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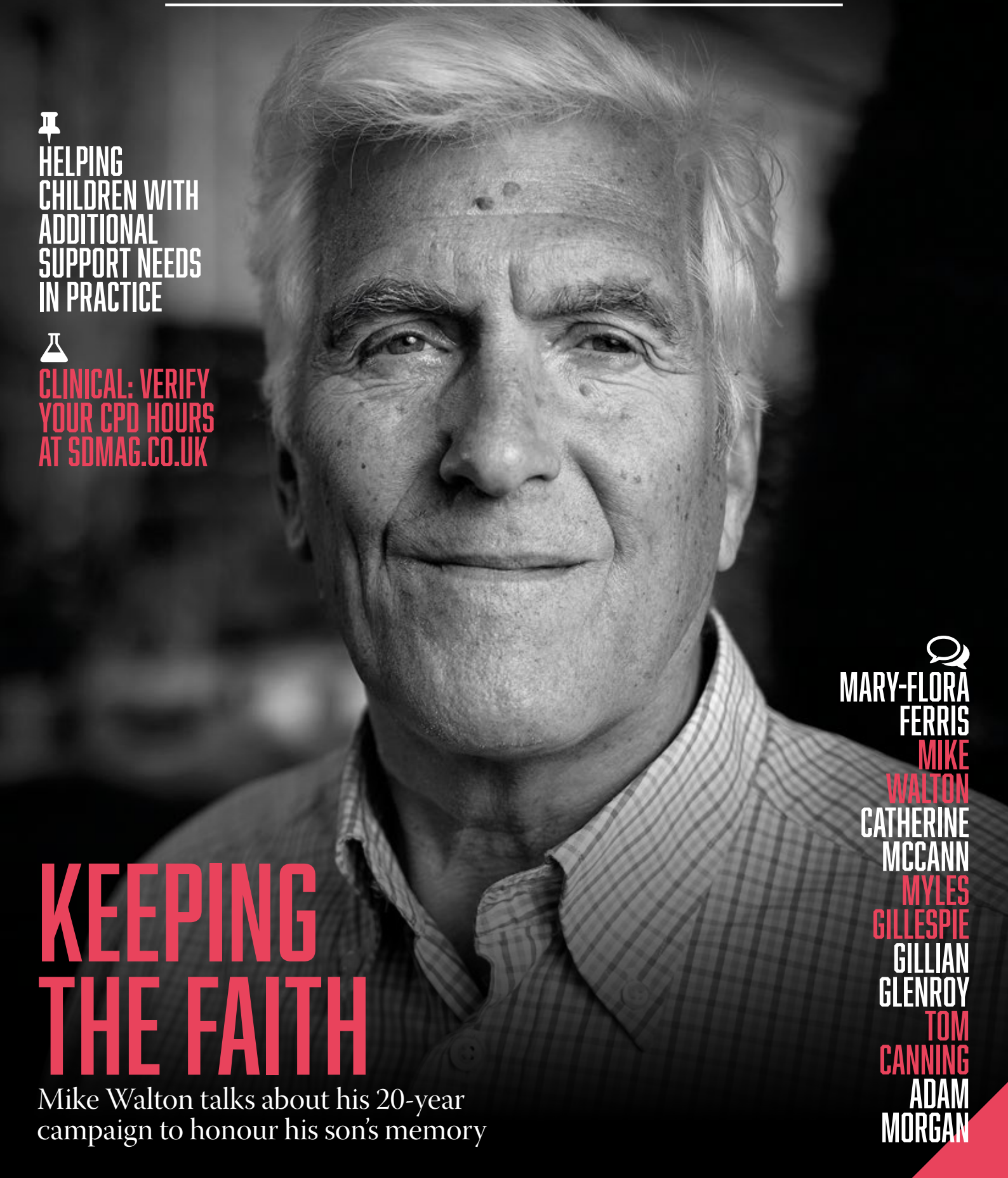

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KEEPING THE FAITH

Mike Walton talks about his 20-year campaign to honour his son's memory

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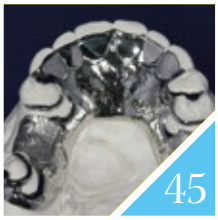

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Dr Jonathan Dougherty

BDS, MJDF RCS (Eng), MFDS RCS (End), MFDS RCS (Glas)

Jonathan Graduated from Glasgow University in 2010 and went on to complete his MJDF RCS (Eng) in 2011. He was awarded his MFDS RCS (Glas) in 2012 & MFDS RCS (Edin) in 2013. He is Currently finishing a diploma in Restorative Dentistry at the Royal Colleague of Surgeons England with the aim of finishing his masters next year at the University of Leeds.

Jonathan was voted young dentist of the year 2015 at the Scottish Dental Awards.

Dr Jillian Clare

BDS (Glas), MFDS, RCS (End)

I have worked at Philip Friel Advanced dentistry for the past four years. I have a special interest in cosmetic dentistry, having previously completed a year course in London, and I have been placing and restoring implantfor over 8 years. Currently I am undertaking the FGDP implant diploma at the Royal college of surgeons in London.

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Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
bruce@sdmag.co.uk

GETTING THE MESSAGE ACROSS

Raising awareness of mouth cancer has never been more important

Earlier this year I was fortunate enough to see Professor Mike Lewis speak at a seminar in Cumbernauld on mouth cancer. As well as challenging the attendees to identify instances of mouth cancer, there was one thing he said during the Q&A at the end that really struck a chord with the dentists in the room.

He said that, in the past, you would maybe see one or two cases of mouth cancer in your career, now it seems to be one every five years for the average general dental practitioner.

And the statistics from the British Dental Health Foundation (BDHF), who run the hugely popular Mouth Cancer Action Month every November, seem to back this up. Cases of mouth cancer have increased by a third in the last decade alone, with the disease claiming more lives than testicular cancer and cervical cancer combined.

With mouth cancer now a recommended CPD topic, there can be no excuse for dentists not to keep themselves bang up to date on the subject. However, awareness among the public and getting the message across effectively is still an ongoing battle.

BDHF research has found that one in 10 people had never heard of mouth cancer and, with Scotland having more cases per capita than England, Wales and Northern Ireland, getting the message out to your patients has never been more important.

To mark Mouth Cancer Action Month we asked Professor David Conway from Glasgow and Professor Graham Ogden from Dundee to give their top tips for GDPs (see page 12) and we also feature an interview with Ben Walton Trust founder Mike Walton (on page 28) who will pick up an MBE from the Queen next month for his work raising awareness of the disease.

As well as mouth cancer awareness, we also feature an article on how general dental practices can help children wth Additional Support Needs (ASNs) be seen in their practices and not be referred on to the community service as a matter of routine (see page 24).

Every dentist wants the best for their patients but time pressures, lack of funding and the skills needed to treat children with conditions such as autism and Down's Syndrome make this problematic in a busy NHS practice.

However, a new play resource from a children's charity could offer hope to parents, children with ASNs and dental teams so that they can keep families together and reduce the stress for all concerned.

I witnessed the impact of this resource first hand when I visited a practice in Kilwinning and the dentist involved said she couldn't believe how effective it was for her son, who has Down's Syndrome.

There are still issues around funding that need ironed out, but this just shows how thinking outside the box can have a definitive impact in practice.

WE COULDN'T HAVE DONE IT WITHOUT...

1

MARY-FLORA FERRIS
(ON A NEW PLAY RESOURCE)
Action for Sick Children Scotland's dental project officer Mary-Flora Ferris works to improve the experience of children in dental settings.

2

MIKE WALTON
(ON MOUTH CANCER AWARENESS)
After losing his 22-year-old son to mouth cancer, Mike Walton has dedicated his life raising awareness among the public and the profession.

3

CATHERINE MCCANN
(ON VULNERABLE CHILDREN)
Queen's University Belfast graduate Catherine McCann is a DCT2 in oral surgery and special care dentistry at Glasgow Dental Hospital.

4

TOM CANNING
(ON MANAGING EXPECTATIONS)
Specialist prosthodontist Tom Canning maintains a specialist practice in Dublin. He has previously worked as a GDP in both the UK and Ireland.

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Insider

HAVING HIS SAY →
Arthur Dent is a practising NHS dentist in Scotland
arthurdent@sdmag.co.uk

QUIS CUSTODIET IPSOS CUSTODES?

"Who will guard the guards themselves?" Arthur argues that this has never been more relevant for the dental profession than it is now

The GDC has not changed since the BDA launched its judicial review late last year and it has now launched another consultation on the Annual Retention Fee (ARF). Already, dentists pay more than any other health professional. It is unlikely this is because we are more dangerous.

Indeed, the CQC, which carries out (among other duties) inspections of dental practices in England, says that dental care "has lower risk than most other sectors". Yet our ARF is still higher.

We are certainly up in front of our regulator more frequently.

The GDC has launched yet another consultation on the ARF. The registrants are, of course, paying for this consultation. Very worryingly, the GDC refers to the people we treat as "consumers", not as patients.

The GDC was found to be the worst of all British healthcare regulators in the Public Standards Agency annual report published this summer. It stated "the view expressed to us by the GDC is that there is a profound misunderstanding by some parts of the profession regarding its approach to fitness to practice".

Various charges have been laid regarding such ludicrous allegations involving floppy fringes and the like. It is also unacceptable that these charge lists are viewable to the general public before the hearing has taken place. This does not happen with the GMC.

Cases are also still available to be viewed long after they have been dismissed, and not removed from the website, which is, of course, highly detrimental to the dentist involved.

I had a spare few minutes the other day and I decided to look at who are the Scottish members of the FtP panel. Of the three Scottish members, one is thought to support the use of homeopathy and another was appointed during their VT year. Many people would say that espousing a belief and support for homeopathy demonstrates a questionable ability to understand basic science, let alone judge on the suitability of a professional to practise.

As for the member who joined as a VT, they should of course be applauded for taking time out from learning basic clinical dentistry to do this. The criticism does not lie with them, but with the GDC for appointing them.

I have heard a colleague report that, in a FtP hearing she was involved with, it was clear that the GDC thinks recently qualified dentists "need support". Yet someone who had yet to complete their VT year is deemed fit to cast judgement on others.

And what about the BDA Principle Executive Committee (PEC)? I understand that at least three members of the PEC are no longer practising clinical dentistry. Online searches of their own published biographies do not reveal that they are no longer wet-fingered. It is questionable how well they can represent a profession they are no longer official members of (one is no longer on the GDC register).

It may also be interesting to speculate as to why someone would withdraw from the GDC register part-way through the year, when there is no advantage in doing so.

Each year, a third of the positions on the PEC come up for election. One is always a UK-wide seat (the current Scottish seat is held until 2017) which anyone who has been a member of the BDA for the previous year can stand for.

Dentists will often complain in conversation that the (dental) political powers that be have sold them down the river. The way to combat this is to stand for elected office. If you're not a BDA member, join now (at the lowest rate) so you can stand in a year's time. Stand, and represent your fellow dentists and insist the BDA supports the creation of a fair dental regulator in Scotland.

No wish to join the BDA? Then get involved with your LDC, who also have representatives on SDPC and SALDC.

No wish to support your LDC? Then don't complain!

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A VERY UNHAPPY PROFESSION

SALDC survey finds that nearly 90 per cent of dentists in Scotland are 'adversely stressed'

An independent survey of Scottish GDPs has confirmed fears that stress among the profession is at dangerously high levels.

The research by the newly-reformed Scottish Association of Local Dental Committees (SALDC) comes on the back of reports of poor morale among Scottish dentists by the HSCIC Dental Working Hours publication.

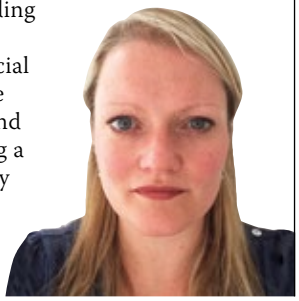
The survey, one of the first orders of business after the SALDC was re-established earlier this year, found that 88.3 per cent of dentists who responded were "adversely stressed" by their profession. On top of this, 84 per cent said they felt more stressed than they were last year and 87 per cent said they were more stressed than they were five years ago.

SALDC chair Arabella Yelland said: "We decided to conduct a survey, firstly to determine whether GDPs in Scotland are adversely stressed by working within the profession and, if adversely stressed, had the level of stress increased in the last five years. The format of the questionnaire was four closed questions, one open question and finally an opportunity to provide comments."

Arabella explained that the sample fairly represented both practice owners (58 per cent) and associates (42 per cent). It showed that the vast majority of dentists feel adversely stressed, and are progressively becoming more stressed.

She also pointed to a recent independent review commissioned by the executive of Ayrshire and Arran health board, which described "a culture of fear" among dentists with regards to performance and patient safety issues.

She said: "Dentists are working in fear of one minor mistake sending them to the GDC. Financial pressures are mounting, and we are seeing a very unhappy profession. This is not good for patients."



NOW TRENDING

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FACT

Heavy smokers and drinkers are up to 35 times more at risk of developing mouth cancer

* British Dental Health Foundation

GDC CHIEF EXECUTIVE RESIGNS FROM POST

A year after facing down repeated calls from the profession to resign over the ARF increase, GDC chief executive and registrar Evlynne Gilvarry has now announced her decision to step down in January.

Gilvarry, who along with GDC chair Bill Moyes was grilled by Mr Justice Cranston as part of the BDA's judicial review into the fee hike, has been at the helm of the troubled regulator for five years.

Last year's court action found that the GDC had acted unlawfully in its consultation process, but declared that the ARF increase should stand.

On announcing her decision to resign, Gilvarry said: "It has been a privilege to lead the organisation for the last five years and I have greatly enjoyed working with so many talented and dedicated colleagues.

"It is now the right time for me to hand over to a new chief executive to lead the GDC going forward. I would like to thank the GDC's council members and staff for their support and commitment during my time with the organisation."

DDRB EVIDENCE CRITICISES SCOTTISH GOVERNMENT APPROACH

The Scottish Government's procurement exercise to collect and analyse the accounts of 200 practitioners in Scotland was "flawed" according to the British Dental Association (BDA).

The criticism is included in the association's evidence to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for 2016/17.

The document stated: "BDA Scotland and the Scottish Dental Practice Committee have invested considerable time and effort to encourage practices to participate in this exercise; however, there have been major flaws in how this project was commissioned.

"The level of detail in the information requested was described by practitioners as 'excessively and inappropriately detailed and intrusive' resulting in a very low up-take up by practices."

In the first phase of the exercise, only one practice out of 200 committed to participating in the process.

A spokesman for the Scottish Government said: "The project was commissioned in line with Scottish Government procurement rules and the BDA was involved throughout the process and given early sight of the relevant documentation and methodological approach.

"This approach provides dentists with the opportunity to give the DDRB information to help identify a way forward, but clearly relies on dentists actively participating in the process."

Eddie Crouch, chair of the BDA's Review Body Evidence Committee, said: "The priority for dentists is high-quality care, and years of sustained cuts have made it difficult to deliver what our patients deserve. Governments appear to have settled on a winning formula for demoralising an entire profession. If we continue on this course, without realistic pay uplifts, we are heading for a retention crisis."

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Mick Armstrong

TIME TO 'DISPENSE WITH WAR CHESTS' SAYS BDA

Dentists' union says the GDC's 'hoarding' of cash reserves is keeping the ARF unnecessarily high

The British Dental Association (BDA) has accused the General Dental Council (GDC) of "hoarding registrants' money" after the regulator recommended keeping the Annual Retention Fee at the controversial £890 rate for another year.

The BDA believes that the GDC "can and should" set a fee level for dentists of no more than £500 for 2016/2017. The association also says that its analysis identifies that the GDC's approach is flawed, stating that the regulator's "excessive reserve policy" is keeping the ARF at £890.

Mick Armstrong, chair of the British Dental Association's Principal Executive Committee, said: "After defeat in the High Court, we had hoped the GDC might actually have learned its lesson on transparency. Sadly, the regulator has served up another fees consultation with a familiar line in disinformation and predetermined results.

"The regulator is continuing to overstep its remit, and is still expecting registrants to pay for that excess. So we have set out to identify straightforward and immediate savings that ensure the GDC can deliver on its core functions.

"Our regulator has not offered any clear justification for maintaining gargantuan reserves at our expense.

"Keeping £10 million of fees set aside for the rainy day its own models suggests will never come isn't 'prudence' or 'best practice' – it's simple hoarding. The GDC could now ensure both fair fees and its own financial security through a realistic policy.

"Setting the annual retention fee at no more than £500 for 2016 would send the clearest possible signal that the GDC is finally prepared to live within its means and focus on its day job.

"It's time to dispense with the war chests and the empire building, and get regulation right."

The GDC's latest consultation on the level of the ARF received 1,255 responses, to read the regulator's statement, visit http://bit.ly/GDCstatementNov15

To read the BDA's response to the consultation, visit http://bit.ly/BDANov15ARF

AUDIT DEADLINE APPROACHES

NHS primary care dentists are being urged to act soon to ensure compliance as the three-year audit cycle starts to come to an end.

The current period ends on 31 July 2016 but, with audit projects normally taking up to six months, any dentists who are short of clinical audit hours need to be aware of their options.

NHS Education for Scotland's (NES) director of postgraduate GDP education and national lead for clinical audit activity Tony Anderson explained that NES has restructured the clinical audit section of its website to provide a simple, step-by-step process.

He said: "Reading the guidance in advance and following the steps, will minimise the risk of a project or a final report being rejected, or amendments being requested."

The deadline for practitioners wishing to use NES's online system for new audit project applications is 18 December at the latest.

"This will allow us time to review the application to request any amendments that may be required and to issue approval by the end of January, which will ensure that the end date for the project is on or before 31 July 2016," said Anderson,

Pre-approved projects will continue to be available to join and submit until the end of January, after which they will be withdrawn. SEA final reports can be submitted until the end of July – events must have occurred in the previous six months.

FOR MORE INFORMATION
Visit http://bit.ly/NESAudit or email dental.audit@nes.scot.nhs.uk if you have any questions on the application, review and approval process.

SCOTTISH PROFESSORS PROVIDE ADVICE ON MOUTH CANCER

Two leading Scottish practitioners are putting their weight behind this year's Mouth Cancer Action Month by highlighting their key messages for prevention and detection of the disease

As Mouth Cancer Action Month kicks off, Scottish practitioners are being advised of the key messages to pass on to their patients.

Professor David Conway, professor of dental public health at the University of Glasgow, said: "I would say that the key prevention messages for patients is that they can reduce their mouth cancer risk by stopping smoking – it is never too late; avoiding heavy alcohol consumption and certainly don't smoke and drink alcohol heavily because the risks multiply.

"The message is one thing, but making patients change behaviour is another. In all areas, there are specialist referral services for both smoking and alcohol counselling, which every practitioner should become familiar with."

Professor Conway said that dentists and patients need to also be aware that, while mouth cancer can occur at any age, in both sexes, and across the socioeconomic spectrum, the determinants which are difficult to modify and which carry greater risk are: low socioeconomic circumstances (i.e. poverty – individual or area-based measures); age – risk increases with age to a peak at 70-75 years (out of 494 cases of mouth cancer in 2013, there were only 23 in those under 45 years); and sex – men continue to have greater risk than women.

Professor Graham Ogden, professor of oral surgery and honorary consultant in oral surgery at Dundee Dental School, said: "While it's true that risk increases with age, it is important to remember that you don't have to be old to get mouth cancer – one in 10 cases is under 45 years of age.

"And, while 75-80 per cent of oral cancers are found in people who smoke and drink heavily, that still leaves approximately one in five people where no obvious risk factor can be found.

"In summary, if patients have any lump or lesion in the mouth (for example a red or red/white patch) or neck or an ulcer that does not heal in two weeks, they should attend their dentist – if in doubt, get it checked out."

Professor Graham Ogden

Mouth Cancer Action Month takes place throughout November. For more information on the campaign, visit www.mouthcancer.org

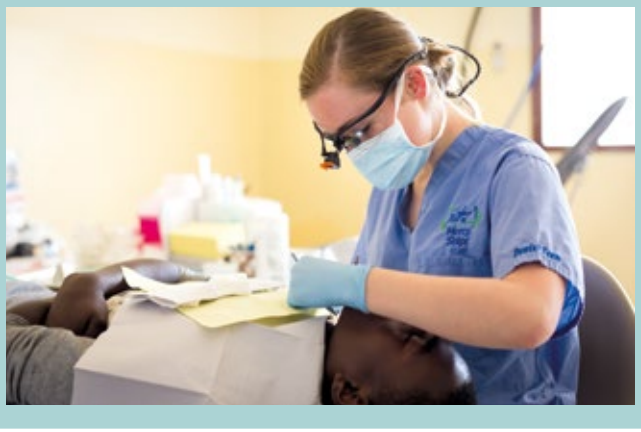
Turn to page 28 for an interview with the Ben Walton Trust founder Mike Walton MBE.

AILSA'S MADAGASCAR MISSION

A young dentist from Scotland who quit her job to volunteer on the world's largest non-governmental floating hospital says she can't wait to go back.

Ailsa Malone, a 26-year-old dentist from Glasgow, recently spent two months in Madagascar on the Africa Mercy, a 16,000-tonne state-of-the-art hospital ship run by international charity Mercy Ships, with a crew of more than 450 volunteers from more than 40 nations.

Ailsa said: "A typical day involves working with a local Malagasy interpreter, assessing and treating adults and children – many of whom have travelled many miles – providing around 20 fillings and extracting up to 40 teeth.



"The most memorable moment from my time volunteering with Mercy Ships was when I first saw the dental queue. There were more than 400 people waiting to be screened, hoping to be one of the lucky 150 to get a ticket for a dental appointment for the next few days. This process happens every Monday and Thursday.

"Witnessing the level of dental need in Madagascar has been very difficult. Managing young children who need eight or more extractions under local anaesthetic has been a challenge.

"I have made some lifelong friends on the ship – it's one of the best things I have ever done. I can't wait to return and I think next time round I will bring a few of my friends along."

Mercy Ships is taking part in the #GivingTuesday campaign taking place on Tuesday 1 December. To support Mercy Ships, you can text GTMS15 on 70070 to donate £2. Alternatively, visit the website at https://www.mercyships.org.uk

DENTAL EQUIPMENT SEIZED AT SHOWCASE

Dozens of potentially dodgy dental products were seized after an impromptu raid at the BDIA Dental Showcase at the NEC in Birmingham recently.

Inspectors from the Medicines and Healthcare Products Regulatory Agency (MHRA) were at the exhibition to raise awareness of the rise in counterfeit and non-compliant dental devices when organisers received a tip-off from another exhibitor. The dental goods in question, which were brought in from China for sale to UK dental customers, included 20 curing lights, 19 hand pieces, 150 drill bits, dental mirrors and false teeth, as well as air prophy units.

Alastair Jeffrey, head of the enforcement group at the MHRA, said: "We were at the dental exhibition to raise awareness of the proliferation of counterfeit and non-compliant medical devices. This ended up being a very practical example and clearly illustrated the problem."

