protection against bacteria[6].

Studies show that Sodium Lauryl Sulfate (SLS) may inactivate chlorhexidine[7,8]. Corsodyl® toothpaste is SLS-free, making it suitable for use with Corsodyl® treatment mouthwash.

References available on request.

Text-campaign help

Small businesses can get help to send text messages in volume at a time and date set by them.

They submit their text wording (160 characters or fewer) and specify the time and date at which they would like their text campaigns sent. They also set the volume of customers to whom they'd like them sent.

Partnership marketing specialist Howse Jackson Marketing subsequently sends a test SMS message to a mobile number to ensure the messaging and all links are correct. The main text broadcast follows at the appointed time and date.

Managing director of Howse Jackson Marketing Nick Howse said: "Text messages are one of the most powerful forms of advertising and perfect for rewarding loyal customers, generating footfall and encouraging repeat business.

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Consultant Orthodontist. Specialist in Conventional and Aesthetic Orthodontics including aligners and lingual appliances.

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

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

Mr.Ahmed Messahel BDS FDSRCS(Eng) MB ChB MRCS(Eng) PGA Med Ed. PGA MLiP FRCS(Eng) OMFS.
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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

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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

Scotland

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Edinburgh Dental Specialists,
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Tel: 0131 225 2666 **Fax:** 0131 225 5145

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
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

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North

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

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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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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.

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Dr Asim Ayub BDS MFDSRCS MClinDent MRDRCS
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Interests: Endodontics
On Specialist List: Yes

230732

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239826

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Dr Nicole Sturzenbaum
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Interests: Children

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On Specialist List: Yes Prosthodontics and Periodontics

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North West

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Interests: Dental Implants, Oral Surgery, Orthodontics, Endodontics, Paediatric Dentistry, Restorative and Cosmetic Dentistry, Sedation and Non-Surgical Facial Cosmetics
On Specialist List: Yes, Endodontics

261006

East Anglia

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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

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Email: reception@grantadental.co.uk
Interests: TMJ, Occlusion, Splints for pain relief & reconstructive treatment planning
On Specialist List: No

237823

South West

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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

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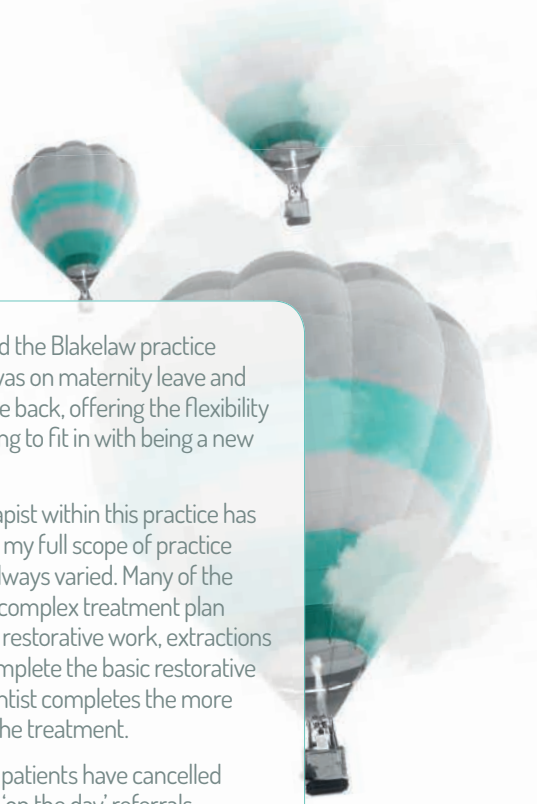

mydentist acquired the Blakelaw practice during the time I was on maternity leave and they welcomed me back, offering the flexibility of part time working to fit in with being a new mother.

Working as a therapist within this practice has allowed me to use my full scope of practice and my days are always varied. Many of the patients require a complex treatment plan consisting of basic restorative work, extractions and dentures. I complete the basic restorative work while the dentist completes the more complex parts of the treatment.

On the days when patients have cancelled or failed to attend, 'on the day' referrals allow these spaces to be filled, helping other members of the team deal with emergency appointments.