For more information on the BDIA's Counterfeit and Substandard Instruments and Devices Initiative, visit www.bdia.org.uk/device-reporting



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AWARDS ON PAGE 17

I felt immense pride for all my colleagues when I was chosen as winner of the first-ever Dental Award

PROFESSOR RICHARD WELBURY

GLASGOW STUDENTS TURN TEACHERS

Awareness day sees undergraduates spread the message about resuscitation

A group of Glasgow dental students took the resuscitation message to heart recently when they set up shop at the Glasgow Science Centre.

The third and fourth-year students were taking part in European Restart a Heart Day on 16 October and put all their medical emergency and basic life-support training to good use, talking to the public and teaching them valuable lifesaving skills.

Supported by tutors Lezley Ann Walker and Liz Webster from Glasgow Dental School, the students spoke to hundreds of children and adults, with more than 175 taking part in a life-support taster session from the students.

ABOVE: the dental students who helped share the resuscitation message

Fourth-year student Jayne Paterson said that changing from pupil to teacher at the event was a great experience, and it also helped her remember her training. She said: "It is completely different, but I have found that it helps to cement it in your mind. I don't think I'll ever forget 30 compressions to two breaths because we have been repeating it over and over today. It actually makes it easier to learn if you are teaching it yourself."

Dental team tutor Lezley Ann said: "This event has been such a good teaching tool for the undergraduates. The repetition is wonderful revision for them and it also gives them the experience in the role of teacher. This enhances their skills, particularly communication, and gives them confidence in their ability, dealing with large numbers of the general public of all ages at the one time."

As well as stressing the importance of basic CPR and resuscitation techniques, they also demonstrated how to use automatic external defibrillators to many of the adults present.

Lezley Ann said: "We had a guy who trains kids' football and they were donated a defibrillator, but only a couple of coaches were taught how to use it – and one has now left. He was concerned about this and after talking to us is now considering speaking to the committee to get everyone trained, including the children. So, we had an impact there that could potentially save a life later on."

INEQUALITIES STILL REMAIN SAY LATEST NDIP FIGURES

Despite a continued improvement in the oral health of primary seven pupils, significant inequalities still remain according to the latest National Dental Inspection Report (NDIP).

The 2015 report of 14,643 children from schools across Scotland, representing 28 per cent of the total P7 population, found that 75 per cent now have no obvious decay experience. This is up from 73 per cent in 2013 and from 53 per cent in 2005.

However, the report also found that socio-economic inequalities still remain in Scotland, with the percentages for children with no obvious decay ranging from 64 per cent in the most deprived quintile, to 85 per cent in the least deprived quintile.

The number of decayed, missing or filled teeth also continues to drop, with the mean number of teeth in the report down to 0.53, compared with 0.60 in 2013 and 1.29 in 2005.

CHARITY PRESSURE LEADS TO NATIONAL SERVICE REVIEW

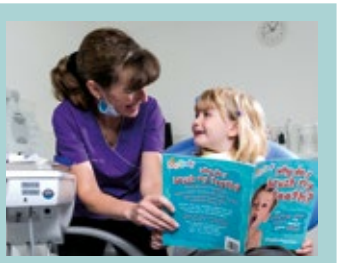
The Public Dental Service in Scotland has been asked to carry out an immediate review of its service provision for children with additional support needs as a result of pressure from a children's charity.

Action for Sick Children Scotland (ASCS), whose Special Smiles project is featured on page 24 of this issue, has revealed a lack of data around children with additional support needs (ASNs) in educational and clinical settings.

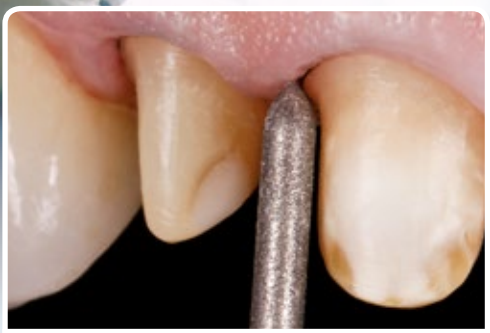
Mary Flora Ferris, dental project officer with ASCS, said that the evidence gathered to date makes it impossible to determine the dental profile of many children with ASNs. She also points out that the National Dental Inspection Programme (NDIP) date doesn't capture specific information on children with ASNs.

Public Health Minister Maureen Watt said: "Childsmile support workers work closely with health visitors to identify and support families with additional support needs from birth.

"Childsmile is dramatically improving children's dental health and has been shown to prevent children having to have fillings and extractions. Families of children with additional support needs should have access to enhanced support, tailored advice and information to improve and maintain the child's oral health. This includes toothbrushing instruction and fluoride varnish application as part of the Childsmile Programme and the National Dental Inspection Programme.



"The clinical leads of the Public Dental Services across Scotland have been asked to undertake a review of service provision to children with additional support needs in education settings."



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PATIENT SAFETY PROGRAMME ROLLED OUT TO DENTISTRY

The Scottish Patient Safety Programme (SPSP) in Primary Care is being extended to general dental practice with Irene Black being appointed as the National Dental Lead for the collaborative.

The SPSP Dentistry in Primary Care Collaborative, which is led and co-ordinated by Healthcare Improvement Scotland, is in the process of recruiting three NHS health boards, which will further recruit five general dental practices to take part.

Successful boards will be expected to recruit a dentistry clinical lead, who will work one to two sessions a week, with the primary care dental teams testing safety tools and interventions.

It is planned that the collaborative will initially run until December 2016.

SPSP is a key part of the Scottish Government's Healthcare Quality Strategy for NHS Scotland that was launched in 2010. The primary care element was introduced in March 2013.

COULD YOU BECOME AN ANTIBIOTIC GUARDIAN?

Scottish dentists are being urged to consider other options to antibiotics in an effort to help fight the growing threat of antimicrobial resistance.

Jacqueline Sneddon, project lead for the Scottish Antimicrobial Prescribing Group, hopes that this year's European Antibiotic Awareness Day on 18 November will inspire dentists to take action to improve the way they use antibiotics.

Dentists are being asked to support the Antibiotic Guardian pledge campaign by considering drainage for dental infections before issuing antibiotics, discussing with patients the importance of antimicrobial resistance and, when seeing a patient in pain, discussing methods of controlling symptoms rather than prescribing antibiotics as the first course of action.

Despite dental prescribing accounting for just 8.4 per cent of antibiotic use in Scotland and the overall use reducing in each of the last two years, Jacqueline has warned against complacency.

She said: "Data has shown marked variation between dental practices with some using far more antibiotics than others.

"This mirrors the situation with GP practices and, for the past two years, GPs have had a national quality indicator with a target to reduce total use of antibiotics using a 'best in class' approach to reduce variation.

"A quality improvement approach such as this may also be helpful to reduce variation in prescribing rates among dentists.

"Antimicrobial resistance is a problem that will never go away, but we are starting to win the battle to prevent further spread.

"All healthcare professionals must remain vigilant to stop unnecessary antibiotic use and ensure optimal use of antibiotics when they are required."

For more information on the Antibiotic Guardian Campaign, visit www.antibioticguardian.com and to find out more about European Antibiotic Awareness Day, visit the official website http://bit.ly/EAADsite

Tom Ferris and Professor Richard Welbury

GLASGOW PROFESSOR PICKS UP DENTIST AWARD

Paediatric dentist Professor Richard Welbury picked up the first-ever Dentist Award in front of more than 500 guests at the annual Scottish Health Awards recently.

The event, which was held at the Corn Exchange in Edinburgh on 4 November, saw Professor Welbury presented with his award by Deputy Chief Dental Officer Tom Ferris.

Professor Welbury, who is based at Glasgow Dental Hospital, said: "I have had my picture behind me when I have lectured before, but this was an altogether grander and more prestigious occasion and, frankly, it was humbling to be viewed alongside all the other candidates on the night.

"I felt immense pride for all my colleagues in the paediatric dental team at Glasgow Dental Hospital and School and QEUH when I was chosen as winner of the first-ever Dental Award.

"We have worked closely together over the last 14 years to introduce significant changes in practices and techniques, including bringing new technology and introducing it to the west of Scotland.

"Our children now have the best available treatment in the world today."

The awards featured 16 different categories celebrating everyone from support workers to volunteers. Professor Welbury said: "The stories on the night were inspiring.

"I did think that Nye Bevan would have been smiling and very proud that such excellence in patient-centred care was being demonstrated."

KASHMIR MISSION FOR GLASGOW-BASED CHARITY

A team of five dentists from Glasgow-based charity Dental Aid Network (DAN) travelled to Kashmir last month on their latest aid mission.

Following on from their successful trip to Palestine in 2014, the DAN team travelled via Islamabad to Mirpur in Kashmir on the 10-year anniversary of the earthquake that devastated the region.

Working in partnership with the Kashmir Orphans Trust, Edinburgh dentist Ferhan Ahmed was joined by Asad Khan and Khuram Shafiq from Glasgow, as well as two English-based dentists, Imran Asghar from Rochdale and Taiyub Raja from Bradford for the visit.

Over five days, the team saw 165 children who were assessed and basic dental treatment, including scaling, fillings and extractions, were provided.

Ferhan said: "Many of the children were visiting a dentist for the first time, but the team coped very well with the challenge of making the children feel at ease in the dental chair.

"The biggest challenge we faced was the regular power cuts during the day. This was overcome by treating patients who required extractions with hand scales at times of no electricity."

For more information on the Dental Aid Network, visit www.dentalaidnetwork.org

NOMINATIONS ARE NOW OPEN

THE COUNTDOWN TO THE 2016 SCOTTISH DENTAL AWARDS STARTS NOW

FRIDAY, 13 MAY 2016

Nominations for the 2016 Scottish Dental Awards are now open and preparations are well under way to make this a night to remember.

The venue for next year's dinner and awards ceremony on Friday 13 May will be the five-star Glasgow Hilton Hotel and the event will be hosted by television personality Carol Smillie. There will be 14 categories presented on the night, culminating in the prestigious Scottish Dental Lifetime Achievement award, which was presented to Elizabeth Saunders last year.

Last year's Dentist of the Year award winner Samuel Barry Lemon is encouraging dental professionals from across Scotland to get involved and nominate a colleague.

The principal of Bluewater Dental in Lochwinnoch, said: "I was delighted to be shortlisted because I'd only really expected to go along with the team for a nice meal and a 'knees up'.

"The night was great craic. I bumped into a few old faces I'd not seen in years, including the lady who taught me about root canals, Liz Saunders. I wasn't nervous about the award until they started calling out names. It was only at that point that I started to realise that winning something was a distinct possibility and my mouth started to get a little dry."

And Barry, as he is known to his patients, family and friends, explained that he was most struck by the reaction of the other people on his table when his name was read out. He said: "It was the reaction from my partner Francesca and the rest of our team that really hit me. I was shocked, but very excited.

"Winning the award was a lovely way to round off a very eventful first year at Bluewater. I think that the award has almost meant more to my staff and patients than it has to me! Lochwinnoch is such a small village with a tremendous sense of community pride, so you can imagine a gong like this went down well."

And Young Dentist of the Year winner Jonathan Dougherty, principal dentist at Kilmarnock Dental Care, explained what winning the award meant to him. He said: "Winning the award was a huge surprise. Everyone in the category deserved to win, but when my name was called, it was a huge sense of achievement.

"The award has been great from a public relations aspect. It is a really good talking point for new and existing patients who come to the practice.

"I would like to thank the Scottish Dental Awards for such a fantastic evening and I am looking forward to what's in store for 2016."

SCOTTISH DENTAL AWARDS 2016 CATEGORIES

Scottish Dental Lifetime Achievement Award
Last year's recipient: Elizabeth Saunders

Young Dentist Award
Last year's winner: Jonathan Dougherty – Kilmarnock Dental Care

Employer of the Year
Last year's winner: Morven Gordon-Duff – Huntly Dental Practice

Website of the Year
– NEW FOR 2016
Last year's (Digital Strategy category) winner: Dental Studios Scotland

Practice of the Year
Last year's winner: G1 dental, Glasgow

Dentist of the Year
Last year's winner: Samuel Barry Lemon – Bluewater Dental, Lochwinnoch

Dental Team Award
Last year's winner: Crown Dental Group

Laboratory of the Year
Last year's winner: Leca Dental Laboratory

Unsung Hero
Last year's winner: Dr Jon Victor

DCP Star
Last year's winner: Kirsty Rodger – Huntly Dental Practice

Business Manager/ Administrator of the Year
Last year's winner: Liz Alexander – Southwest Smile Care Centre

The Community Award
Last year's winner: Linsey Paton – Tryst Dental

The Style Award
Last year's winner: Glasgow Southside Orthodontics

Scottish Dental Representative Award 2015
Last year's winner: Donna Morrison – The Dental Directory

SCOTTISH DENTAL SHOW

Registration for the Scottish Dental Show at Braehead Arena on 13 and 14 May is now open and, if you sign up for your free delegate pass online, you will be entered into a prize draw to win a new iPad.

Delegates can earn up to nine hours of CPD from a world-class field of speakers, including Professor Mike Lewis, Professor Tim Newton, Christine Park, Steve Bonsor, Professor Jan Clarkson, Professor Peter Mossey, Adam Morgan and many more.

There will be CORE CPD sessions on mouth cancer, decontamination, safeguarding and legal and ethical issues as well as a dedicated technicians stream on the Saturday and a business stream throughout the two days.

The Taste of Braehead featuring many of the food outlets in the shopping centre is back again this year and will be expanded to allow delegates to sample some of the delicious food and drink on offer in the food court. On the Saturday afternoon there will also be a special drinks reception, 'One for the Road', where delegates and exhibitors could win a £500 Braehead shopping voucher.

For more information and to register, visit www.sdshow.co.uk or follow @ScottishDental on Twitter for all the latest news – don't forget to use the hashtag #SDShow16 when tweeting.

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Dispatches

WITH PAT KILPATRICK, →
BDA Director for Scotland
dispatches@sdmag.co.uk

DÉJÀ VU ALL OVER AGAIN

After years of real-terms pay cuts, the BDA is making its annual case for an above-inflation rise to lift the crushed morale of our members

We've been here before. To quote Yogi Berra, it is déjà vu all over again. It's that time of the year when the BDA makes the case to governments across the UK that dentists deserve an above-inflation increase in pay to help reverse years of decline.

Pay erosion and worsening conditions are having an impact on dentists in all four UK countries. We have described this in depth to the Review Body on Doctors' and Dentists' Remuneration (DDRB) for the 2016/17 round of pay negotiations. We have given a detailed analysis of the challenges facing dental professionals in general practice, the community/salaried services, and in academia.

For the eighth year running, the BDA reports a continuing fall in dentists' real incomes, and argues strongly that this is unsustainable. We repeat that the priority for dentists is high-quality care, but years of sustained cuts have stretched the goodwill of the profession to near breaking point. Cuts have consequences, and it is patients who inevitably suffer when practitioners cannot invest in new equipment for the surgery, and are subjected to ever-increasing bureaucracy, leading inevitably to poor morale.

However, these are not the only issues frustrating dentists and the BDA. Despite our evidence on the extent to which dentists' pay and conditions has been eroded over the years and how this threatens their ability to provide NHS care, the value of the DDRB process has been undermined by successive governments who choose to ignore inconvenient facts or even bypass the DDRB process altogether. The Scottish Government was unique in implementing the DDRB's recommendation in the 2015/16 pay round for general dental practitioners (GDPs) and using the DDRB's formula for expenses.

FAIRNESS BATTLE: We are fighting for a deal that at least partially reflects members' years of sacrifice

However, the one per cent award on pay, net of expenses and 1.6 per cent uplift in fees, capitation and continuing care payments, still failed miserably to compensate dentists adequately for the high cost of providing quality care for patients.

Using the government's own figures, we pointed out at the time, and have reiterated in our latest DDRB evidence, that, from 2009 to 2013, the pay award in Scotland was in fact a pay cut of more than £16,000. We told the Scottish government that it would take a pay rise of 23.5 per cent just to bring GDP earnings back to 2008/2009 levels.

There was also a sting in the tail in the award made in 2014-15 in that the Scottish Government said that it would not accept the validity of the earnings and expenses information produced by the UK Government's own Health and Social Care Information Centre, but would only accept information taken from the actual accounts of dental practitioners with a minimum 90 per cent NHS commitment in Scotland.

This has proved to be a futile exercise since dentists found that the level of detail requested was excessive and unnecessarily intrusive. It thus resulted in take-up by just one practice out of 200!

We hope to persuade the DDRB that the data provided by both the Health and Social Information Centre and the UK Dental Market Report 2015 is more than adequate, and the issue of securing access to dental practice accounts is a 'red herring'.

If the Scottish Government is in any doubt, a key piece of evidence in our latest submission to the DDRB is that Holyrood would need to uplift GDPs fees by 23.5 per cent to enable dentists to achieve the same level of average taxable income as the income level in 2008-9

Governments across the UK appear to have settled on a formula for demoralising the entire profession. If we continue this way, without realistic pay uplifts, NHS dentistry could face a retention crisis.

It is patients who inevitably suffer when practitioners cannot invest in new equipment for the surgery

We have warned governments, but they seem intent on listening solely to their own voices. Perhaps the next time an NHS patient comes to see you as a matter of urgency, in palpable agony, you should refer them (obviously after treating them) to their MP's surgery. Politicians might not think they will gain votes by increasing dentists pay, but they can certainly lose them by damaging the profession and the NHS provision irrevocably.

ABOUT BDA
The evidence submitted by the BDA to the DDRB is available on the union's website, www.bda.org

In depth

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ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

CHILD'S PLAY

AN INNOVATIVE WAY TO HELP CHILDREN SETTLE INTO TREATMENT

See page 24

THE POSSIBILITIES OF PLAY

A CHILDREN'S CHARITY INTRODUCES A PLAY RESOURCE TO HELP YOUNG PATIENTS WITH ADDITIONAL SUPPORT NEEDS SMILE IN THE DENTAL CHAIR

BRUCE OXLEY MARK K JACKSON

Extensive data is collected every year on the oral health of the nation's children, allowing the Scottish Government and the dental profession to paint a picture of the progress being made year on year.

However, children's rights charity Action for Sick Children Scotland (ASCS), the only charity that campaigns for the rights of all sick children, says it has uncovered a gap in this information.

The charity says that the evidence gathered to date makes it impossible to determine the dental profile of many children with Additional Support Needs (ASNs).

ASCS also believes, but there is no evidence to support this, that more children with ASNs require tooth extractions. Since tooth extractions must be carried out under general anaesthesia (GA), this group of children could be receiving more general anaesthetics in comparison to other children.

With the number of children being admitted to hospital for tooth extractions standing at more than 11,500 in 2013/14, this demographic could account for a large percentage of these cases. However, as the number of children with ASNs being admitted for extractions under GA is not gathered, the proportion is currently unknown.

As well as this, ASCS has highlighted that the National Dental Inspection Programme (NDIP) data doesn't capture specific information on children with ASNs. Equally, there is also no record of the experience of children with ASNs and their families when they visit their general dental practitioner.

Mary-Flora Ferris, dental project officer with ASCS, said that if we don't know the extent of the problem, then it makes it harder to overcome one of the biggest barriers to incorporating ASN children into general practice, namely anxiety and stress – for both the patients and the dental professionals treating them.

She said: "We think we have found a way of reducing anxiety in children with additional support needs and at the same time decreasing stress by keeping families together in their local practice, so that children with ASNs are not referred to be treated somewhere else or sent for hospital treatment if, actually, in the lead-up to that it could have been prevented in the first place. Our ultimate aim, like the profession, would be to support children to attend their family dentist and be able to co-operate during treatment and to improve the experience for all concerned.

"Imagine if preparing a child through play meant that, at the point of treatment, the dentist is pleasantly surprised by the co-operation of the child, therefore providing both opportunity and time for treatment. Would that not be both cost effective and enjoyable for the dentist?

"Preventable treatment would hopefully reduce the number of general anaesthetics. Ultimately, if our play resource can help to improve this situation is it not worth trialling it, in the general dental practice setting?"

PLAY MODE

ASCS has devised a unique resource primarily for children with ASNs, to help them and the dental team reduce the stress and anxiety of dental visits.

For a young child, new experiences with strange sights, sounds and smells can often be quite overwhelming and a reassuring touch or word from mum or dad is required to put them at ease.

LEFT: Clare Craven's children Oliver and Sara have fun with the dental playbox

However, for children with ASNs such as autism or Down's Syndrome, it can be much harder to find the right formula to put them at ease, regardless of where they are and who they are with.

Add in the bright lights, strange sounds and new smells of the dental surgery and it can be problematic to encourage children with ASNs to actually sit in the chair and stay still long enough for a check up or treatment. Not every practice has the experience or skills, let alone time, to help anxious patients of any age relax enough to be seen by the dentist, but a simple and relatively inexpensive resource could provide the answer.

Through their Special Smiles Project, ASCS has put together a series of 'Dental Playboxes' which address three key themes: making healthy choices around low sugar snacks; caring and taking responsibility for teeth; and – the one that is particularly relevant in this instance – preparing children for dental treatment and procedures.

The playbox resources have been used extensively across local authority additional support needs education settings. Evidence to date from teachers, parents and children shows that it is indeed successful in reducing anxiety and preparing children for treatment. The resource offers dental practice teams the concept of play as an early intervention approach to reducing anxiety and stress for children with ASNs and Mary-Flora is keen to get feedback from dental teams. ASCS believes that if children with additional support needs are able to be seen at the same practice as the rest of their family and not referred on, it would be a vital step in ensuring their general wellbeing, as well as reducing the stress for dental teams themselves.

The playbox idea is incredibly simple, the box is packed with books, toys, fancy dress, puppets and props that aim to reduce anxiety and help children relax before treatment. Items such as a dentist outfit, complete with tunic and mask, along with a toy dental mirror, help children tap into what Mary-Flora describes as their "play mode" and understand their role as a patient when they get into the surgery itself.

> "PLAY WORKS SUPERBLY BECAUSE IT TAKES THE FEAR OUT OF EVERYTHING"
>
> MARY-FLORA FERRIS, DENTAL PROJECT OFFICER, ASCS

She said: "We know that it is more difficult to treat children with additional support needs because it does take more time, it does take more patience and it does take more preparation. But, it is not really fair putting the dentist under pressure at the point of treatment when a child comes in and won't sit in the chair.

"So, if we take that back a few stages and think about intervention, then we are going for the full preparation, whether that is two to three visits in the surgery, knowing where they are coming to, trying out the play resources, playing with the resources, pretending they are the dentist and linking that in with preparation at home with the tailor-made play packs for home use. The children become very familiar with all the instruments and tools and the role that they'll play well before entering the surgery. Nothing is unfamiliar to them."

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

And Mary-Flora believes that the dental play resources she has put together can help patients, parents and practices prepare for treatment and avoid aborted appointments due to anxiety and stress. She said: "Play works superbly because it takes the fear out of everything well before it happens. The resources are tailor-made for the dental surgery.