I really enjoy being part of the team at mydentist, it feels-very rewarding to work alongside my colleagues. I always feel supported by team members and look forward the continuing to work within this practice.

Amanda Brownlee
Blakelaw Dental Practice

Business skills CPD

Q1: Which of the following statements is true?

A A leader would respond to poor performance by a staff member by putting them into the poor-performance process

B A leader would respond to poor performance by the team by setting and monitoring targets more tightly

C A leader would believe poor performance by the team can be solved by taking them on a team-building event

D A leader would try to understand each everyone's skills strengths and motivations

Q2: Which of the following is a core CPD subject?

A Oral cancer – early detection

B Disinfection and decontamination

C Legal and ethical issues

D Safeguarding children and young people

Q3: When testing yourself to see if your belief that an employee has committed misconduct is reasonable, to which of the following do you *not* need to be able to answer "yes"?

A Would I would be able to explain my decision to a stranger without feeling awkward or embarrassed?

B Am I satisfied on the balance of probabilities that they have committed the misconduct?

C Am I satisfied beyond reasonable doubt that they have committed the misconduct?

D Would someone else find my reasoning logical?

Q4: Under the *Fit for Work* scheme, an employer's referral for a free occupational-health assessment can be made after an employee has been off sick for how many weeks?

A one week

B two weeks

C three weeks

D four weeks

Q5: Discounts and price comparisons must reflect a product's or service's most recent price, which must have been the price asked for how long previously?

A five days in a row

B seven days in a row

C 14 days in a row

D 28 days in a row

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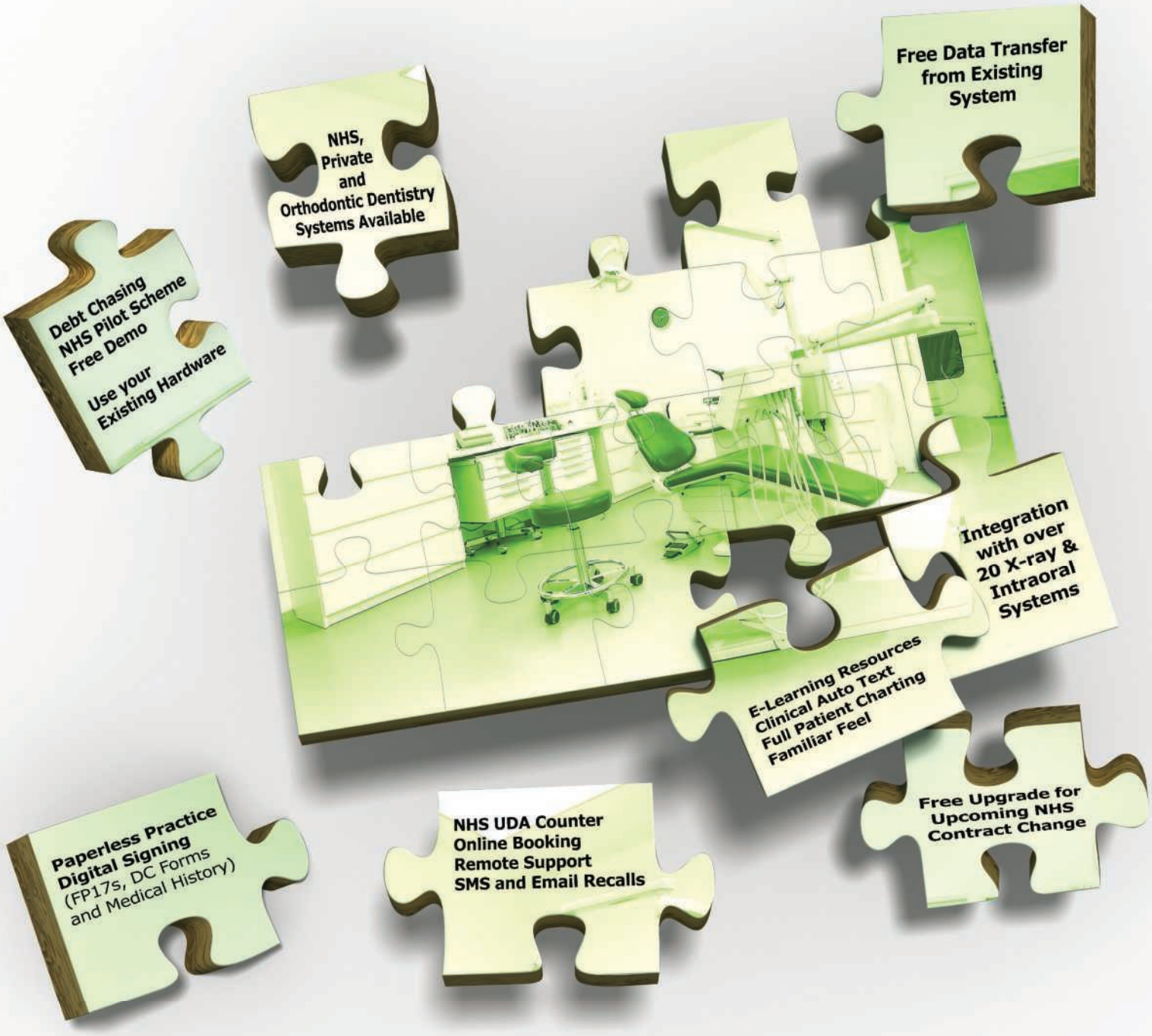