"Children love to play and they are creative when they play. They solve problems through play and work scenarios in their own heads when they play. They will just do that naturally because that is their way of learning when they are young."

OLIVER'S STORY

Glasgow graduate Clare Cravens has worked in general practice at Three Towns Dental Care in Saltcoats and Stevenston for the last 12 years, She has three young children, Sara (4), Oliver (8) and Aidan (10). Oliver has Down's Syndrome and historically has been anxious about receiving dental treatment, despite the fact that it is his mother doing the examination.

Clare said: "He is normally quite anxious about dental treatment. He is quite good if his sister or brother are there, he always wants to copy them. But the minute he gets up on the seat and the minute you move it he is normally straight back off it. He wants to do it but he is normally quite apprehensive and unsure of the seat moving.

"He certainly won't open his mouth to let me look in it. He has been better with some of the dental nurses, sometimes they have looked in and been able to put the varnish on his teeth, but he won't let me.

"Oliver has had a lot of medical investigations over his lifetime, so he is not just like that with me. He has to get to know someone and do the same thing quite repeatedly before he can be happy doing it.

"He has had some investigations that have been quite stressful, like taking blood, and he has been really upset by it. So he is naturally really apprehensive when it comes to anybody doing a medical examination at all, no matter what it is."

With this in mind, Clare agreed to visit Three Towns Dental's sister practice in Kilwinning last month to trial ASCS's playbox resources. Mary-Flora met Clare, Sara and Oliver in the waiting room of the practice and introduced Oliver to the dressing up materials and other props. Despite never having met Mary-Flora before, and with the *Scottish Dental* photographer taking pictures at the same time, Oliver immediately put on the dentists' uniform, gloves and mask and started brushing the teeth of a toy.

Clare was certainly taken aback by how quickly Oliver settled into his play mode. She said: "I was totally amazed. I just couldn't believe it. He obviously tapped into his play mode and he was really comfortable and was reassured. Because of what they were doing, it showed him that nothing was going to hurt him, nothing was going to be sore."

In the playbox is a blow-up dental chair and Mary-Flora explained that this is quite an important item, as it reinforces the element of trust. If the child can be persuaded to play at lying down in the blow-up chair in the waiting area, it plays a large part in encouraging the child to do the same when it comes the real thing.

She said: "Dentists work above the child looking down. Often the child is looking upwards and backwards to see the dentist and lying down on your back looking backwards can sometimes cause uneasiness. So, practising this position several times lets the child familiarise themselves with the sitting on, lying down and looking upwards movements. This builds trust between the child patient and their dentist."

After a few minutes playing with the toy dental mirror, looking in his sister's mouth and letting Mary-Flora mimic the actions of a dentist in the blow-up chair. Oliver was taken through to the dental surgery and he immediately sat up on the dental chair.

Looking on, operations director Sharon Morrow was amazed. She said: "I was really pleased that he interacted so well and that he was so keen to put on the uniform. When I have seen him in the practice before with Clare, he wouldn't go into the surgery, his behaviour was quite different and he was upset.

"I've seen him sit in the chair maybe once, but that was a bit of a struggle with Clare having to coerce him. That can be quite a lengthy and stressful period for Clare because she knows he doesn't like it

and he's unhappy about sitting in it.

"So, to see that today was amazing. For me, I want this play resource in the practice. It has sold it for me and I think for Clare as well.

"Oliver has not been upset by the experience, he has enjoyed it and he is totally relaxed. It has been very positive."

And Clare added: "I think the dressing up and allowing them to touch clinical things like the gloves and the mirror, and giving them the chance to explore it all themselves, makes a big difference. Because of the role play I think it helps them to relax and become curious and then they are quite happy to try out new things. It is natural for them to be curious and to want to know what is going on, but unfortunately if they are anxious, that takes over first and then we don't get anywhere with them.

"With the play equipment it helps to override that initial anxiety straightaway and the children relax. Because of their natural curiosity they want to sit down and they want to get involved."

Clare said that she believed her nephew, who is autistic, could certainly benefit from the play resource as well. She said: "He is not getting seen with his brother, he is having to go somewhere else and I think that is detrimental, he should be seen with the rest of his family.

"It's making him feel different once again and he is seven, so he is at an age where he is beginning to recognise that there is an issue there. I don't think he wants to be reminded of it all the time. It is a real shame that in a dental environment he can't be seen along with his brother, the way he does a lot of family things.

"I think he would definitely benefit from the play resources because he loves things like dressing up as well."

> "WITH THE PLAY EQUIPMENT IT HELPS TO OVERRIDE THAT INITIAL ANXIETY STRAIGHTAWAY AND THE CHILDREN RELAX. THEY WANT TO GET INVOLVED"
>
> CLARE CRAVEN, THREE TOWNS DENTAL CARE

LONG-TERM GAIN

Despite the obvious success of Oliver's experience with the play resources, Clare acknowledges that in order for this to be implemented by more practices, the way dentists are remunerated has to change. She said: "Unfortunately we often don't have the resources in practices and we don't have enough staff either to follow this through before the child comes in to the dental setting. You may need extra staff to do this for you, before they come in to see you and all that costs money. The resources themselves would probably be quite expensive as well.

"So we would need some sort of remuneration to go forward with it.

"I do this a lot, because I feel I really have to do it. I might get children in for three, four, five visits without doing anything and I'm not being paid for that, but I don't want to upset kids and have them fighting it. I want to work with them and work with the families so that they come and they are quite happy.

"It normally works, the desensitisation, but in the long run it might help if we had all the play equipment first – you might not need four visits before you can do something, you might only need that one longer visit."

And Sharon agreed that the play resources have the potential to make a real difference. She said: "I think if you can get the co-operation from the child eventually the child will sit at every visit, the dentist won't be stressed and you won't have this worry every six months when the 'dreaded patient' comes in and won't sit in the chair. They will know that this has been addressed and dealt with.

"Most dentists don't like treating nervous patients because it makes their job a lot more difficult and stressful. In a busy NHS practice, appointments are brief and you don't get a huge amount of time with patients. So, if your nurse has already done that job for you if you like, then it makes life so much easier.

"It is the long-term effect and gain you are going to get and not just for the practice, but for the patient."

MORE INFO

To find out more about the Special Smiles project and the dental playbox resources, visit www.ascscotland.org.uk

HONOURABLE ACHIEVEMENTS

FOLLOWING THE DEATH OF HIS SON TO MOUTH CANCER, MIKE WALTON HAS SPENT 21 YEARS CAMPAIGNING TO RAISE AWARENESS OF THE DISEASE AND HIS EFFORTS THROUGH THE BEN WALTON TRUST MUST BE COMMENDED

STEWART MCROBERT MARK K JACKSON

Ben Walton was an honours psychology student, accomplished pianist and trombone player. He was healthy, fit, did not smoke, drank moderately and had excellent oral hygiene. He'd had a good diet from early childhood.

In summer 1994, he felt run down, had pains in his neck and shoulders and a mouth ulcer on the side of his tongue. Over the next few months things worsened. That December, he saw an oral and maxillofacial surgeon, and a diagnosis of squamous cell carcinoma of the tongue, at a late stage, was given. Almost a year later, despite some temporary periods of remission, Ben died.

"Ben had a remarkable attitude toward the disease," said his father, Mike. "Sitting at his bedside one day, he said 'Something has to be done about this'. After he passed away, we set up The Ben Walton Trust in his honour."

Looking back on the 21 years since then, Mike acknowledges that a lot has been achieved, but he says much still has to be done.

"Back then, 'head and neck' wasn't a discrete subject area and mouth cancer was treated by a variety of specialists. There was poor professional and public information about the disease and little good news to shout about – approximately 50 per cent of sufferers do not survive five years after contraction.

"And it seemed the patient was always to blame. The general feeling was that if you contracted the disease you'd done something wrong – smoked or drank too much – and therefore it was your fault.

"We wanted to create awareness, encourage and support research, support people in palliative care, remove blame and get the message over that almost anyone could contract this disease."

Working with a range of individuals and institutions, he believes progress has been made toward meeting those goals.

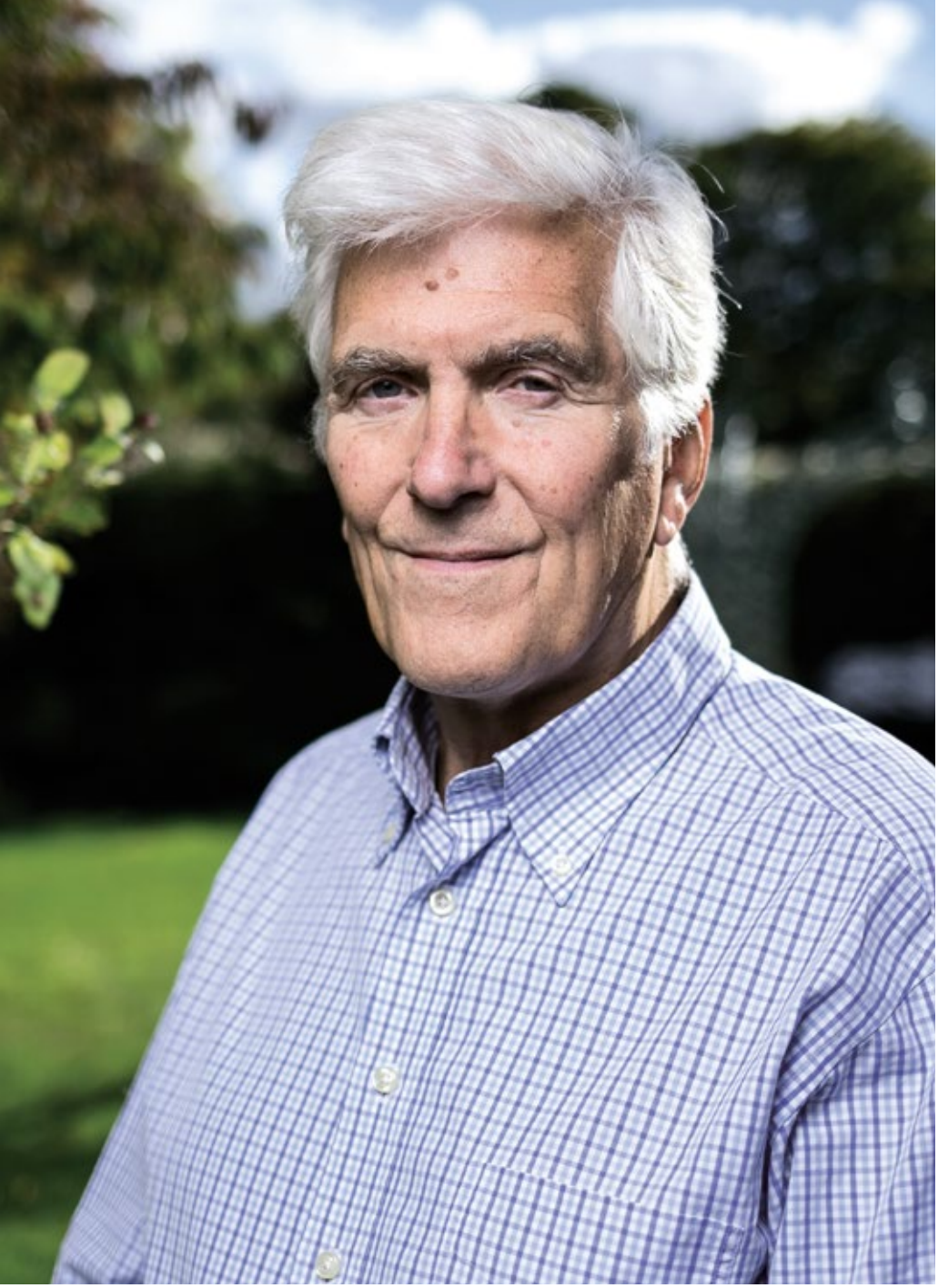
"We are moving towards a situation where dentists are regarded as specialists in the mouth and there is a discipline of 'head and neck' – that has helped a lot. When Ben was ill an 'urgent' referral was 16 weeks, and that time has been drastically reduced.

"Awareness among professionals has improved enormously, and there are efforts, such as Mouth Cancer Action Month, to increase public awareness."

BREAKTHROUGH

One of the Trust's first breakthroughs came when Mike had a meeting with Professor Newell Johnson of King's College, London. It led, in 1997, to the employment of a part time researcher. Notably, she was the first person to get councils in England to compile cancer statistics on a like for like basis – previously they'd kept them in different formats, making comparisons and research difficult. The researcher's work also led to the 'King's study'. This looked at a group of patients aged under 45 who had contracted mouth cancer and found that in 25 per cent of cases alcohol or tobacco were not causal factors. "That was an important development," said Mike, "because it helped change the way patients are regarded. It also highlighted that the disease was no respecter of age or sex, almost anyone could contract the disease."

In 2000, working with PR professional Richard Horner, the Trust established the Scottish Oral Cancer Action Group, which helped bring together leading figures in Scotland. Mike believes the Group helped prompt two major developments. First, Richard set up Mouth Cancer Action Week (it would later become a month-long



MOUTH CANCER FACTS AND FIGURES

Mouth cancers are more common in people over 40, particularly men. However, research has shown that mouth cancer is becoming more common in younger patients and in women. In the last year 6,767 have been diagnosed with mouth cancer in the UK – an increase of more than a third compared to a decade ago.

Sadly, more than 1,800 people in the UK lose their life to mouth cancer every year. Many of these deaths could be prevented if the cancer was caught early enough. As it is, people with mouth cancer are more likely to die than those having cervical cancer or melanoma skin cancer.

Mouth cancer may affect anybody but many cases are linked to lifestyle choices and certain risk factors increase your chances of developing the disease. These risk factors include:

- Smoking: The leading cause of mouth cancer, tobacco transforms saliva into a deadly cocktail that damages cells in the mouth and can turn them cancerous.
- Alcohol: Excessive use is linked to more than a third of mouth cancer cases in men and a fifth in women. Heavy drinkers and smokers are up to 35 times more at risk.
- HPV: A sexually transmitted virus which experts suggest could rival tobacco and alcohol as a leading risk factor within 10 years. Those with multiple sexual partners are more at risk.
- Diet: New research has suggested that there is a noticeable risk reduction for mouth cancer with each additional daily serving of fruit or vegetables. A healthy, balanced diet is vital.
- Smokeless tobacco: Although some people believe this type of tobacco is safer than smoking, the reality is that it is much more dangerous. The types of smokeless tobacco products most used in the UK often contain a mix of ingredients including slaked lime, betel (or areca) nut and spices, flavourings and sweeteners.

event) which helped generate a great deal of publicity. Meanwhile, the Group gave a presentation at the newly formed Scottish Parliament and subsequently held a meeting with the then Health Minister, Malcolm Chisholm. Soon after, free dental checks were re-introduced in Scotland. Dentists began, as standard practice, to carry out routine full oral mucosa checks.

"Although the Scottish Oral Cancer Action Group did not continue, it proved to be a good and vital thing," Mike said.

Other positive developments he cited include the establishment of managed 'head and neck' clinical networks such as SCAN in Scotland, and the creation of a SIGN (Scottish Intercollegiate Guidelines Network) guideline covering the topic, on which Mike served as a patients' representative.

"A surprising success," he added, "has been the online module we created with BMJ Learning. Academics sympathetic to our cause, such as Professors Graham Ogden at Dundee, Kasturi Warnakulasuriya at King's College, London and Paul Speight at the University of Sheffield developed the content. The international success of the module has exceeded our wildest dreams."

Mike lauded the backing the Trust has received from dentists and dental students. "We have been supported by FGDP (Faculty of General Dental Practitioners (Scotland)) and the British Society of Dental Hygienists and Therapists, and many practices have raised significant sums for us during Mouth Cancer Action Month.

"Our work with dental students started with Professor Graham Ogden, who has always been passionate about trying to improve services for mouth cancer. His students picked up on his enthusiasm and have supported us for many years, raising substantial sums of money along the way."

That willingness to help has spread and numerous dental schools, such as Glasgow, Manchester, Leeds, Sheffield, and UCLAN (University of Central Lancashire) take part in Mouth Cancer Action Month.

MORE TO DO

Although there have been significant achievements by the Trust and others, Mike is clear that there remains a lot to do.

"The level of treatment patients can expect still depends to some extent on their location, the knowledge base of the professionals involved and how rapidly they get referred. And we still don't fully understand the disease and its causes."

While praising both the medical services in Scotland and the Scottish Parliament, he is wary that gains made could be lost. "One of the best things to have happened in recent times has been the introduction of target waiting times. I was horrified to hear the other morning on

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LEFT: Mike has spent years campaigning in the memory of his son, Ben, who suffered from mouth cancer

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the news that GPs are going to be offered more cash not to refer people to specialists. That's going backwards."

Though his experience of the Scottish Parliament has been positive, he realises that when it comes to influencing political priorities it is often that those who have the means to shout loudest get the most attention.

"My biggest fear is that achievements we have made will erode through lack of resources."

He explained that there was never an aim to be a wealthy charity; influencing people and increasing awareness have always been the priorities.

"Of course you need cash to support projects. Fortunately, we've always managed to find money one way or another. We know that donations we do receive must be carefully shepherded. We have always been frugal and tried to be sensible. We've been very lucky – people have given us their time and expertise without expecting payment in return."

He thinks it's been useful not being a medic or scientist. It has allowed him to come at things from a different viewpoint, and not be bound by convention. You can achieve a lot with a small group of people who are motivated and dedicated.

Looking forward, on the immediate horizon is the global oral cancer forum, which will take place in New York in March 2016. Mike will be a panel member on this long awaited event which will bring together many of the international specialists in mouth cancer looking at how to progress early diagnosis and prevention.

In the longer term, Mike's aim is for the Trust to be self sustaining. "I have looked at the prospect of who carries on the work when I'm not here and it's very difficult to find somebody with the time to do it." He believes there will be enough synergy from what has been done so far for activity to keep going. And he is hoping there will be continuing pressure on governments and their agencies. In particular, he pointed to a well informed and passionate debate about mouth cancer that took place in Westminster around four years ago. "Since then not a lot has happened, and we need further action."

When asked what his much loved and much missed son would say about his efforts, Mike answered: "Ben would probably say something simple like 'Well done; I'm pleased with what you've achieved.'

"But it's all been about honouring him and his terrific courage. We were normal middle class people who hadn't thought much about the issue and hadn't seen other people's realities. When your eyes are opened you realise just what some people have to go through, and you witness their bravery and strength.

"I hope people feel that the topic of mouth cancer is slightly less neglected than it was. It's still in the shadows, but slowly coming out, thanks, in large part, to the dental profession."

USEFUL SITES:

www.benwaltontrust.org

www.orlcancerldv.org/en

To find the BMJ module search for 'Mouth cancer: recognising it and referring early'

MONTH OF ACTION

Every November, the British Dental Health Foundation (BDHF) organises and runs Mouth Cancer Action Month, under the message 'if in doubt, get checked out.' The campaign has become an influential springboard in educating the public about mouth cancer, highlighting the risks, symptoms and causes of the disease.

The campaign is about taking action and raising awareness, particularly among those groups who are most at risk. The charity want people to look out for ulcers that do not heal within three weeks, red and white patches in the mouth, and unusual lumps or swellings while encouraging them to regularly visit a dentist to ensure they're checked for signs of mouth cancer.

By working closely with the dental and health profession and supporting them in their activities to patients and local communities, the BDHF continues to increase mouth cancer awareness and save lives through early detection.

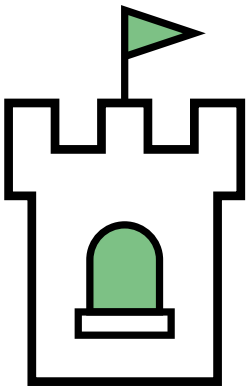
Mouth Cancer Action Month is sponsored by Denplan and also supported by Dentists' Provident, plus a number of other professional and commercial partners including Dental Update.

MORE INFO

For further information please register your details at www.mouthcancer.org and www.mouthcancerfoundation.org

ROYAL RECOGNITION

Before devoting himself to the Trust, Mike Walton was a director of first year studies at Edinburgh College of Art. Thanks to the work he has carried out, in December he will be presented with an MBE at Buckingham Palace. "It is recognition for all the people who have done quizzes, held coffee mornings, run marathons, opened their gardens and so on to raise money and support our work. I'll be proud to accept it on their behalf, and on behalf of all the patients who have suffered from this cruel disease."



HISTORY BITES

WOULD YOU FANCY A BLACKSMITH PULLING OUT YOUR ROTTEN TOOTH (WHILE YOU PRAY THEY TOOK THE RIGHT ONE), OR HAVING DENTURES MADE FROM THE TEETH OF FALLEN SOLDIERS? TAKE A TRIP TO THE OLDEN DAYS TO DISCOVER WHY IT'S GOOD TO LIVE IN THE 21ST CENTURY...

TIM POWER

Before the introduction of the profession as we know it today, dental patients went through some dark times – suffering everything from dodgy practitioners to torturous treatments. Delve in to the distant, and not-too-distant past, for an insight into just how far we have come...

THE BAD OLD DAYS

Suffering from toothache in the distant past was a grim affair. If you were wealthy, then you could employ the services of a skilled goldsmith to pull teeth or create false ones... but the not so wealthy had to make do with the local healer or blacksmith, hoping they pulled out the right tooth.

In medieval days, it was believed that tooth decay was caused by worms in the teeth, as this 16th-century cure for toothache describes: "For ye toothache or wormes in ye teith. Take peper and stampe it and temper it w'gude wyne and supe th'of warme and hauld it in thy mowth till it be cauld and then spit it out, and do this oft and thow salbe delyverit of angwysh and greif."

The original 'dentists' developed from the formation of a new profession: the Barber Surgeon. This resulted from a papal decree by Pope Honorarius III (1150-1227) that prohibited all persons in holy orders from practising medicine. That meant the monasteries, which had often provided hospital services to their local communities, had to employ the skills of barbers. Already used to working with sharp blades, they were trained to undertake minor surgical procedures.

From then on, 'barbers' would be called upon to do anything from cutting hair to amputating limbs, and over time created their own guild of Barber Surgeons. However, other trades, such as blacksmiths, farriers and shoe makers, offered to pull teeth for a fee as they had the tools and the brute strength to provide such a service.

> "EVEN UP TO 1800, THE BARBER STILL INVARIABLY COMBINED TOOTH EXTRACTION WITH BLOOD LETTING, HAIRCUTTING AND SHAVING"

Unfortunately, their ignorance of teeth often led them to damaging other teeth and even jawbones, causing even more pain.

While medieval cures for toothache might sound ridiculous, a dental book published in 1829 shows that the profession had not progressed much further in its treatment of tooth decay.

It suggested the use of leeches to reduce the inflammation of the gums caused by caries – termed 'gangrene of the teeth' – and after excavating the 'gangrene', filling the cavity with gold, tin or lead. The book also mentions using sulphuric acid and 'corrosive caustics' to treat carious cavities.

While surgeons made great strides in pushing the boundaries of medical practice, and thus lifting the esteem of their profession, dentists did not enjoy such admiration. Even up to 1800, dentistry was held in very low status, as the barber still invariably combined tooth extraction with blood letting, haircutting and shaving.

While the 'gentlemen' practitioners of dentistry were trying to promote the professionalism of the sector, their efforts were seriously undermined by the profusion of 'quacks' – opportunistic

practitioners with little or no training – who also blatantly advertised their services (positively frowned upon by the gentlemen dentists at the time) and eroded the reputation of dentists by their poor practice, over-charging and carrying out unnecessary work.

Dentists did not actually exist as a profession until the Dentists Act of 1878, which meant that only those who had undergone recognised training could call themselves a 'dentist' or 'dental surgeon' and be admitted to the official Dental Register. Unfortunately, there was a loophole in the law, as there was no requirement to register. People could practice dentistry as long as they did not call themselves a dentist – they used signs like 'Dental Rooms' or Dental treatment here' to publicise their services.

It was not until 1921 that another Dentists Act was created to raise standards and ensure that only those trained at a dental school could be admitted to the Dental Register and be allowed to practice dentistry.

KING JAMES IV – ROYAL DENTIST

Hunting, falconry and jousting are the typical sports of kings in the long-distant past, but James IV of Scotland (1473-1513) had another hobby: dentistry.

It all started in 1503 when the king summoned a 'barbour'[1] to extract one of his teeth for the sum of 14 shillings (around £450[2] in today's money).

King James IV obviously had an interest in all things medical, as it is recorded that he tried bloodletting on patients and even treating and dressing ulcer wounds. He was also keen on dental hygiene, as it is recorded he bought two gold toothpicks suspended from a chain.

In 1511, he decided to get a more practical experience of dentistry and purchased "ane turcase [pincer] to tak out teith" and extracted a tooth of 'one of his subjects', for which the King paid him 14 shillings. Bizarrely, it is also recorded that the king pulled two teeth from one of his own barber-surgeons:[3] "To Kynnard the barbour for twa teith drawn furth of his hed by the king, 14s".

Scottish historian Lindesay of Pitscoe (1530-90) described the king's medical knowledge in rather florid terms: "This noble king, James IV, was well learned in the art of medicine, and also a cunning chirurgenor[4], that none in his realm, that used that craft but would take his counsel in all their proceedings."

However, his interest in dentistry was far from just a royal whimsy, as he was responsible for granting a Charter of Privileges in 1505 to the barbers and surgeons of Edinburgh. A year later, this was ratified as a Royal Charter for the establishment the Royal College of Surgeons of Edinburgh on 13 October 1506.

Although James IV met his death on Flodden Field in 1513, his interest in bloodletting and pulling teeth helped to start a new age of enlightenment in Scotland in medicine and science.

IN MOST CASES, THE BODY REJECTED THE IMPLANTS, AND THE CLIENTS RAN THE RISK OF INADVERTENTLY CONTRACTING SYPHILIS

LEFT: An engraving showing a dental surgery of the time with the dentist engaged in a struggle to remove a lady's tooth with some forceps, (the reflection of which can be seen in the mirror) while standing on a purpose-made stool and with an arm-lock round the patient's neck. Artist: George Cruikshank (1792-1878)

Image courtesy of the British Dental Association Museum

LEFT: Pelicans were first mentioned in 1363, and by the 16th century they were the main extraction tool favoured by itinerant tooth-drawers. Their name derives from the resemblance of the claw to the beak of a pelican. The pelican worked by placing the claw over the crown of the tooth to be extracted and the bolster against the outside gum. Pressing down on the handle levered the tooth out.

Image courtesy of the British Dental Association Museum

THE FIRST IMPLANTS

In the 18th century, surgeons started experimenting with implants for wealthy clients by extracting a suitable 'live' tooth from a donor – usually a poor wretch who was willing to trade teeth for payment – and insert the new tooth into the empty socket of their client. This would be fixed in place by a silver wire or silk ligature.

British surgeon John Hunter (1728-1793) pioneered this approach and it is recorded that one of his patients stated that he had three implanted teeth which lasted for six years, although the donated teeth never properly bonded with the patient's gums.

In most cases, the body rejected the implants, and the clients also ran the risk of inadvertently contracting syphilis or tuberculosis from the recipient's tooth and blood during the operation.

WATERLOO TEETH

As the sun rose on the morning of 19 June 1815 in northern Belgium, the carnage of one of the greatest European land battles could be witnessed: 50,000 soldiers lay dead or wounded. While it meant celebrations in Britain, as Napoleon was finally defeated

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*Source: Online Denplan / YouGov survey September 2015. All respondents (figures have been weighted and are representative of all UK adults aged 18+): 2077

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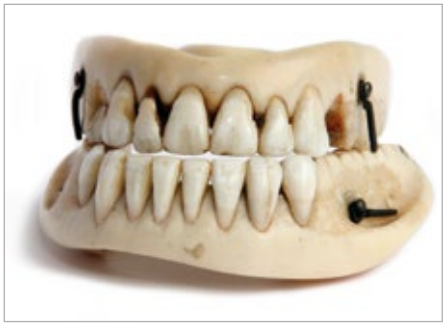
CAM1596 09-15

LEFT: The transplanting of teeth was popular at the end of the 18th century. Poor people were paid to have their healthy teeth removed for immediate placement into the waiting mouths of wealthy, older patients. Artist: Thomas Rowlandson (1756-1827)

BOTTOM LEFT: Ivory was difficult to carve to fit well over the whole palate so upper sets were normally horseshoe shaped. Full lower sets were weighted. To help upper sets stay in place, springs were attached to the bottom set and the spring pushed the upper set upwards. Partial dentures were tied on to surrounding teeth with a thread of metal or silk, or carved with holes to slot around remaining teeth.

BOTTOM RIGHT: If you wanted a nice set of dentures, you needed real human teeth cemented into an ivory base

Images courtesy of the British Dental Association Museum



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Dentistry – then and now, J. Menzies Campbell, 1981

NOTES

1. During the Middle Ages, 'barbers' would be called upon to do anything from cutting hair to amputating limbs, and over time created their own guild of Barber Surgeons.

2. Calculated using www.measuringworth.com

3. www.ncbi.nlm.nih.gov

4. Surgeon

FROM PREVIOUS PAGE>

at Waterloo, it also brought a cheer to dentists as the grisly harvest from the dead flooded the market with cheap, human teeth for dentures.

In the past, dentures had always been the preserve of the wealthy. They were usually made from elephant, hippopotamus or walrus ivory or animal bone, which were carved into dentures to replace full sets of teeth – a skill provided by goldsmiths or clock makers rather than medical specialists.

However, ivory and bone had two disadvantages: the teeth did not always look natural and they also deteriorated relatively quickly, rotting in the mouth and causing the most evil-smelling breath – a reason why many genteel ladies of the upper class carried fans to waft away the stink.

Of course, the best dentures were made out of human teeth, but they often came from dubious sources, providing lucrative work for 'resurrectionists' – body snatchers – who dug up corpses.

As the battle of Waterloo was over as night fell on 18 June, it allowed plenty of time for the battlefield scavengers to plunder the fallen undisturbed, taking valuables and also deftly pulling teeth that they know would bring them riches.

"THE BEST DENTURES WERE MADE OUT OF HUMAN TEETH, BUT THEY OFTEN CAME FROM DUBIOUS SOURCES, PROVIDING LUCRATIVE WORK FOR 'RESURRECTIONISTS' – BODY SNATCHERS – WHO DUG UP CORPSES"

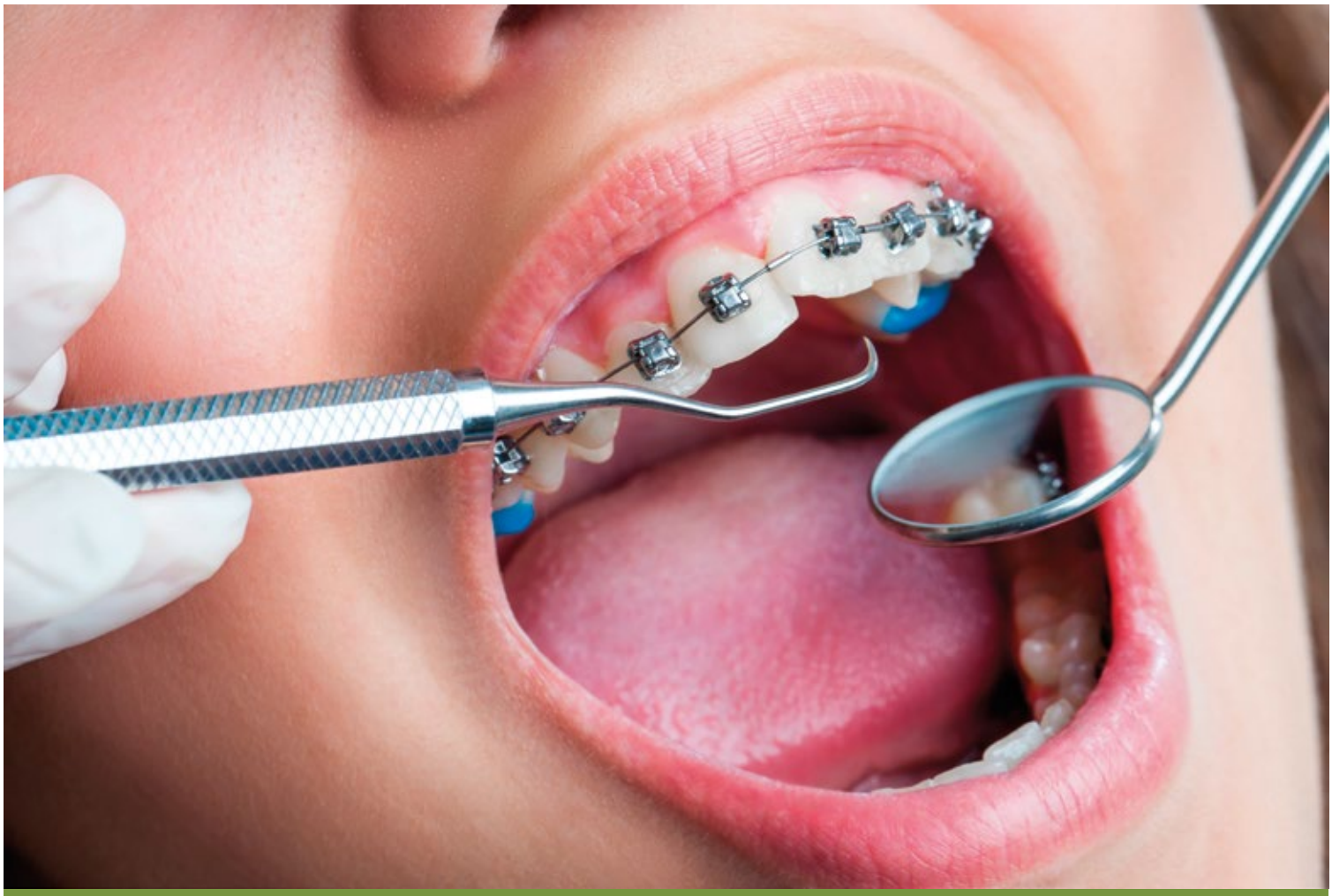
But the volume of teeth that made it onto the market caused the price to drop and helped to make good quality dentures more affordable for the middle classes of England.

In fact, the dentures, with teeth inserted into a gold or bone base, soon became known as 'Waterloo teeth' for years afterwards.

There were so many spare teeth it is reported that supplies were shipped to the USA by the barrel.

However, the use of human teeth started to decline in the mid 1900s with the development of porcelain teeth by London goldsmith and denture maker Claudius Ash, who had perfected the manufacturing process and started to produce them commercially in 1837.

The invention of vulcanite in 1840s also helped to revolutionise the denture market by providing an ideal mouldable, hardened and durable rubber base to hold the teeth, making them even more affordable.



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SAFEGUARDING VULNERABLE CHILDREN

VULNERABLE CHILDREN

While not expected to make the decision to remove a child from an abusive carer, dental teams still have a crucial role in identifying and reporting potential incidences of abuse

CATHERINE MCCANN, MYLES GILLESPIE, GILLIAN GLENROY

The members of the dental team hold a unique position in the safeguarding of children. This article seeks to highlight the important role of each member of the dental team in the safeguarding of children and aims to ensure that passivity related to this issue will become a thing of the past.

Dentists and dental care professionals (DCPs) are not expected to make the often difficult decision to remove children from abusive carers, but should be confident in their professional responsibility to highlight and escalate concerns in an appropriate and timely manner. The importance placed on this professional duty is supported by the recent changes to recommended Continuing Professional Development (CPD) topics by the General Dental Council (GDC), with the addition of safeguarding children and young people added in April 2015.

The professional standards expected of every member of the dental team regarding safeguarding are clearly stated in the Standards for the Dental Team GDC guidance [1] and highlighted below:

Standard 1.9

You must find out about laws and regulations that affect your work and follow them.

1.9.1 – You must find out about, and follow, laws and regulations affecting your work. This includes, but is not limited to, those relating to:

- data protection
- employment
- human rights and equality
- registration with other regulatory bodies.

Standard 8.5

You must take appropriate action if you have concerns about the possible abuse of children or vulnerable adults.

8.5.1 – You must raise any concerns you may have about the possible abuse or neglect of children or vulnerable adults.

You must know who to contact for further advice and how to refer concerns to an appropriate authority such as your local social services department.

8.5.2 – You must find out about local procedures for the protection of children and vulnerable adults. You must follow these procedures if you suspect that a child or vulnerable adult might be at risk because of abuse or neglect.

What is child abuse?

The national guidance for child protection in Scotland 2010 describes abuse as "forms of maltreatment of a child". [2] This can be caused by significant harm directly to the child or failing to act to prevent this harm occurring. In this guidance there are four recognised types of abuse:

- Physical abuse: causing of significant physical harm to the child: examples are shaking, hitting, burning and choking.
- Emotional abuse: continued emotional neglect or ill treatment that has a detrimental and long-term adverse effect on a child's emotional development. This can be caused by the child being made to fear their guardian, or feel worthless. In all types of child abuse, there will be an emotional factor attached.
- Sexual abuse: any child involved in any activity for the sexual gratification of another person. This is irrespective of whether it is claimed that the child has consented to the act. These activities can be physical or non physical, which includes using sexual language towards a child.
- Neglect: "persistent failure to meet a child's basic physical and/or psychological needs, likely to result in the serious

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Dentists may be the only healthcare professionals that "at risk" children visit, so it is important that a thorough examination is carried out

impairment of the child's health or development". This general neglect may result in the child being diagnosed with "non-organic failure to thrive", meaning that the child has significantly failed to reach the normal weight, growth and development levels of those of similar age.

Child abuse is rarely inflicted on a child by a stranger, it is much more likely to occur by someone who is known to the child whether that is a direct relation or not. Radford, L et al (2011) [3] states that over 90 per cent of sexually abused children were abused by someone they knew, and that one in 20 children have suffered from some kind of sexual abuse.

Dentists may be the only healthcare professionals that "at risk" children visit, so it is important that a thorough examination is carried out. Children are likely to have bumps and bruises, however the location of these injuries may make you suspect that there is a non-accidental cause. Dental trauma can also be a presentation of child abuse, so it is important to obtain a clear history of the incident from both the child and the parent.

Aspects to consider when carrying out this examination are:

- Do the child's and parent's stories match?
- Does the story change when being retold?
- Do the parent and child have a normal relationship?
- How is the child's demeanour in the surgery?
- Do the injuries match the description of the incident?
- Is there a history of trauma?

As dental professionals, we are not expected to diagnose these types of abuse, nor are we qualified to tackle such sensitive issues alone. This being said, we must be able to recognise patients who are at risk, look out for the signs of abuse and know when and with whom we should share our concerns. (Figs 1 and 2)

What is dental neglect?

The British Society of Paediatric Dentistry defines dental neglect as "the persistent failure to meet a child's basic oral health needs, likely to result in serious impairment of a child's oral or general health or development".

Dental decay is a disease that is almost completely preventable yet, the most common cause for a child to be admitted to hospital is for tooth extraction under general anaesthetic (GA). [4] There are numerous factors contributing to this issue and in isolation they should rarely raise suspicion about the care the child is under. The child's general health, social-economic status and previous dental experience should all be considered when deciding if you have concerns for a child's welfare.

Some features, which cause particular concern, are:

- Severe untreated dental disease, especially if it can be noticed by a non-dental health professional
- Disease that is significantly impacting upon the child
- Parents/carers that have access to treatment and dental care but persistently fail to obtain treatment for the child
- Repeated failed appointments
- Failing to complete treatment plans
- Only returning for emergency appointments
- Repeat GAs for dental extractions.

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FIGURE 1
Typical features of accidental injuries

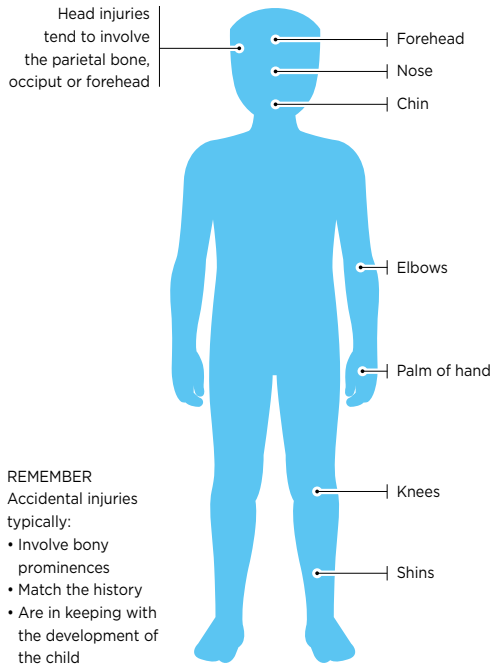
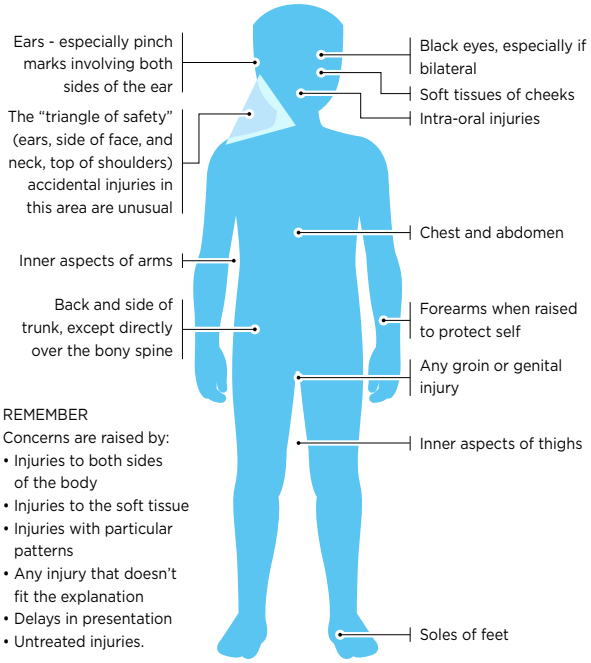


FIGURE 2
Typical features of non accidental injury

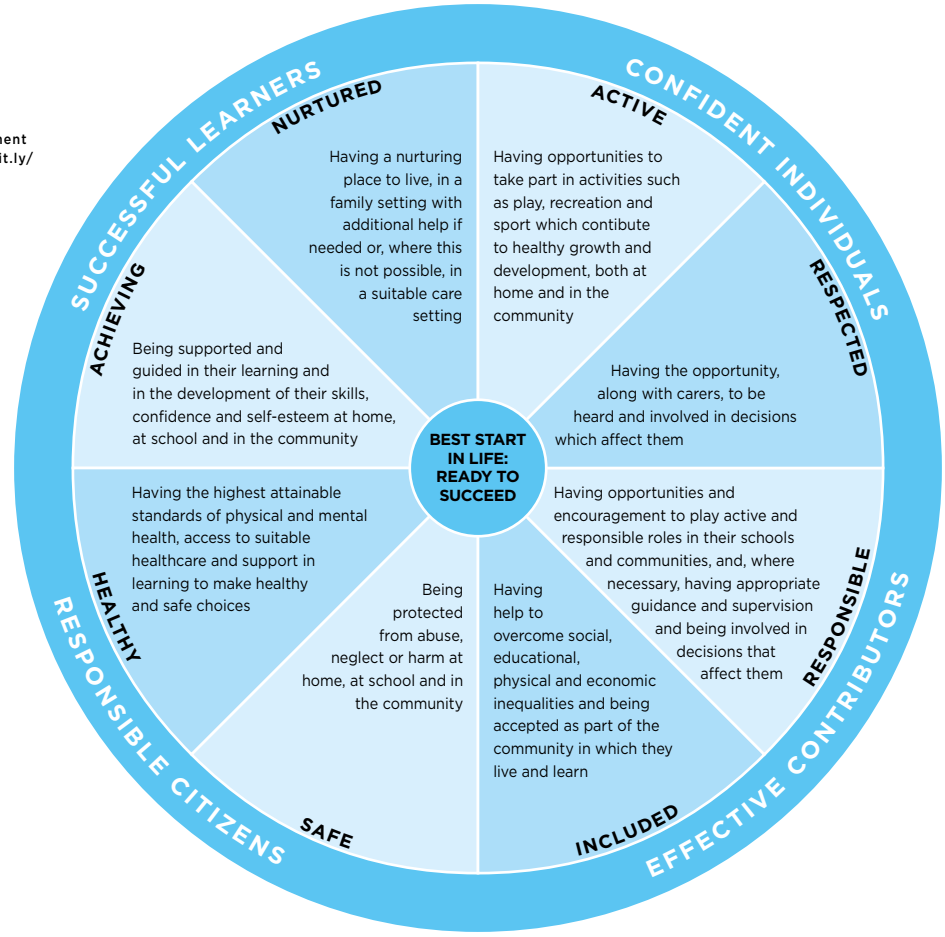


SOURCE

The Child Protection and the Dental Team website: http://bit.ly/recognisingabuse

FIGURE 3
The GIRFEC Wellbeing Wheel

SOURCE
Scottish Government website: http://bit.ly/GIRFECwheel



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If a child's dentition is neglected they may experience toothache, loss of sleep and have difficulty eating. They commonly have repeated courses of antibiotics, have only attended the dentist for emergency appointments and have had repeated GAs. All these factors increase the likelihood of the child to grow up having an overall negative perception of the dentist. These children are therefore more likely to be dentally anxious adults and continue the pattern of attending only for emergency care, which creates a vicious cycle for generations to come.

Dental neglect can be part of a wider problem in the child's life and it is important to decide whether you need to raise your concerns. If, after repeated failed appointments to complete treatment and a discussion with the parents regarding your concerns you are still not satisfied, then you must share your concerns.

What is the relevant legislation and how is this applied to dentistry?