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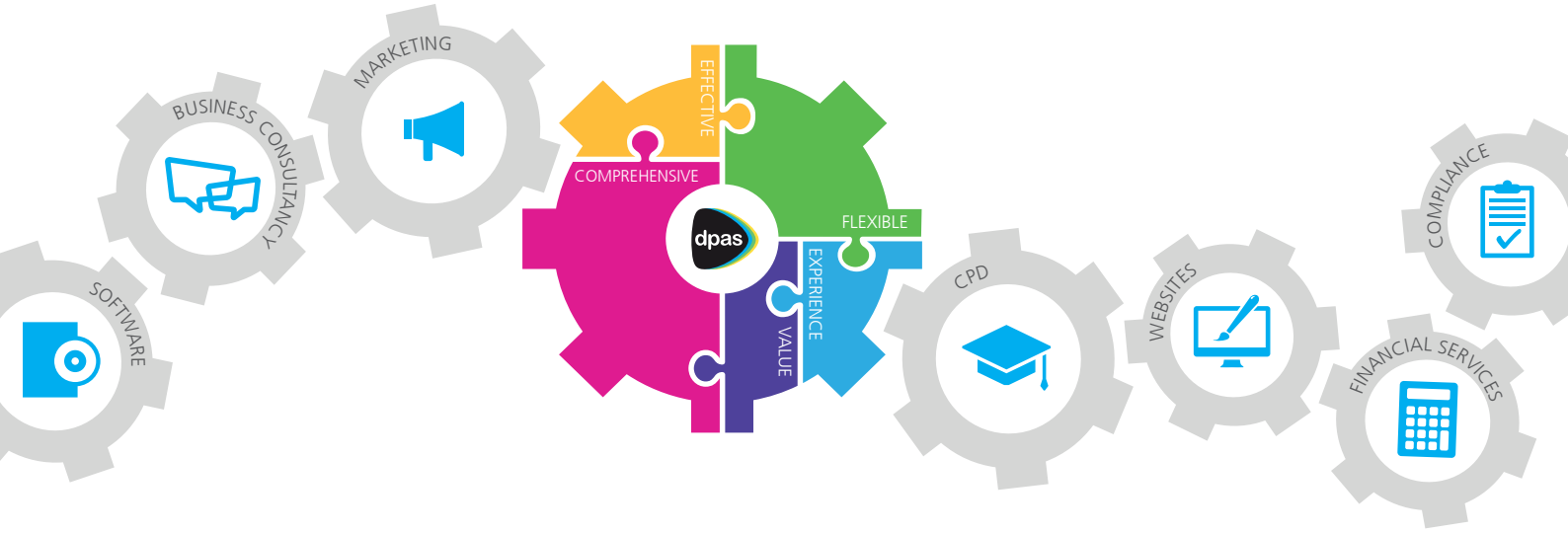

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