UN Convention on the Rights of the Child 1989 [5]

This international treaty states that the best interests of the child should be a primary consideration and children should be protected from all forms of physical or mental violence, injury, abuse or neglect. The core values from the Convention underpin the ethos of all subsequent legislation regarding child protection.

Scottish Legislation

Legislation passed within Scotland is of most relevance to dental teams working in Scotland and are detailed here:

Children's Act Scotland 1995 [6]

This act has incorporated key defining principles of the UN Convention on the Rights of the Child into Scottish law. This act works to promote child welfare, preventing discrimination and ensuring 'the voice of the child' is heard.

Children and Young People Scotland Act 2014 [7]

This act is the legislative embodiment of the Scottish Government's ambition for "Scotland to be the best place to grow up in by putting children and young people at the heart of planning and services". The legislation from this act is currently in the process of being implemented through "Getting it Right for Every Child" (GIRFEC). [8]

The GIRFEC Wellbeing Wheel (Fig 3) shows eight areas of wellbeing, which if all are attained, should enable the child to grow and develop into a healthy and well rounded individual. It has also highlighted the need for an improvement in "joined up working" between agencies, education and healthcare. To facilitate this co-operation, two key roles have been identified, which are discussed below to help members of the dental team understand their roles and how to communicate effectively with these role-holders.

Who is the Named Person?

A Named Person should be appointed for every child in Scotland from birth until their 18th birthday or until they leave secondary education. The role will usually be given to someone already known to the family, for example the health visitor or a senior teacher. The Named Person should be used as a starting point for specific concerns. It could be useful for a general dental practitioner to make a record of a child's

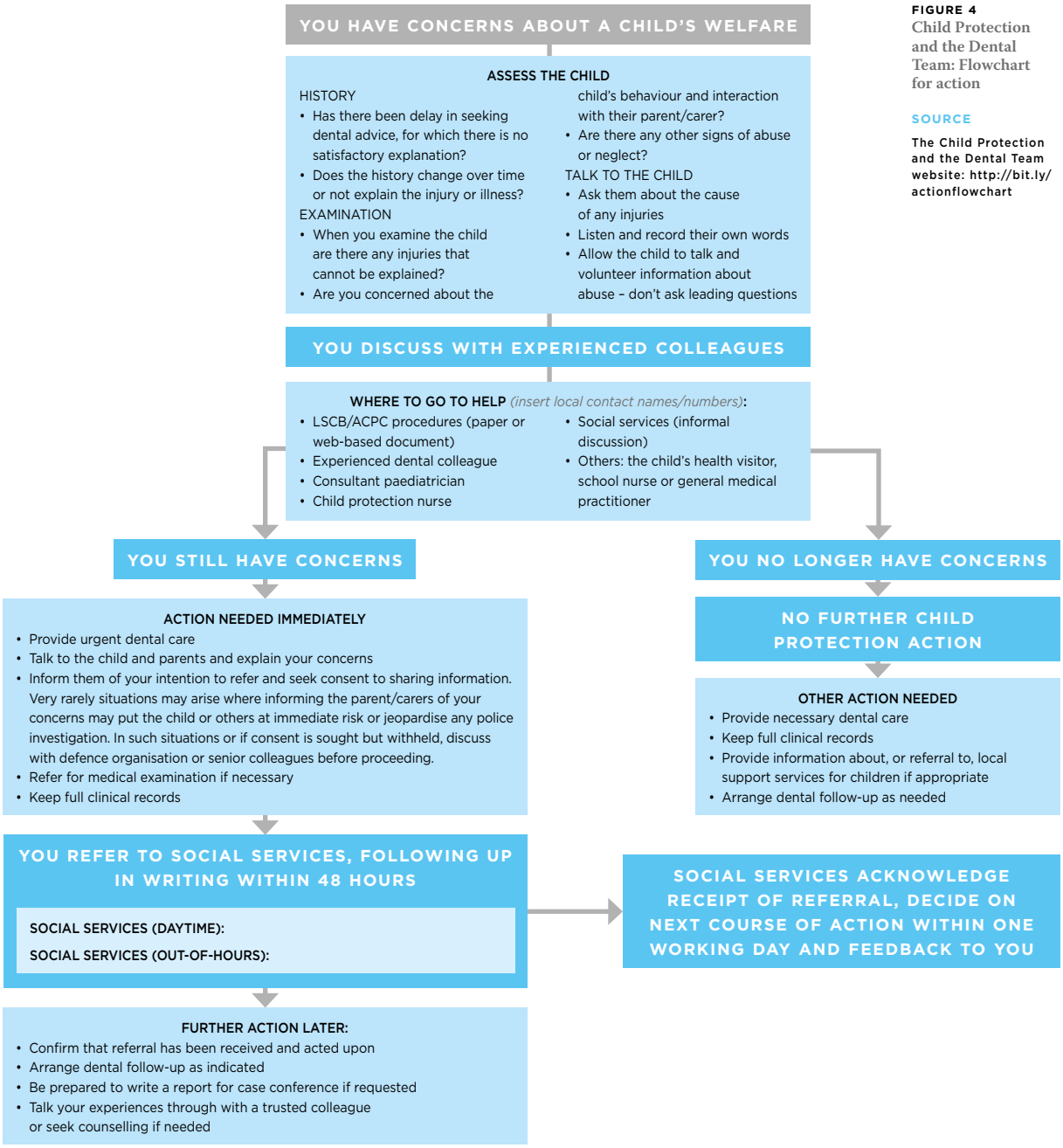

FIGURE 4
Child Protection and the Dental Team: Flowchart for action

SOURCE

The Child Protection and the Dental Team website: http://bit.ly/actionflowchart

Named Person, for example at their first appointment, in case contact regarding a concern is ever required.

The Named Person's role is to act as a single point of contact, and to instigate further help, advice and support. They can support the family's confidence to raise their personal concerns and to ensure the young person's views are heard.

The infrastructure supporting the provision of Named Persons is currently being rolled out nationwide and may not yet be in place everywhere. We advise that you check locally regarding the stage of implementation that has been reached so far in your area.

Who is the Lead Professional?

When two or more agencies are involved in helping a child or young person, a Lead Professional will be appointed. The Lead Professional holds a number of responsibilities, from acting as the main point of contact, to promoting interagency working to supporting the child through crucial transitional stages.

This role is usually undertaken by a social worker. A dentist would not be expected to undertake the role of either a Named Person or a Lead Professional, but to simply consider contacting these individuals with concerns.

What is expected of me and what do I do if I have a concern?

The protocols for this scenario are clearly outlined in the flowchart in Figure 4, which has been taken from 'Safeguarding Children and Young People: A Guide for the Dental Team.' [9]

The first concern should be to obtain as detailed a history and examination as possible, as these records may be relied on later as evidence. Negative findings as well as positive are important to record. Important questions to consider have been discussed earlier in this article. Regarding examination, it is important to examine the child thoroughly, noting any facial, oral or dental injuries. You should also appraise the

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overall appearance of the child: do they appear well cared for or are they "failing to thrive?" The child's interaction with their carers can give insight into the presence or absence of abuse within the relationship.

You should always make it a priority to discuss any injuries with the child and allow them the opportunity to tell their story if they volunteer it. Do not ask leading questions and always take disclosures seriously. You should listen to the child in a non judgemental way and remain calm.

It is extremely important that you treat any injuries or symptoms appropriately, and the child should not be left in pain.

Your next consideration should be to discuss your findings with an experienced colleague to gain their insight into the situation.

If your concerns remain following this discussion, you should follow your local protocol by referring to your local social services department, the police, Area Child Protection Committee or equivalent. Referrals should be made by telephone, and should be followed up in writing within 48 hours. Ensure that the telephone conversation is documented in your clinical record, along with a clear action plan.

Best practice would indicate you should discuss your concerns with the parents and child, and inform them of your intention to escalate your concerns. Each case should be assessed individually, and it is reasonable to not disclose to the parents if you feel by doing so the child would be placed at greater risk or the referral would be unnecessarily delayed.

Comprehensive medical assessments (CMAs) are a common tool employed to compile evidence in suspected cases of child abuse/neglect. A paper published recently in the British Dental Journal [10] explored the impact of dental input into CMAs conducted in Glasgow in recent years and clearly illustrates the importance of co-operation between different healthcare specialties. The two case studies described in this article are extremely useful learning tools. Common themes are revealed with regard to "at risk" children including multiple failed healthcare appointments, signs of dental neglect and the general appearance of the child. The case studies are an important opportunity to reflect upon your own clinical learning, including:

- Have I seen a patient with a similar presentation?
- Did I feel something was not quite right?
- Did I ask the right questions?
- Would I do anything differently the next time?

The dental practice as a whole can also reassess their practice policies with regard to safeguarding, and ask the question: "What measures have we put in place to ensure our paediatric patients are safe and healthy?" For example, policies regarding missed appointments should not punish or exclude the child patient, and patterns can become obvious more quickly if all the siblings of the same family are linked and their attendance patterns monitored as a unit.

Empowering the dentist and other DCPs to have the confidence to realise and utilise their role in safeguarding is paramount. General dental practitioners should be encouraged to discuss their concerns with colleagues within the practice and liaise with other healthcare professionals. For example, a telephone call to the patient's general medical practitioner to ask their opinion on a patient's unkempt appearance or uneasy interaction with their carer. Verbalising a concern does not automatically lead to social work involvement or a court case, but it is always better to be safe than sorry.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To gain an understanding of and be able to implement appropriate safeguarding practice for children and young people
- To review the legislation and requirements related to the safeguarding of children and young people in Scotland
- To further develop the dental team's understanding of the principles of 'getting it right for every child' (GIRFEC) policy in Scotland
- To improve the dental team's understanding of and ability to recognise child abuse and neglect
- To augment the dental team's understanding of, and ability to recognise, dental neglect
- To further develop the dental team's understanding of, and ability to respond to, a concern about child abuse and neglect.

LEARNING OUTCOMES

- The dental team should be aware of the latest legislation related to safeguarding of children in Scotland
- The dental team should be able to describe the principles of GIRFEC in relation to safe guarding children
- The dental team should be able to identify a child at risk of/or experiencing neglect or abuse and take appropriate actions.

HOW TO VERIFY YOUR CPD

Go online to www.sdmag.co.uk and click on the CPD tab to access all our CPD Q&As and certificates

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Conclusion

Recognising child abuse, in particular dental neglect, is an important part of dentistry and must be followed up in an appropriate manner to make sure that children do not slip through the care net. With new legislation coming into place in Scotland and the GDC recommending safeguarding of vulnerable children and young people as a CPD topic, dentists should understand their role in child protection.

As previously mentioned, dentists are not expected to make the diagnosis of child abuse, however they may be the only health professional a child is coming into contact with, so any relevant findings should be raised appropriately. Healthcare professionals should be moving away from assuming that someone else will voice concerns about a child, as this can allow a cycle of neglect or abuse to continue. The only way this can be achieved is by knowing when it is appropriate to seek help and by focusing on multidisciplinary communication and care for each vulnerable young person.

COMPREHENSIVE CASE MANAGEMENT

TREATMENT OPTIONS

Not all cases are as straightforward as they may seem. The heavily restored dentition requires a careful, comprehensive assessment if the best treatment plan is to be arrived at

The following case reports on a patient initially referred for dental implant rehabilitation of posterior segments who, following comprehensive planning, elected for an entirely different treatment option.

The case

The patient was a 60-year-old female with a heavily restored upper and lower dentition. She was referred for possible implant replacement of upper and lower posterior dentition.

Previous dental history

She was a regular attender with significant restorative care over her lifetime, most recently restorations and tooth loss required as teeth have failed due to loss of tooth structure.

Last treatment was fabrication of a new upper p/- chrome and RCT of lower 6s following crown loss.

Medical history

Slightly elevated blood pressure, controlled, otherwise clear.

Patient requirements/goals

1. Aesthetics was the highest priority. She disliked the spaces in the upper and lower posterior segments as well as visible clasps of upper chrome (Fig 1).
2. Longevity and planning for future problems was important.
3. She would also like to improve function.

Patient assessment

Extra-oral

Soft tissue assessment – no abnormalities detected.
Smile line – medium/high, showing gingival margins during a wide smile.

Intra-oral

Soft tissue assessment – no abnormalities detected.
Teeth present:
7__4321 – 12345_7
76__321 – 123__67
(Figs 2-4)

Restorative status and prognosis of remaining teeth:

Maxillae

Eleven teeth remain, having had premolars on either side previously removed. Of the 11 remaining teeth, all of them are restored, with the eight upper front teeth having full coverage crowns (which have apparently been present for about 20 years). Three of these have root canal treatment and posts. The root fillings are all inadequate, with short posts.

No significant periapical pathology. A number of the crowns do not fit the underlying teeth, with the possibility that secondary dental decay is ingressing. The three root-filled teeth are sufficiently heavily restored that further treatment is unlikely and they are likely to be lost in the future.

The remaining back teeth on both sides, while again heavily restored, do appear sound at this time. There are no immediate dental restorative needs in the upper arch, just the concern that, as and when problems occur with the crowns in the upper front teeth, these teeth will be lost (Fig 5).

Mandible

Ten teeth remain, again having lost premolars on either side. The lower six remaining front teeth, other than being slightly discoloured, are intact with minimal restoration and good prognosis. The second molars on either side have direct placement silver amalgam restorations, but are otherwise sound with good prognosis.

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The first molars on either side recently had temporary crowns placed following root canal treatment. Radiographs show incomplete root canal fillings and insufficient tooth structure for predictable re-restoration (Fig 6).

Existing removable restorations

The upper denture is a cobalt chrome reinforced denture with a palatal strap and visible buccal clasping. In the lower, there is a temporary all-acrylic denture (Fig 7).

Periodontal condition

BPE
1/1/1
0/2/1
Full chart not required.
Oral hygiene was fair, some areas of supra and subgingival plaque deposits. OHI practical required for effective plaque removal.

Occlusal assessment

TMJ healthy – full range of motion and no pain on loading.
Centric relation – first point of contact UL7 /LL7 and less than 1mm vertical slide to centric occlusion.
Guidance – group function on both sides with non working side interferences on both lower 7s.
Interarch spacing – limited above roots of lower 6s.
No evidence of significant parafunction.

Aesthetics

Medium/high smile line showing gingival margins of all upper anterior crowns and clasps of p/- chrome.
Unaesthetic old PFM crowns, poor width/length ratio, unaesthetic margins.
Lower spacing evident.
Staining and colour mismatch from restorations to remaining tooth structure.

Radiographic assessment

OPG – no non-dental issues, assessment of vertical bone height for possible implant placement suggest favourable situation in the lower arch with the need for bilateral sinus augmentation in the upper. (Fig 8 – OPG).

Periapical radiographs – upper anterior dentition heavily restored with root canal fillings, posts and crowns on teeth, no significant apical pathology (Fig 9 – periapical radiographs).

Diagnosis

Reduced aesthetics and function as a result of repeat restoration and tooth loss in a heavily restored dentition, with a high likelihood of further tooth loss, especially in the lower posterior and upper anterior sextants.

Discussion/treatment options

The patient was initially referred for possible implant replacement of missing posterior teeth in both arches. Initial assessment would suggest this as a reasonable and predictable way of restoring the posterior sextants to full function, with good bone height available in the lower and predictable augmentation likely in the upper.

Critical in any case assessment, however, is the overall assessment of the full mouth in order to predict, as far as possible, where problems will next occur and how they can be managed within the context of the planned treatment. This is never more important than when considering dental implants.

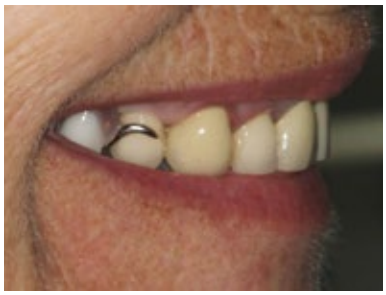

FIGURE 1
Visible clasp from existing denture

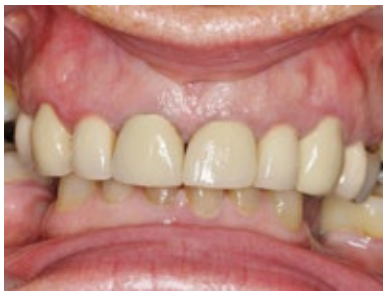

FIGURE 2
At presentation

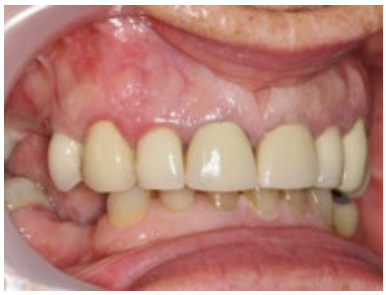

FIGURE 3
Right lateral view

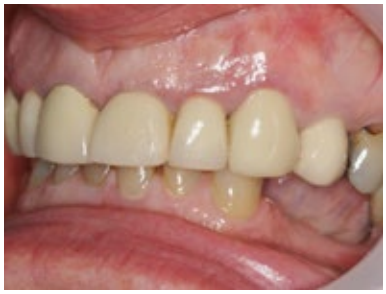

FIGURE 4
Left lateral view

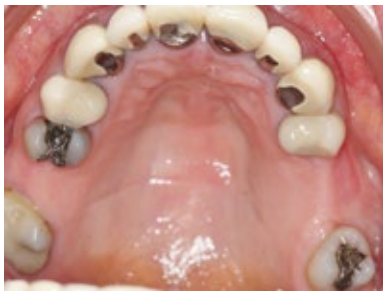

FIGURE 5
Upper full arch mirror view

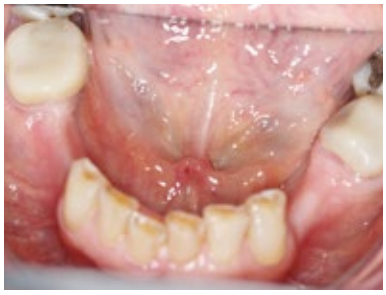

FIGURE 6
Lower full arch mirror view

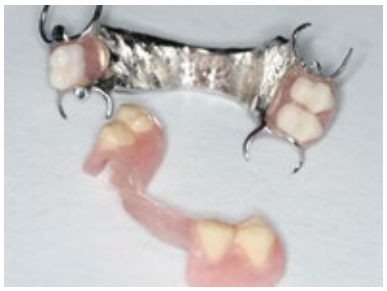

FIGURE 7
Existing removable restorations

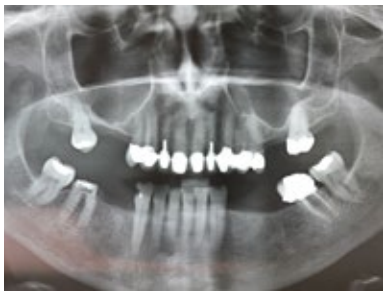

FIGURE 8
OPG

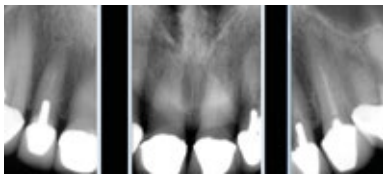

FIGURE 9
Radiographs of upper anteriors

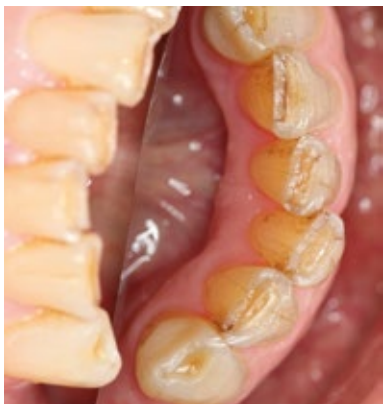

FIGURE 10
Composite rests lingually on lower canines

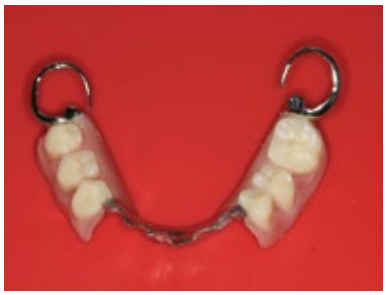

FIGURE 11
Completed lower rotational chrome

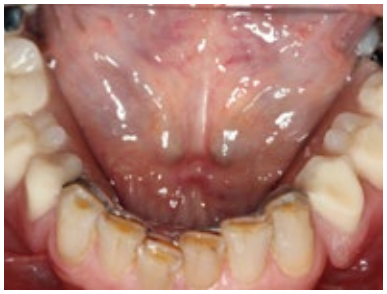

FIGURE 12
Lower rotational denture fitted

However it is managed, dental implant treatment is a costly process, financially and in terms of what patients may have to endure. It is important that, if we can predict that more implants are likely, the patient is made aware of this at the outset of treatment. Often a patient will stretch themselves for the treatment they have been told they need, but be unable to rise to additional complex treatment in the future.

Therefore, we need to look to the evidence available in order to predict what may happen to a heavily restored dentition. With this information, the patient is then much better informed and able to make the right decision about their care. In addition, as clinicians we are much better able to manage a situation if we have predicted and explained it in advance.

In compiling the treatment plan, advice on evidence-based prognosis and treatment outcomes was sought from specialist clinicians in prosthodontics, oral and maxillofacial surgery and endodontics.

With this particular case, the restorations most at risk of future failure are the upper post crowns. Due to the proximity of a number of post crown restorations, failure of any one would result in a significant challenge:

1. Tooth loss will result in unaesthetic apical migration of the gingival margin.
2. Fixed bridgework is unpredictable due to lack of structural integrity of adjacent teeth.
3. Lifting a flap for implant placement, in the upper anterior sextant, will likely result in exposure of the crown margins on adjacent teeth. Restoration of these teeth to manage this would again be unpredictable due to lack of ferrule and structural integrity.
4. Were it either of the lateral incisors that was lost, implant placement would be in a less than ideal strategic position, given that future tooth loss is likely.

REFERENCES

References available by request, email Tele-dentist@edinburghdentist.com for more information.

Discussing the situation with the patient involves presenting the information in such a way that they can balance their wishes, what is possible and what is affordable both now and in the future.

In this case, we established that to resolve the original concerns, a minimum of two implants would be required in the upper arch and four in the lower.

Multidisciplinary planning suggests that additional treatment as problems arise in the upper would likely result in an additional two to four implants carried out in a "piecemeal" approach on an "as required" basis.

Many patients are happy to accept this and proceed as they originally intended. Here, however, the patient felt that their previous experiences and our observations meant further treatment would be highly likely and that they could not, and did not wish to, afford piecemeal implant dentistry.

The patient was willing to compromise their criteria to accept "removable" rather than "fixed" restorations if their other wishes could be achieved.

We therefore looked to provision of removable chrome reinforced partial dentures, designed in such a way as to achieve as many of the patients original wishes as possible as well as managing predicted future problems.

Agreed treatment:

Upper arch

Using a modified RPI (rest/plate/i-bar) system (Equipoise System), we were able to design an upper removable

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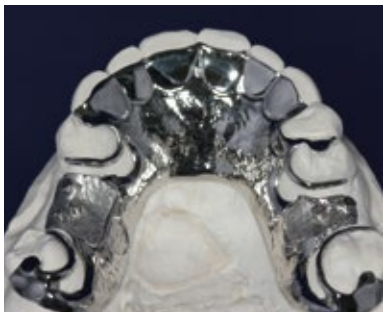

FIGURE 13
Upper Equipoise framework

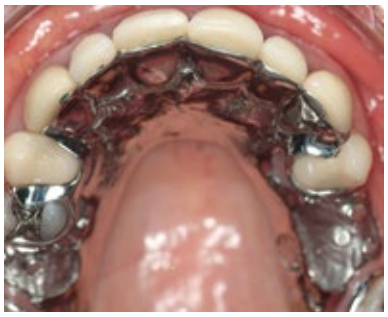

FIGURE 14
Try-in of Equipoise framework

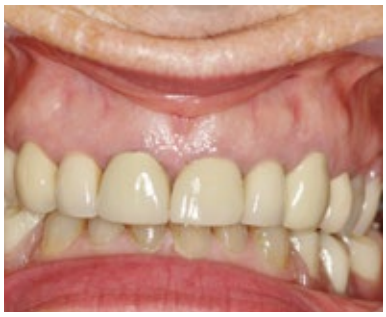

FIGURE 15
Upper and lower chromes fitted

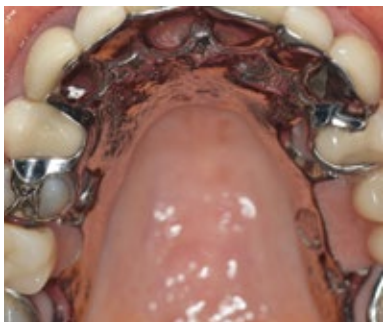

FIGURE 16
Upper fitted

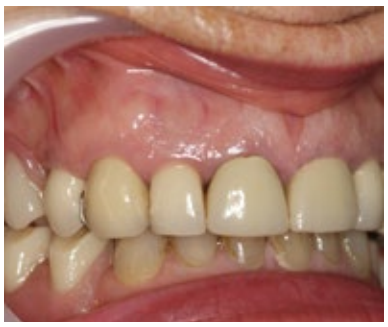

FIGURE 17
Right lateral completed case

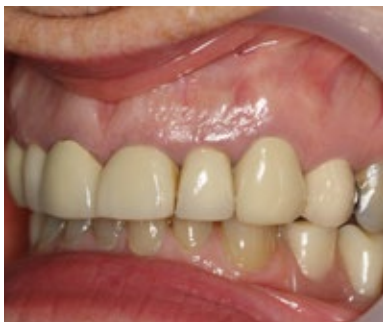

FIGURE 18
Left lateral completed case

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partial denture that did not show any of the metal clasping which had been bothering the patient. In addition, by opening the occluso-vertical dimension, in centric relation, it was possible to provide an anterior chrome bite platform that would both limit functional and para-functional forces on the existing post crowns while providing support for possible future tooth addition as and when required.

Lower arch

A "rotation" type chrome was fabricated to rest on composite additions to the lingual of the lower anteriors and within distal undercuts. The interocclusal space was limited over the remaining roots of the first molars, deeming them unsuitable as potential overdenture abutments, and these were therefore removed three months before restoration fabrication.

During treatment, the patient was instructed on optimal oral hygiene for the existing and planned restorations.

Treatment progression

Figs 10-18.

Conclusion

A case has been presented demonstrating comprehensive, multidisciplinary, treatment planning as a result of which the patient chose a different treatment option from that which they had originally intended.

Planning advanced restorative dental care, in an already heavily restored dentition, is a complex and challenging process. If predicable results and patient satisfaction are to be achieved, then informing patients fully of all potential outcomes and possible future complications is essential at the outset.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To understand the process of comprehensive case evaluation
- To appreciate the role of evidence based dentistry in case assessment
- To appreciate that dental implants are not always the best solution for tooth replacement
- To show that, integral to any comprehensive treatment plan, should be a prognosis not only for the planned restorations, but also the existing dentition.

LEARNING OUTCOMES

- To appreciate that comprehensive case assessment is a complicated process, bringing together not only the patient's wishes and budgetary restraints, but also balancing these with knowledge of evidence-based treatment outcomes across a number of specialities
- To understand that a patient's decision on the treatment they choose to have is dependent on the clear presentation of information in a way that is sympathetic to their current and future dental needs.

EXAMPLE QUESTION

1. What are the important aspects of a full case assessment?
a. Understanding the patient's expectations
b. A full medical and dental history
c. Presenting all possible options in a clear understandable format
d. Predicting the potential future problems and how they may be managed
e. All of the above.

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ABOUT THE AUTHORS
This article was submitted by Edinburgh Dental Specialists.

PATHWAY TO PERFECTION?

COSMETIC DENTISTRY

Dr Tom Canning demonstrates the techniques and factors that need to be considered when dealing with patients' high expectations in aesthetic cases

TOM CANNING

Modern dentistry has undergone a revolution in the area of cosmetic or aesthetic dentistry. Patients more frequently put an emphasis on improving the appearance of their teeth and often have high expectations. This article aims to demonstrate some factors that need to be considered and techniques used in order to achieve this goal. Clinical cases will be used to illustrate this process.

Patient history

Patients who wish to improve the appearance of the front teeth generally do so as there is a particular feature of their smile with which they are unhappy. Discolourations, previous dentistry, missing teeth, misshapen teeth, excessive gingival display, gingival recession, tooth crowding, spacing or movement are some examples of the dental factors affecting the smile (Figs 1 and 2).

Depending on the individual patient's presentation, different treatment options may be indicated to achieve their goals. The most important factor for success is accurately distilling from the patient what particularly concerns them about their teeth. Once this has been established, the clinician can then begin to visualise how the case will look upon completion. It goes without saying that it is particularly important to undertake a thorough extra-oral examination (Table 1). The clinician should be looking for any indications of factors that are detrimental to the appearance of the teeth.

During the intraoral examination, attention should be given to the occlusion, both static and dynamic, as this may influence the treatment plan, restoration type, number of teeth to be restored and even the materials to be used. Of importance also is the presence of tooth wear. Its location, distribution and characteristics will point to the underlying aetiology[1] and correct management. A diagnosis of bruxism or parafunction may impact on the treatment plan.

ABOUT THE AUTHOR

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Dento-gingival complex and importance of pink aesthetics

An understanding of the normal size, shape, position and arrangement of the natural dentition is essential. Much has been written about certain values or proportions that are key to a "perfect smile" but in reality, there is no single formula for all.

In practical terms, average anterior tooth size[2], height:width ratios[2] and relative proportion of anterior

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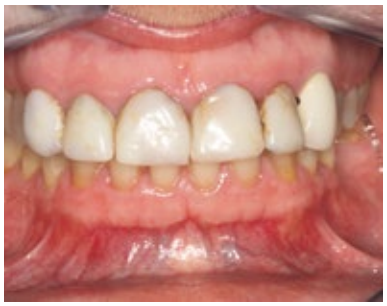

FIGURE 1
Patient A intra-oral. Discoloured, leaking restorations. Teeth are too broad and have poor axial alignment

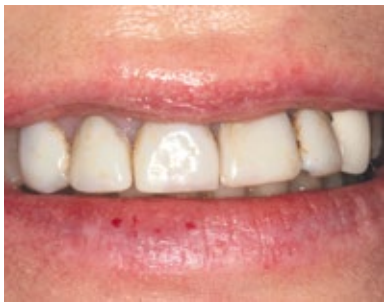

FIGURE 2
Patient A smiling. Poor smile aesthetics, occlusal plane disruption and poor tooth form

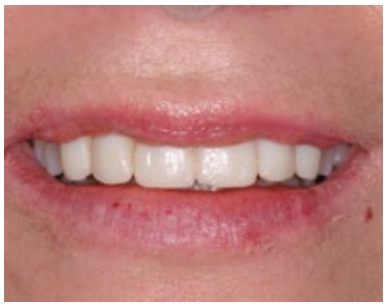

FIGURE 3
Patient A – provisional restorations with corrected incisal edge position

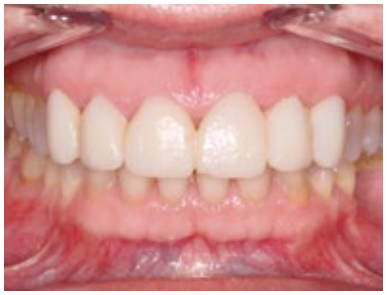

FIGURE 4
Patient A – in order to develop correct tooth size (Height:Width ratios) minor crown lengthening was undertaken

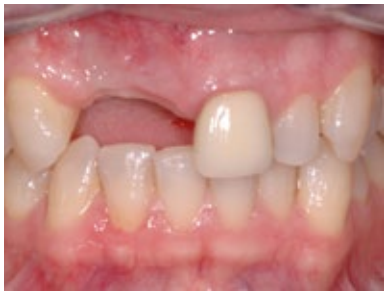

FIGURE 5
Patient B – combined vertical and horizontal ridge defect with loss of gingival architecture

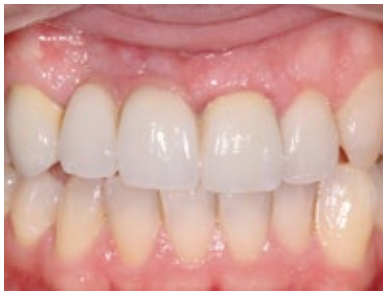

FIGURE 6
Patient B – use of pink porcelain to create an artificial interdental papilla and achieve more ideal pink-aesthetics

Modern dentistry has undergone a revolution in the area of cosmetic or aesthetic dentistry

teeth[3] are of use. This information can be taken together with a desired incisal edge position of the final restorations to arrive at a tentative starting point. When restoring anterior teeth, the most important starting point is the proposed final incisal edge position as this then determines tooth size and length. This may have important consequences on the gingival margin positions in order to maintain 'ideal' tooth proportions for an aesthetic outcome (Figs 3 and 4).

An example of this would be where tooth wear has occurred and the worn teeth may have experienced compensatory over-eruption maintaining the position of their incisal edges. In this instance, further addition to the incisal aspect of the teeth would not result in an aesthetic outcome and consideration must be given to either orthodontic repositioning of the teeth prior to restoration, or possibly crown lengthening to reposition their gingival margin levels.

The relationship of the periodontal tissues – in particular, the gingival margin positions, symmetry, interdental papilla and amount of gingival display – are all important (Fig 5). Much has been written on the need for aesthetically correct gingivae to frame the teeth or restorations to provide highly aesthetic outcomes. Periodontal plastic procedures can aid the outcome of restorative dentistry, so co-ordination with periodontal colleagues is vitally important. An understanding of the limitations of grafting procedures is also important and the use of alternatives, in particular the use of pink porcelain, should be considered (Fig 6). Careful communication with your laboratory is needed in order to develop natural-looking prosthetic gingivae.

Excessive gingival display (gummy smile)

Most often as restorative dentists we are challenged by a deficiency in periodontal tissues either as a consequence of periodontal disease or tooth loss. However, an excess of gingival tissue display can also be unsightly and can lead to a patient being unhappy with their gummy smile (Table 2).

In certain instances, subtractive periodontal procedures alone can be sufficient in the management of such cases. Where roots of teeth may become exposed by surgical crown lengthening procedures, root coverage may become necessary and should be planned for.

Depending on the aetiology and the contributing factors, dentistry alone may not provide the solution. Orthodontic treatment in isolation or together with maxillofacial or plastic surgery may be necessary to achieve the ideal aesthetic outcome, therefore a careful assessment should be made for such patients prior to treatment.

Treatment planning: diagnostic wax-up or virtual smile design

Before making any reversible alterations to the existing teeth, it may be necessary to undertake a diagnostic wax-up. This is of particular importance if changes are planned in relation to tooth size, shape or position. This can aid in patient acceptance, but more importantly gives a clear indication of the proposed final appearance of the teeth.

More recently, digital manipulation of clinical

TABLE 1.

Extra-oral examination

FACIAL VIEW:	
Occlusal plane orientation	Tooth display (incisal edge position)
OVD assessment	Gingival display
facial symmetry/centre lines/alignment of teeth	
SAGITTAL PROFILE:	
Skeletal pattern.	OVD assessment
Labial-lingual position of incisor teeth	
SMILING VIEW:	
Smile line-normal, flat, reversed.	Tooth display
Gingival display	buccal corridor
Tooth colour	Any other obvious deviations from ideal

TABLE 2.

Factors associated with excess gingival display

Tooth position	Large maxilla (vertical maxillary excess)
Delayed passive eruption	Gingival overgrowth
Short upper lip	Hyper-mobile upper lip

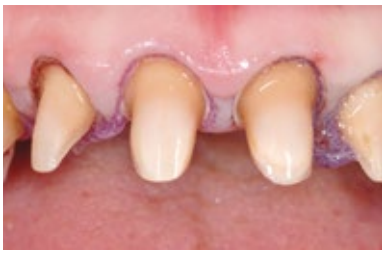

FIGURE 7
Patient A – smooth tooth preparations and well-fitting provisional restorations allow for maintenance of periodontal health and ease of impressions

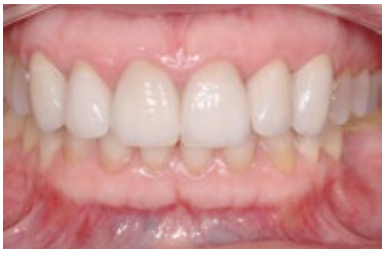

FIGURE 8
Patient A – final restorations with improved proportions, alignment and characterised porcelain

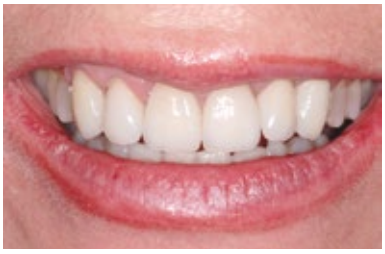

FIGURE 9
Patient A – overall improvement in smile from restoring six anterior teeth

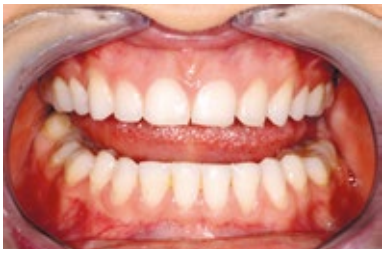

FIGURE 10
Patient C – bright natural teeth with minor surface loss

photographs using dedicated software has become available and this can be very useful to contrast pre-op images and planned results. Ideally, some form of temporary mock-up should be provided to see the effects of proposed changes in the patient's mouth. This is not always feasible, as in some instances subtractive changes are being planned and this is where virtual smile design has an advantage.

Provisionalisation and tissue management

Once a treatment plan has been accepted and teeth have been prepared, careful provisionalisation following the blueprint of a diagnostic wax-up may be required. A period of time spent in provisional crowns can be useful for a number of reasons. This gives the clinician an opportunity to review questionable teeth, assess planned occlusal changes and finally review with the patient any alterations and their effects on the final aesthetic arrangement of the teeth. Should further changes be requested, provisional crowns can easily be adjusted and once acceptable can then be copied to create a go-by cast to be followed in final restorations.

In order to achieve acceptable aesthetic results with anterior crowns, subgingival crown margin placement is generally required. The maintenance of periodontal health is essential in order to allow for accurate impressions of the prepared teeth. Highly accurate impressions of stable gingival tissues allow for crowns to be made precisely resulting in better marginal fit and ongoing periodontal health. This is essential for predictable long-term aesthetic success (Fig 7).

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1) Verrett RG (2001): Analysing the aetiology of an extremely worn dentition. J. Prostho; 10:224-233.
2) Width/length ratios of normal clinical crowns of the maxillary anterior dentition in man. Sterrett JD, Oliver T, Robinson F, Fortson W, Knaak B, Russell CM. J Clin Periodontol. 1999 Mar;26(3):153-7
3) Dentists' preferences of anterior tooth proportion-a web-based study. Rosenstiel SF, Ward DH, Rashid RG. J Prosthodont. 2000 Sep;9(3):123-36

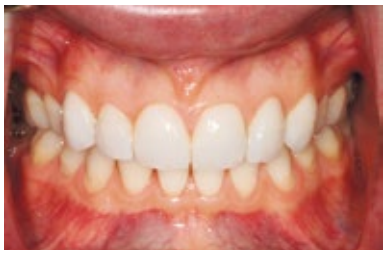

FIGURE 11
Patient C – conservative preparations and restoration with feldspathic veneers to improve appearance

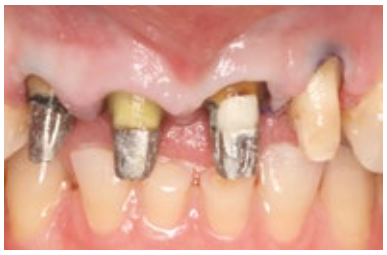

FIGURE 12
Dark crown preps with discoloured cores

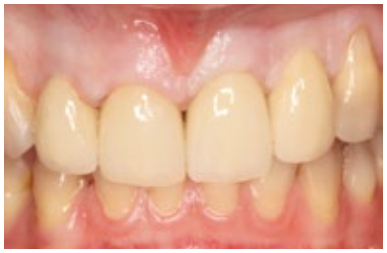

FIGURE 13
Opaque zirconia-based restorations to mask underlying discolouration

VERIFIABLE CPD QUESTIONS

AIMS & OBS:
- Understand factors to be considered for predictable aesthetic outcomes
- Illustrate the role of preliminary planning, gingival tissues and their position and management and choice of appropriate restorative materials.

LEARNING OUTCOMES:
- Understand the role of the diagnostic wax-up in planning aesthetic dental treatment
- Understand the role of marginal gingival position and how to evaluate it
- Choose the appropriate indirect materials for a given clinical situation.

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Tooth colour: selection of appropriate materials

Patients generally do not complain that their teeth are too light and trends towards brighter teeth are seen in everyday practice. When restoring anterior teeth, the colouration of the prepared teeth should be carefully considered.

How light will interact with the final restorations is important here. Currently available indirect restoratives can be grouped according to their degree of translucency or opacity. Indeed, some currently available systems offer a range of translucency depending on the prevailing clinical conditions (Table 3).

In achieving the most aesthetic outcome, a balance must be struck between the nature of the prepared teeth, selection of the appropriate restorative materials and the degree of tooth preparation undertaken. The ideal situation would consist of a naturally coloured tooth allowing for a translucent restoration with minimal tooth preparation (Figs 10 and 11).

The other end of the spectrum, however, is also frequently encountered. Teeth that are highly discoloured will require more opaque restorations to mask their underlying darkness and the ceramist will need additional thickness of porcelain to create lifelike restorations. Unfortunately, there is no perfect system for all eventualities.

In the author's opinion, there is still a place today for porcelain fused to metal crowns on anterior teeth in aesthetic dentistry in selected cases. Excellent results can be achieved when the ceramist is given enough room in terms of tooth preparation for creating natural-looking porcelain.

In order for our technicians to achieve the results we desire, as much information as possible should be made available to them. The final desired shade often is not enough and the shade of the prepared tooth stump should also be indicated. Photographs of prepared teeth are beneficial in this respect (Figs 12 and 13).

TABLE 3.

Translucency of commonly used indirect restorative materials

TRANSLUCENT MATERIALS	VARIABLE TRANSLUCENCY	OPAQUE MATERIALS
Feldspathic Porcelain	E-Max	Zirconia based
Empress Esthetic	Procera Alumina	Metal-ceramic

Customising the smile

When considering "ideal" aesthetics using "normal" measurements and relationships there can be a tendency towards arriving at an artificial or a "too-perfect" result. Many discerning patients want their teeth to be improved upon, but also request that the end result appears natural.

Nature inevitably demonstrates some asymmetries and this usually adds character to an individual's smile. Minor tooth rotations and attention to detail in terms of surface texture and shading can go a long way to achieving this goal.

Incorporating characteristics from the patient's own natural teeth into the final restorations can also be a useful tool. Photographs of unprepared healthy adjacent or opposing teeth offers the ceramist an idea of shade transitions, enamel surface texture, tooth form and translucency and adds to the overall micro-aesthetics of the case (Figs 8 and 9).

RECORDS ERROR PROVED COSTLY

CASE FILES

Dental Protection serves more than 64,000 dental healthcare workers worldwide, and that vast experience is reflected in its risk management publications. This series has been prepared for *Scottish Dental* magazine from the Dental Protection case files by Dr Claire Walsh, an associate dento-legal adviser in the Edinburgh office

CLAIRE WALSH

Dr T was a relatively new graduate when she joined her first practice as an associate dentist. One of her first patients was a 15-year-old boy who had resumed attendance at the practice after a break spanning back to a single course of treatment from another dentist six years earlier.

The patient complained of a hole in a tooth in the lower right, which was sensitive to temperature changes and aching. A cavity with deep mesial caries was noted in the LR6. Further investigations did not fully confirm the vitality of the tooth, and a large amalgam restoration was placed, with warnings that further treatment, such as endodontic therapy, or extraction, could be needed. At this stage, Dr T did not take any radiographs of the tooth.

The patient missed his six-month review, but presented 15 months later with a swelling in the lower right quadrant, which was associated with the LR6. At this stage, the tooth did not respond to vitality tests, and when options for treatment were discussed – endodontics or extraction – the patient was not enthusiastic.

Antibiotics were prescribed, and an entry simply stating 'warned' was placed in the records, with no further details. Other carious teeth were recorded, and a review was arranged 10 days later

The patient again failed to attend, but he did turn up for a final appointment three months later, suffering from swelling as before, and still refusing to undergo further treatment to LR6. A dressing was placed in the tooth, and further antibiotics prescribed. The patient was advised to return if the need arose, with a planned review in six months. This was the last time Dr T saw the patient.

Unknown to Dr T, the patient was admitted to hospital in an emergency and the LR6 was extracted. The patient suffered some submandibular scarring, together with lost time at work and the cancellation of an impending holiday.

The patient complained to the dental practice about perceived negligent treatment, and copied this correspondence to the local health board, while also threatening to involve the General Dental Council.

Dr T contacted Dental Protection's telephone advice line, where a dento-legal adviser assisted her in writing the responses required to the complaint. At this stage, it seemed as if the matter had been concluded, but this was not so.

Two years later, Dr T was contacted by a solicitor who, after seeking access to the patient's dental and medical records, issued a letter of claim, alleging negligence and seeking damages in relation to the avoidable loss of the LR6, as well as avoidable scarring, pain and inconvenience.

Dr T felt her records stood up to scrutiny, particularly as one allegation related to a failure to tell the patient endodontic treatment was required; this was clearly marked in the records, and this aspect could have been robustly defended. She also insisted radiographs were not required as the diagnosis was made clinically with relative ease.

The records showed the patient had been repeatedly told of the need to treat LR6. But Dr T's defence had two significant vulnerabilities:

- The complete lack of radiographs over the care period which, although not required for the caries diagnosis in LR6, would have presented a fuller picture of the condition of the tooth, particularly when swelling developed.
- No information noted about any warnings given to the patient in the event that treatment was not carried out, such as acute severe swelling and associated adverse outcomes.

Dental Protection's advice to the member, on this occasion, was to settle. Even if only one allegation is accepted, the entire case has to be settled. However, Dental Protection did rebut several of the allegations, and reduced the cost of remedial treatment (implant replacement of LR6) on the basis that the patient had refused treatment and had effectively hastened the loss of the tooth by his own inaction.

This was an unfortunate case where the patient had been clearly advised to have treatment, but the clinician had not recorded the fact that the patient was warned about possible adverse outcomes.

Hence, the patient had not been in possession of the full facts when deciding not to accept the recommendation, and therefore the consent process was flawed.

EVERYTHING DENTAL

HENRY SCHEIN DENTAL'S EQUIPMENT SALES SPECIALIST KELLY PATERSON OFFERS AN INSIGHT INTO HENRY SCHEIN DENTAL'S NEW EQUIPMENT SHOWROOM AND EDUCATION FACILITY IN PAISLEY

KELLY PATERSON

Availability and choice are two important factors for me and my team here at Henry Schein Dental. Giving dental professionals the opportunity to select from a wide range of options, all supported by expert advice and consultancy, is what I aim to provide through my work as a Henry Schein Dental equipment sales specialist.

When considering new equipment such as a treatment centre or digital equipment to improve a practice's workflow and efficiency, obtaining expert advice and support is always a crucial component of the decision-making process. For instance, one of the most important investments that a dental professional has to make is in choosing their treatment centre, and during this process it's vital that as a dental supplier we are on hand and ready to provide all the necessary support before and after purchase.

The extension of our dental offering to include digital and hi-tech equipment required us to create a showroom in

Scotland that did our products and services justice. Originally located in Clydebank, our showroom recently moved to new premises in Westpoint Business Park in Paisley and is now positioned in an even more convenient location for our clients, just 15-20 minutes from the city centre and adjacent to Glasgow airport.

The new showroom enables us to offer much more than we could in our original premises. Dentists who are considering an investment into the industry's latest equipment can visit the showroom and see three different working surgery set-ups, including a decontamination room, specifically designed to give our clients the feeling of being in a real working practice.

Each surgery features a different treatment centre from leading manufacturers, including the very latest from Belmont and Sirona, and every chair can be specified to each customer's individual needs and preferences. Alongside this, the showroom displays a selection of furnishings and equipment combinations, including CEREC, X-ray machines, lasers and autoclaves, all of which combine to give clients a stronger visual idea of how each component of their practice would integrate and assist in the smooth running of the daily workflow.

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Come see our new show room on the 11th of November! It is easily accessible adjacent to the M8 at Glasgow airport. Our showroom displays the latest in digital and equipment technology. We can help you design your practice layout and let you 'try before you buy'.

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Henry Schein Dental, Ground floor Westpoint 3, Westpoint Business Park, Marchfield Drive, Paisley PA3 2RB

Meet your Scottish team

Field Sales Consultants

Anne McDougal
07971 128 169

Paula Bones
07971 128 082

Joanne Robertson
07971 128 054

Equipment Sales Consultants

Kelly Paterson
07971 128 069
Equipment Sales

Gordon Thomson
07971 128 075
Digital Imaging Specialist

Engineers Team - Services 0800 028 4749

Allan Brown
Service Supervisior

Donald Crosby
Senior Engineer

Gary Brown
Senior Engineer

Peter Shearer
High Tech Engineer

Decian Mclgan
Engineer

SALES 0800 023 2558
OFFICE 01418 478 670
ONLINE henryschein.co.uk

EMAIL everything@henryschein.co.uk
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HENRY SCHEIN® DENTAL

FROM PREVIOUS PAGE>

In addition to the surgeries, the showroom also has a new dedicated teaching area where we can host a range of educational and training CPD courses, accommodating up to 30 participants at a time. This facility, ideal for presentations, lectures and webinars, is also open to dental professionals in and around the Glasgow area to use for training, seminars and meetings with fellow professionals, an ideal alternative to using their own premises.

Visits to the showroom are by appointment and we strive to offer a very personalised service to our clients by providing a navigated and consultative walk through each area. No two practices are ever the same, so it is my job as Henry Schein Dental's equipment sales specialist to understand what our clients are looking for and what their specific requirements are and then find a solution to their needs. We are very flexible on appointment times, recognising the fact that many dentists can only visit us in the evenings or at weekends, and this is something we are more than happy to accommodate.

We understand that it is important not only to keep within a client's budget, but also to ensure that the chosen equipment and fittings will work effectively within their practice. I routinely make site visits to a practice, either before or after a showroom appointment, to take detailed measurements and draw up plans to guarantee everything will operate correctly with any existing equipment and make sure that new equipment operates comfortably within the available space.

This approach ensures we take into consideration the specific features required by the practice and recommend how new equipment can be integrated within their current practice workflow.

For those fitting out a brand new surgery, Henry Schein Dental has a team of highly experienced equipment specialists and field service engineers always on hand to answer questions and offer advice on practice design. We offer a bespoke surgery solution that includes planning, supply, installation and maintenance packages to ensure that your whole surgery can be delivered using a single experienced team.

Our recent showroom open day was a great success and the dental professionals in attendance got the opportunity to find out more about how they can integrate the latest CAD/CAM and digital technology into practice using equipment such as CEREC, lasers and CBCT scanning. We also provided advice on finance options and practice management strategies.

We understand that choice and availability are only two of the components within great customer service, and alongside these we ensure that each customer benefits from our accumulated years of industry experience to ensure that we provide the very best service alongside the latest in dental technology and equipment. We have a great team here in Paisley so why not book an appointment and come and visit us – I look forward to meeting you very soon!

MORE INFORMATION

To book an appointment with the team at the Glasgow showroom, or to arrange a practice training or Study Club event, contact Henry Schein Dental on Freephone 0800 028 4870 or visit henryschein.co.uk

everything@henryschein.co.uk

Twitter: @HenryScheinUK

Facebook: HenryScheinUK

Henry Schein Dental Glasgow Showroom
Ground Floor, Westpoint 3,
Westpoint Business Park,
Marchfield Drive, Paisley PA3 2RB

Management

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BE INSPIRED

HOW TO MOTIVATE YOUR STAFF THROUGH EFFECTIVE MEETINGS

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DÜRR DENTAL

PERFECT TEAM MEETINGS

HOW TO DELIVER TEAM MEETINGS WITH PURPOSE AND IMPACT – AND THAT YOUR TEAM WILL LOVE ATTENDING

ADAM MORGAN

If your team meetings are always the same, then I encourage you to implement the following four-step process immediately. I often hear that team meetings consist of the same topics run by the same people each time while the rest of the team sit quietly.

From working with companies around the world I have found that all great teams share the same four ingredients in their team meetings.

Before I share my top four 'must haves' that should always be present when getting the team together with you, I want to mention that all meetings should be:

1. Worthwhile. If you have nothing to say, don't pull the team together. It might be nice to have a good old catch up, but your team will not thank you for cutting into their productive time if you have nothing of value to say.

2. Be engaging. This might sound obvious, but if you want to create a good atmosphere, you have to raise the level of your energy without being disingenuous.

So, when holding your team meetings, remember 'TEAM.'

T – TALK

I often see team meetings held by the business leader or manager and then the rest of the team sit in silence. Usually, the team talks and has high energy at the start of the meeting and then this energy slowly diminishes as the minutes tick by.

When you are planning to get your team together, break up topics and hand them out a few days prior. Ask them to get creative and come up with a fun way of bringing their topic to the team during the meeting with the following two rules:

1. It must get people talking – the team has to discuss what was said and give their views on it or contribute in some way

2. It must be upbeat – regardless of the topic, it must be lively and delivered with enthusiasm.

E – EDUCATE

Secondly, every meeting should be used to educate the team in some way. This can form a large or small portion of the meeting but it must be in there.

I often tell businesses to have a 'learning board' that the team should write every bit of development they need or would like to have. Then during the team meetings, someone is designated to educate the entire team on a topic of their choice.

This is where I use my subject matter experts. They often are the most passionate about their given topic and can answer team questions.

A word of advice here: learning should always, always be fun – adults remember information better that way – so come up with fun games, songs, drawings or raps if you have to, to make the information stick!

I have seen some of the most brilliant 10-minute learning segments that have been so much fun to learn, and the more fun and memorable this can be, the more learning will be embedded in the long term for your team. You can even have a trophy that gets passed around for the best educational piece. Either way, make it fun and make it memorable where everyone takes part.

A – ALIGN

All team meetings should be used to continually align your group of individuals towards your business goals and longer term vision. You have got to know where you want to get to – otherwise your team may work hard but feel no sense of belonging to building something bigger than themselves.

When talking about vision and goals, talk about the successes that have been achieved as a team since the last meeting or last business quarter. What has changed? Why are we being successful? Or on the flip side, what could we change to be more successful?

And most importantly, how are we all contributing towards achieving our vision of being the most highly skilled in the market, or having the best service excellence in our town for example – you put your own vision here – but talk about it. Every member of your team should know exactly what you are all working towards and this should be communicated constantly.

> "TEAM MEETINGS SHOULD LEAVE PEOPLE FEELING PUMPED UP AND READY TO TAKE ON THE WORLD. PRAISE GREAT BEHAVIOUR"
>
> ADAM MORGAN

M – MOTIVATE

Finally, team meetings should be highly anticipated by the team. If they are not, then you need to find as many ways to motivate your team as possible, and then use them in and out of your meetings.

Team meetings should leave people feeling pumped up and ready to take on the world. Praise great behaviour. Thank each person individually for something they did that impressed you. Talk about what really matters to people – their families, holidays, time with friends, hobbies, sports – anything that your team is passionate about.

Ultimately, most people work to have a better quality of life with the people that matter to them, so talk about it, appreciate their hard work and then inspire them to continue to give their best.

So, when you have your next team meeting, think about TEAM. *Talk* together, *Educate* and make it memorable, *Align* everyone with your vision and goals and, finally, *Motivate* them to go even further than they thought possible.

USE IT OR LOSE IT

TAKING FULL ADVANTAGE OF ISA ALLOWANCES WILL HELP REDUCE YOUR TAX BILL THIS YEAR AND IN 2016

ALASDAIR MACDOUGALL

In our opinion, the only reason you wouldn't utilise your ISA Allowances is if you didn't have the money at hand to do so. The government offers generous tax breaks to encourage people to save and an ISA is still one of the most popular and accessible.

The best way to think of an ISA is as a "wrapper" into which you can shelter your savings and investments from tax.

Within a Stocks & Shares ISA, you pay no Capital Gains Tax and no further tax on income and you don't need to declare an ISA on your tax return. ISA allowance for 2015/2016 is £15,240, so a couple can invest over £30,000 each year and shelter all gain and income from the tax man.

Where you invest will depend very much on timescale, investment expectations and appetite for investment risk. Within an ISA wrapper, you can invest in as low or high risk a manner as you like and can choose cash, fixed interest, commercial property, or UK & Global equity to diversify your investment strategy to match your investment goals.

WHAT DID WE LEARN FROM THE PENSIONS REVOLUTION?

On 6 April 2015, a number of significant changes were made to pensions with regard to contributions, withdrawal of funds and death benefits. Pension contributions are subject to a £40,000 Annual Allowance for most people, providing you have earnings up to this level. A new £10,000 Annual Allowance has been introduced for people who have flexibly accessed their pension.

Most pension investors, aged at least 55, now have total freedom on how they take income and/or lump sums from their pension funds. Previously, it was normally only possible to pass a pension on as a tax-free lump sum if you had died before the age of 75 without having taken any tax-free cash or income.

There are now no restrictions on where lump-sum death benefits are paid from a money purchase pension fund and there is no limit on the number of successors, so, in theory, funds could be passed on for generations to come.

TIPS FOR 2016

It may be in your best interests to ensure that any unused ISA Allowances are utilised before 5 April 2016 and, where possible, 2016/2017 allowances are utilised after 6 April.

We would strongly recommend that any money-purchase pension, stake-holder pension, personal pension, SIPP, or executive pension is reviewed in light of the new pension freedom legislation, as not all providers will facilitate all the new flexible options. It is imperative that your pension Expression of Wishes is regularly reviewed and updated.

It is strongly recommended that Independent Financial Advice is taken when considering an ISA investment or a review of pension arrangements, as personal circumstances, needs, priorities, appetite for risk and inheritance tax liabilities will be unique.

LOOKING FOR FURTHER TAX-SAVING IDEAS AND PLANNING TIPS?

If so, look no further than our Tax Planning for Life guidebook for year ending 5 April 2016. You can find it on the maco.co.uk home page. Tax-saving ideas for individuals, married couples/civil partnerships, business and working life, investments, pensions and some forewarnings based on recent announcements in the 2015 Budgets.

The purpose of this article is to provide technical and generic guidance and should not be interpreted as a personal recommendation or advice. Martin Aitken Financial Services Ltd are authorised and regulated by the Financial Conduct Authority. This is based on our understanding of current HMRC rules and guidance which may be subject to change.

ABOUT THE AUTHORS

Alasdair MacDougall is a director at Martin Aitken Financial Services Ltd. To contact Alasdair, email amd@maco.co.uk

THE GOLD STANDARD

The NSK Ti-Max Z45L, the world's first 45-degree contra-angle, has been awarded gold in the Dental & ENT Surgical Tools category at the 2015 Edison Awards. These awards are recognised as among the highest accolades a company can receive in business and innovation, honouring excellence in new product and service development.

In restorative and surgical dentistry, the Ti-Max Z45L delivers smooth control, powerful torque and complete operational visibility thanks to its 45-degree angled head, facilitating access to the molar region that standard contra-angles simply can't match.

The slim, straight body of the Z45L creates more space between adjacent teeth and the handpiece to maintain an optimal bur angle. Providing excellent visibility and operability, clinicians can engage in high-precision, minimally invasive procedures with complete accuracy.

Capable of reaching speeds of up to 168,000 min-1, the Ti-Max Z45L functions with low noise and virtually no vibration, and takes both standard (20mm) or long (25mm) burs.

When combined with the NSK NLX nano electric micromotor, the high power and stable torque helps deliver powerful and consistent cutting. Available with external irrigation, the Z45L is compatible with popular surgical units such as the NSK Surgic XT and NSK Surgic Pro.

"Switching to the Ti-Max Z45L handpiece allows me to avoid bumping upper incisors and thereby have a better bur angulation on tooth preparations," said Dr Basil Mizrahi, Specialist in Restorative Dentistry (www.basilmizrahi.co.uk).

Take advantage of NSK's no obligation 10-day 'try before you buy' and equipment rental scheme, call your NSK territory manager, Angela Glasgow, on 07525 911 006 or visit www.nsk-uk.com

Buying a practice

STARK MAIN & CO. DENTAL HAS HELPED COUNTLESS DENTISTS ACHIEVE THEIR DREAM OF PURCHASING A PRACTICE THANKS TO THE FIRM'S WEALTH OF FINANCIAL EXPERTISE

IAN MAIN

At Stark Main & Co Dental we have helped many ambitious associates or existing practice owners to realise their dreams of acquiring a new practice. Our expert knowledge in this sector allows us to assess the commercial viability of the acquisition to ensure that what might be the biggest investment of your life is financially sound and does not put your wealth, health and happiness at risk.

During this process, we pride ourselves on having a 100 per cent record in achieving finance offers for every practice acquisition we have been involved in.

The current finance availability remains strong and, despite the rising values of goodwill at present, most of the specialist healthcare finance providers see the sector as a real "green light" opportunity to offer funding.

We recommend that a process of what's known as 'matching' finance is undertaken to ensure that the syndicated package of finance you use to acquire the practice is in line with the lifetime of the assets involved.

Normally we will use a combination of mainstream bank finance (predominantly term loan) and short-term working capital sources. In addition, we may suggest 'secondary' lenders and asset finance to fund any capital expenditure which may be required. We can assist with other finance sources and can leverage them to best advantage where there is a shortfall and perhaps avoid the need in some cases to rely on your own capital reserves or the "Bank of Mum and Dad!"

Presently for any associate wishing to purchase, a minimum you will need is a deposit of 10-20 per cent to acquire, however, we ensure your deposit increases your spending power dramatically and allows you to benefit from the spoils of your return on investment.

We continue to introduce our ambitious practice owners to others looking to exit within our portfolio and beyond. If you would like to discuss acquiring your first or next practice and whether the finance deal you have been offered is commercially competitive, or indeed, if you are looking to raise finance and don't know where to turn, we would be delighted to hear from you.

MORE INFO
To get in touch with Ian, call 0131 248 2570, or email ian@starkmaindental.co.uk

The paperless practice

AS THE MOVE TOWARDS THE PAPERLESS PRACTICE GATHERS PACE, IAN HAMILTON FROM SOFTWARE OF EXCELLENCE LOOKS AT THE IMPLICATIONS FOR SCOTTISH PRACTICES

As we all know, currently there are two ways to submit GP17 forms; either through Electronic Data Interchange (EDI), or on paper. However, this is set to change in the near future.

Practitioner Services recently circulated a letter to Scottish dental practices announcing the launch of the eDental payment and approval modernisation project. The document suggests roll out of this project may be towards the end of 2016.

A key aim of the project is to create a facility through which all practices in Scotland can submit claims electronically and, crucially, to make electronic submission mandatory.

The project is seeking to:

- Improve existing EDI functionality
- Create a new web form enabling submissions to be sent electronically for those practices without a computerised Practice Management System (PMS)
- Support the movement towards a streamlined approach for prior approval, thereby aiding decision making
- Be able to report data more accurately.

What you need to do:

If your practice uses a PMS and submits EDI claims then you don't need to take immediate action, Practitioner Services and the Scottish Dental Practice Board, who jointly chair the project, are liaising with PMS suppliers regarding any changes. However, if your practice submits claims on paper you will have these options:

- Use the web form
- Continue to use paper until such time as electronic claiming/prior approval is mandated
- Move to a PMS and submit electronically, or in the case of those with a PMS system, move to EDI submission immediately.

Practices still submitting paper GP17s will need to consider their processes such as the time/cost involved in inputting all the data to the new web form compared to implementing a practice management system, and weigh up the potential benefits of both these approaches.

The time to consider these options is now. This will allow you to make an informed choice and implement changes to your business processes in plenty of time and with minimum disruption.

Software of Excellence is the global leader in providing dental practice management software and marketing solutions to dentists and dental professionals. They are members of the Association of Scottish Dental Professionals, an association of dental experts dedicated to supporting the dental profession in Scotland.

SOFTWARE OF EXCELLENCE
A HENRY SCHEIN COMPANY

MORE INFO

For more information, contact Ian Hamilton, regional business manager on 07814 370 797 or email ian.hamilton@soeuk.com

Are you braced for the unexpected?

STUART PETRIE FROM ANDERSON ANDERSON & BROWN LLP EXPLAINS THE BENEFITS OF BUSINESS PROTECTION ARRANGEMENTS

STUART PETRIE

Have you planned for the future of your practice? In addition to recruiting and retaining a new generation of dentists, financial planning needs to be undertaken to ensure that the practice can buy out the interests of retiring partners.

Even with planning in place, funding this payment can prove problematic, particularly when an exiting partner is entitled to a share of the goodwill and property values. So what if this funding requirement is unexpectedly sprung upon your practice due to the sudden death of a partner?

Would your practice have sufficient funds to make the payment due to the partner's estate? Or, would you and the other partners be in a position to inject the capital required?

The future of your practice could be put at serious risk if you do not have appropriate arrangements in place to allow the required payment to be made. This risk can be eliminated quickly, effectively and relatively inexpensively by putting business protection arrangements in place whereby:

- Each partner takes out a life assurance policy
- An agreement is put in place for the continuing partners to acquire the deceased's interest from the estate
- The proceeds from the policy can be used to fund the payment.

The precise structure of such arrangements can vary and specialist advice should be sought to ensure that your practice implements the structure most appropriate to it. By introducing a trust into the arrangement, it is also possible to secure a tax efficient structure which allows more of the value of the partner's interest to pass to their family and not to the tax man.

Business protection arrangements therefore help secure the future of your practice, while also delivering benefits to the family of the deceased partner at a time when they need it most.

MORE INFO
Stuart Petrie is a private client tax senior manager at Anderson Anderson & Brown LLP

Considering an exit?

IN RESPONSE TO INCREASED DEMAND FOR DENTAL PRACTICES IN SCOTLAND, SPECIALIST ADVISORS CHRISTIE + CO HAS RECENTLY EXPANDED ITS DENTAL TEAM ACROSS ITS OFFICES IN EDINBURGH AND GLASGOW

PAUL GRAHAM

For practice owners considering an exit strategy, it is encouraging to know that currently demand exceeds supply for dental practices in Scotland. When marketed properly, not only does this create a safety net by having competition to buy, it also ensures the best possible price for your practice is being achieved.

As 2015 draws to a close, it is an appropriate time to consider what your plans are for 2016, a principal owner considering retirement involves much more than just giving up work. You will have worked hard to build and nurture goodwill that you wish to ensure is not only maintained but will flourish further.

Aside from Christie + Co providing a realistic appraisal for your practice, there are a number of aspects in the mix that need to be working coherently in order to ensure a smooth and successful sale.

There are three main buyer profiles: corporates, multiple operators and independent/first time buyers. The current demand from buyers is a major catalyst for activity and each purchaser type has its strengths and weaknesses. On the dental transactions that Christie + Co are instructed on, we act for the seller and therefore have no conflict of interest when speaking to a wide audience of buyers. This helps ensure a healthy and fair bidding process.

Banks see dentistry as a 'green light sector' and are lending heavily in it.

Relative to other sectors, such as social care, the dental sector has been very resilient during the recession. Funding is readily available from many high street and specialist lenders.

The allure of all types of dental practices in Scotland continues to attract buyers from across the UK and this is enhanced by the fact that the average value versus turnover for practices in Scotland is still considerably behind that of the English market. Recent reports announcing a new low for dentists' income will also create drive for the more entrepreneurial associate/buyer looking to take charge of their first practice.

As we head into a more sustained economic recovery, buyers are becoming more confident and overall this is driving activity.

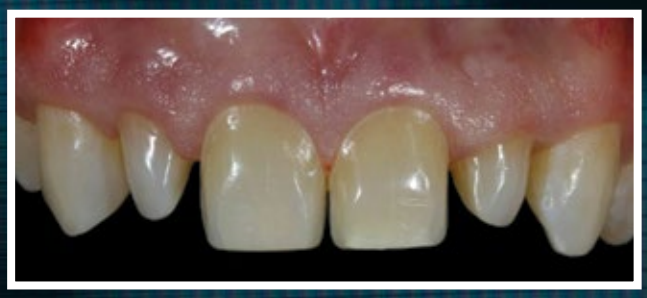
MORE INFO

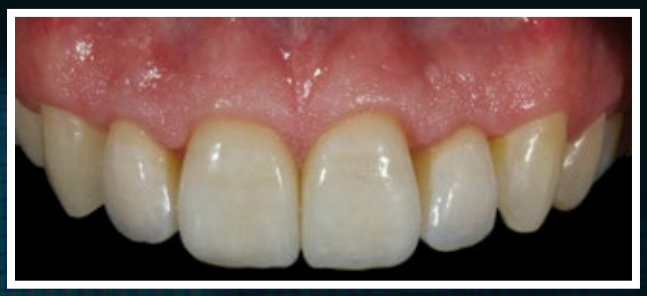
With years of experience valuing businesses across many market sectors and experts located across the UK, Christie + Co understands the significance of local knowledge in ensuring the optimum values are met.

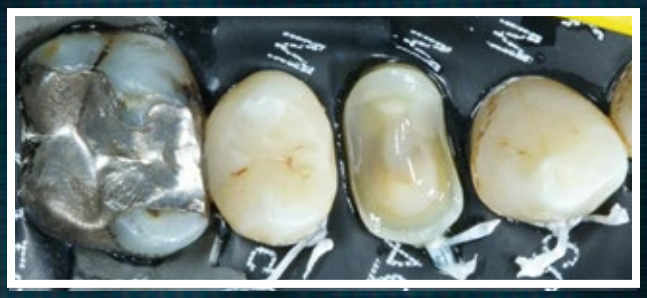
To discuss how Christie + Co might help you achieve your future plans, please contact Paul Graham on 0131 524 3416.

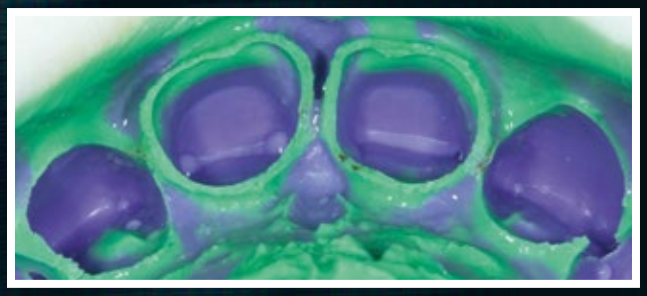
THE PREP COURSE

JASON SMITHSON









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A RELATIONSHIP BUSINESS

TARIQ ALI, OF THE CENTRE FOR IMPLANT DENTISTRY IN BISHOPBRIGGS, ON THE IMPORTANCE OF WORKING IN PARTNERSHIP WITH REFERRING PRACTITIONERS

Coming from a general practice background, we are fully aware of what it's like to refer a patient for implant therapy. In the middle of a busy day, it can be difficult to choose where to refer to and it is often the first name you can think of that gets the referral.

We appreciate that you have long-standing relationships with many of your patients so it is important to feel comfortable with the implant partner you choose. After all, you want the best for your patient and they trust you for advice. So, when a colleague asks us to see their patient, we feel duty-bound to give that person the best level of service possible.

But what does that really mean? Well, firstly, your patient remains your patient. In addition, because we only do implants, we refer your patient back to you for any other work. By far and away the most successful way of working with our referring dentists is working together in true partnership.

We believe that you, as a referring dentist should become involved in your patient's treatment, ideally restoring your own cases. It's something different and brings value to your patient and your practice as a whole. So, in partnership with Dentsply Implants, we provide the Implant Restorative Programme, which involves free training with a free restorative kit so you and your team are competent to carry out your new implant role within your practice.

It's easy to refer to us, just contact us in the usual way and we will take care of the rest. Your patient will be offered an appointment within a week and we always alert then to associated costs. Not everyone is suitable for implants so that's why their first appointment with us is free. We will also keep you informed at every stage.

We offer all kinds of implant therapy, from simple advice, to referrals for CBCT scanning, implant placements and block grafting. A popular treatment has been the introduction of intraoral welding which allows us to provide edentulous patients with a fixed, fully restored arch using a durable titanium framework, all in one day.

MORE INFORMATION
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The Beauty of Dentistry

BRANCHING OUT

ENTREPRENEURIAL HUSBAND AND WIFE TEAM EXPAND THEIR COLLECTION OF DENTAL PRACTICES FROM TWO TO THREE WITH NEW KILWINNING BASE

RICHARD GOSLAN

When their new practice opened in Kilwinning at the end of July this year, it marked the latest expansion in operations for husband and wife team Simon and Sharon Morrow.

The practice has its origins in Saltcoats in Ayrshire, where Simon took over when he completed his VT year after graduating from the University of Glasgow in 1996.

After meeting Sharon, the couple designed and built a completely new practice in Stevenston, which opened in 2010, and then five years later expanded further, converting a shop unit in Kilwinning.

For operations director Sharon, the decision to grow the practice was a natural one.

"Both Simon and I are quite entrepreneurial, we're quite like minded in that way, and for us it was about recognising that there was a need in this area for high quality NHS dental care," says Sharon.

"At first we weren't sure about going for it, because Kilwinning is quite near to our other two sites in Saltcoats and Stevenston, but we recognised that if we didn't do it, somebody else would. I feel a big pull towards my staff, and if somebody else had opened in Kilwinning, we could have lost patients there.

"The new practice has also allowed us to meet demand for ground floor premises, which has been a big issue in Kilwinning, and the feedback from patients has been really positive. Previously, it was a struggle for patients with mobility issues, even for parents with their prams, but not any more."

As well as architects Stewart Associates, Sharon involved the existing staff from the Three Towns Dental Care in the planning period and decision making when it came to choosing equipment such as the Belmont chairs as well as the practice furnishings and other items sourced through Wrights. This, she feels, emphasises the teamwork that now takes place across the three different sites.

"Most of our staff work between the sites, so even though we have different premises, it's very much a full team effort," says Sharon. "I tried to include everyone in the planning for Kilwinning and involve them as much as possible with what was going on. That's been a big part of it."

Having the experience of already running two practices also informed decisions relating to equipment and what innovations it

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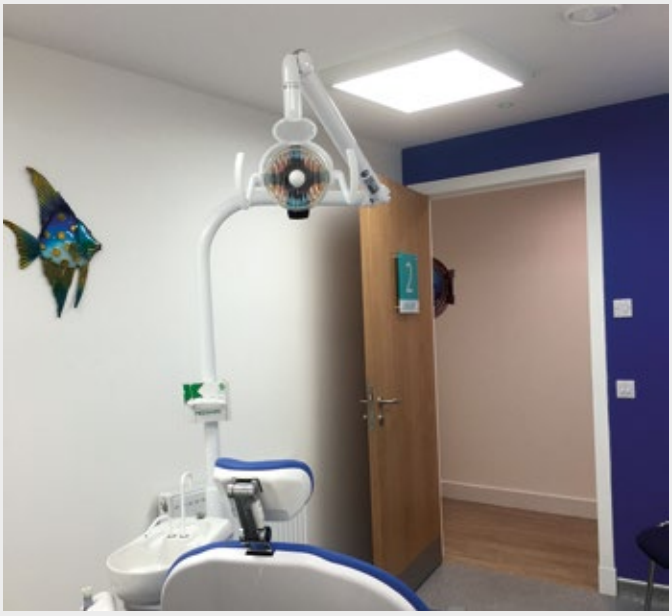

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might be possible to introduce. One area Sharon was determined to make a difference was in running as close to a paperless practice environment as possible, and Kilwinning gave her the opportunity to try to reach that goal.

"Going paperless was one obvious step, it leads to less administration and less scanning, so we opted for the Carestream Clinical+ practice management software, along with the e Forms electronic signature pad," says Sharon. "That has been a slight change to how we work elsewhere, but all the staff now know how to operate it and they enjoy using it.

"So we're using that experience with the aim of passing it on to the other sites. It's all about doing things in small steps, and gives us a chance to try something out first before introducing it elsewhere."

With two surgeries, the Kilwinning practice offers additional NHS services, with sedation, orthodontics and oral surgery. Three Towns Dental Care is also involved in a number of different pilots, including the Keep Well health programme that is aimed at increasing the general standard of health in 30 to 64 year olds in the local community.

The programme focuses particularly on early intervention for people at high risk of coronary heart disease and diabetes to help them modify their lifestyle.

"The additional services often reduce the need for our patients to travel to other NHS service providers such as the PDS or Crosshouse hospital," says Sharon. "We try to do what we can to make things easier for patients."

Sharon originally studied general nursing and then went on to do a degree in health and social care, with a focus on health promotion, particularly among children. That background in general health – combined with a qualification as a dental nurse in 2010 – gives her a wide range of experience that she brings to the three practices.

"We don't only look at the mouth, we look at the patient and take a holistic approach to what we do," she says. "That is demonstrated by us being involved in other projects in the practice around a pilot for early intervention for children and young people. We also are looking at expanding our Childsmile service to provide better access for children with additional needs. Both Simon and I firmly believe you need to look at the bigger picture, and we have a duty in our roles to improve public health. We certainly share the same ethos in that respect."

The husband and wife team also work well together – although Sharon says they often don't even see each other until they're both at home in the evening.

As well as his clinical work, Simon is involved in supporting newly qualified dental graduates and is also a dental practice and sedation inspector for NHS Ayrshire and Arran, and a sedation practice inspector for NHS Greater Glasgow & Clyde and NHS Lanarkshire.

He is past chair and current member of NHS Ayrshire and Arran's Area Professional Dental Committee and a member of the National Dental Advisory Committee, as well as sitting on several other committees.

"With so many interests outwith the practice, it's important he can fulfil those duties as well as his clinical commitments," says Sharon. "But even if he's in surgery, we don't see a lot of each other during the day – and we do try to escape the subject of dentistry in the evenings!"

With three practices now up and running, involving a total of 35 staff, and three children aged between 10 and 15 at home, Sharon and Simon certainly have their hands full – but for a perfectionist such as Sharon, there is always more to do.

"When we finished building and then opened the practice at Stevenston four years ago, and it was doing very well, somebody asked me what our next project would be," she says. "I said at the time that there was no way we were going to be opening anymore, and a few years down the line here we are!

"But at this point I don't see any further expansion taking place. It's more about maintaining a good reputation and a high quality service for our patients. It's important to me to continually monitor how we're doing and continually investing, whether it's in the building or in staff training or technology. In this day and age and in the current market, you can never sit back and say, well that's it, we've done our job."

MORE INFORMATION
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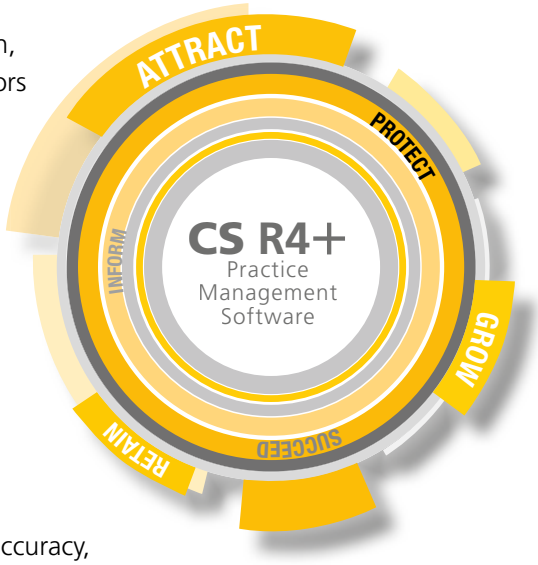

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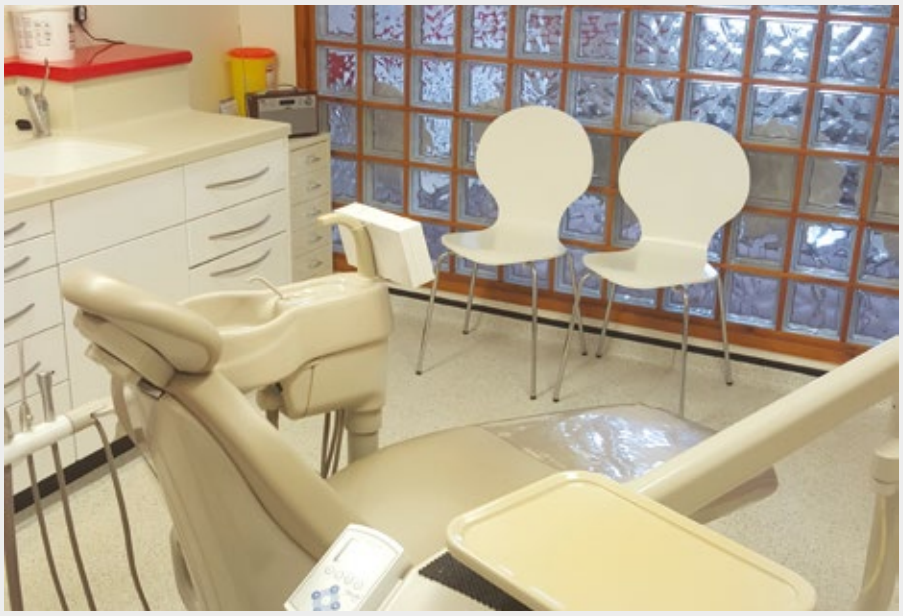

FROM STRENGTH TO STRENGTH

BRUCE OXLEY

ST ANDREWS ORTHODONTICS OPENED ITS DOORS ON 15 JUNE 2012 AND HAS FIRMLY ESTABLISHED ITSELF AS AN INNOVATIVE TREATMENT PROVIDER

One of the main success stories for St Andrews Orthodontics has been the establishment and development of strong working relationships with local dental practices and hospitals.

To cope with the demand for orthodontic treatment and to compensate for reduction in the local hospital orthodontic service, its clinical hours have been increased and the practice has added an experienced orthodontic therapist to the team. In response to patient feedback, owners Nimo Rostami and Nick Baker have also put special emphasis on developing the practice's facilities and the environment.

Over time, St Andrews Orthodontics has built up a large number of NHS and private patients. While providing the standard "every-day" range of orthodontic treatments, it has also focused on offering the latest cosmetic and discreet appliances. Mr Rostami has developed a vast wealth of experience in using fixed lingual appliances and clear aligners over many years.

He said: "For me, currently, there is no single lingual technique that is suitable for all patients. As such I use a wide range of lingual appliances, such as Incognito, Harmony and eBrace. I also use a wide range of aligners, including the well-known American Invisalign or the less widely recognised German Ortho Cap.

"We also take pride in trying to engage with our dental colleagues towards helping them with multi-disciplinary cases, aiming to provide the best pre or post-orthodontic solutions possible. This is how we soothe our nostalgia for general dentistry!"

As most colleagues involved in managing a practice will agree, staffing is one of the most challenging issues to address successfully. Nimo added: "I will admit that on occasion we have got it wrong, however, we feel that we have now developed a great team with friendly and responsive staff.

"We now have two receptionists/admin staff and three qualified dental nurses with extensive professional knowledge within orthodontics. All of our nurses are able to extend their duties to such tasks as taking dental impressions, clinical photographs and clinical radiographs, as well as making retainers within the practice to enable a quick turnaround for patients who have had their fixed appliances removed."

St Andrews Orthodontics was the finalist in the Scotland's Dentist Award 2013, which Nimo admits "made us all feel more energetic and motivated to push this wagon further forward".

Along with orthodontic practitioners Nimo and Nick, Shirley Rankine, an experienced orthodontic therapist, who qualified in Leeds, joined the practice last year.

Nimo continued: "We are very proud that, for the last three years, we have not resorted to a waiting list for our patients.

"It is a key part of our commitment to providing a responsive and flexible local service that our team continues to work hard to avoid the need for one. For the convenience of referring clinicians we accept referrals via post (referral pads are available upon request), telephone and electronically on our website.

"We look forward to welcoming you and your patients to St Andrews Orthodontics."

MORE INFORMATION
www.standrewsorthodontics.co.uk

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Situated in Glasgow's West End, with ample parking and good transport links, Park Orthodontics accepts referrals for adults and children, both NHS and private. The three-surgery clinic has been refurbished to give the practice a fresh, contemporary feel, which patients love and feel instantly at ease in.

All referred patients are assigned to their personal orthodontist, who they remain under the care of throughout treatment. After a comprehensive orthodontic assessment, patients and parents are suitably informed to choose from the full range of treatment options, both NHS and private, ranging from quick fixes to complete corrections.

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MORE INFO

To get in touch, email manager@parkorthodontics.co.uk, visit www.parkorthodontics.co.uk or call 0141 332 5107.

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CRAIG IS TAKING THE CLINICAL LEAD

SPECIALIST ORTHODONTIST DR CRAIG BRIDGES JOINED THE ALL 1 SMILE GROUP IN FEBRUARY 2014 AFTER A LONG AND HAPPY CAREER IN DENTISTRY AND ORTHODONTICS AS PRACTITIONER, CLINICAL MENTOR, HOSPITAL SPECIALIST AND AUTHOR

Craig graduated from Glasgow University in 1974 and his career has seen him spend time in Missouri, Boston and latterly in Gloucestershire. After an extensive cardiac problem, Craig effectively retired from full-time practice in Gloucester City. However, once recovered, he was delighted when George Campbell, a fellow specialist, invited him to take over as clinical lead in his successful Hamilton orthodontic practice.

He started in February 2014 and soon was also doing a small list in the East Kilbride practice.

Craig practises bioprogressive orthodontics taught to him at Washington University at St Louis School of Dental Medicine, which uses extremely light forces and no extractions wherever possible. Since 2002, he has been an exponent of the Damon system of self-ligating orthodontics, which uses light force along with gentle self ligation. This approach achieves maximum mid-face development and brings the mandible upwards and forwards, resulting in a better airway. Due to their cost, Damon braces are available on a private basis from Craig and he would be happy to speak to interested practitioners about these appliances.

CLINICAL TIP

Remember, Class 11/2 cases are cephalometricaly Class 111 cases "trying to escape" per se. The upper arch needs to be developed to allow for the sagittal and vertical problems.

Therefore, advance the maxillary incisors, then treat the case functionally, basing the Tx around the lower arch. It is better to advance the maxillary anteriors and advance the mandible functionally (ie. Twin Block) thus enhancing the facial profile and the pharyngeal airway. So, "face and braces".

Remember, LOOK AT THE LOWER ARCH FIRST and consider extractions for pathology only. If in doubt, we are all on the end of the phone at any All1Smile centre for a chat.

ORTHODONTIC REFERRALS AT SCED

A welcome addition to the referral services offered at the centre is a range of NHS orthodontic treatment for children under 18 years.

These treatments include removable/functional appliances and fixed metal braces. In addition to the NHS treatments available, the centre offers private orthodontic treatments to all age groups, which include the services above as well as tooth-coloured ceramic braces, lingual braces and Invisalign.

All orthodontic treatments will be carried out by the highly experienced Yannis Levisianos, specialist in orthodontics. Graduating in 2005, Yannis has concentrated on his orthodontic postgraduate education since 2007 and he was appointed as a specialist registrar at the Eastman Hospital in London in 2008. In 2010, he was awarded an MSc in orthodontics from the University

of London and, during this time, he undertook his research degree in muscle cell regeneration, for which he was awarded the Houston Prize by the European Orthodontic Society.

In 2011, he gained his MOrth from the Royal College of Surgeons of England and was awarded the prestigious JK Williams Gold Medal as the top-performing candidate in the Royal College examination.

His clinical interests are varied and include orthopaedic/functional appliances as well as many of the multi-disciplinary aspects of adult orthodontics. He joined the Scottish Centre for Excellence in Dentistry team in 2014 and has been carrying out extensive orthodontic treatments since that time.

The centre has, for the past six years, offered an all-encompassing referral service to dentists and their patients and has been recognised as the Best Specialist Referral Practice in the United Kingdom.

MORE INFO

For information on referring patients or for a referral pack, call 0141 427 4530 or email secretary@scottishdentistry.com

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INVISALIGN ON STAGE

More than 6,000 delegates converged on London for the World Orthodontic Congress, hosted by the British Orthodontic Society, recently.

On the second day, more than 1,000 delegates attended the Invisalign satellite symposium to hear from experts about the biomechanics of tooth movement and the clinical treatment of increasingly complex malocclusions with the Invisalign clear aligner system.

In the first presentation, by John Morton, Director of Research and Technology at Align Technology, explained the science behind the Invisalign system and the biomechanical principles used to achieve greater control of tooth movement.

The second part of the symposium saw Mr Morton being joined by Dr David Couchat, who shared his early experiences of InvisalignG6. Dr Couchat, who treats all his patients with Invisalign clear aligners, demonstrated how a wide variety of malocclusions can be treated with the clear aligner modality.

MORE INFORMATION
To learn more about InvisalignG6 and discover greater possibilities for treating with Invisalign clear aligners, visit http://invisalign-g6.com/en-GB/

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Prof Paul Tipton lecturing at L&T Dental Group CPD Day

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PUTTING THE L&T IN DENTAL TEAM

DENTAL GROUP'S CPD DAY HIGHLIGHTS ITS APPROACH TO SUPPORTING AND NOURISHING THE DEVELOPMENT OF ITS STAFF

Professor Paul Tipton was the star attraction at the at the recent CPD Study Day hosted by L&T Dental Group.

More than 75 staff and 10 guests were in attendance at the five-star Blythswood Square Hotel on 31 October for a day of world-class CPD. Adam Morgan moderated the event and he also featured alongside L&T partner and clinical Director Dr Abid Faqir for the day's first presentation entitled 'Dental implants – an overview for GDPs, common misconceptions and communication stumbling blocks'. Abid and Adam were joined on stage by a patient treated by Abid and the audience had the opportunity to ask the patient about the journey through implant therapy.

Abid also announced the launch of the Esthetic Alliance programme to all L&T Dental Group associates who wish to become more involved in dental implant treatment and, at the same time, maximise their earning potential. The Esthetic Alliance programme is being conducted in collaboration with Nobel Biocare and consists of set modules. It is both lecture and hands-on based.

That was followed by Glasgow graduate Dr Jameel Gardee, who spoke about digital smile design, with a lot of the staff being overwhelmed with what can now be achieved with digital dentistry.

Sandy Littlejohn from DTS then presented on the importance of and how to take 'better impressions', before L&T partner Dr Ferhan Ahmed described the recent aid trip by the Dental Aid Network charity to Kashmir.

The afternoon belonged to Prof Tipton and delegates were captivated by his 'Top Tips for GDPs' presentation.

Host Adam Morgan said: "The day went so quickly thanks to a group of fantastic speakers and well-crafted presentations. There was a great atmosphere of fun and enthusiasm from start to finish, which is very typical of L&T Dental Group events, and a great deal of excitement for the topics that were being shared throughout the day.

"For me, the best part of any event like this is the look on people's faces during the presentations – I love to see that moment in a person's eyes where their passion or motivation goes up a gear. There were many moments like this during the event."

Margarita Kapsazova, an associate dentist at Shawlands Dental Care, said that she has already implemented some of the lessons from the study day into her clinical practice. She said: "I thought the day went very smoothly and was packed with a lot of different presentations, which kept it interesting. The audience was definitely engaged throughout.

"I found the advice from Sandy Littlejohn about impressions assessment and the influence of distortions on poor fit, as well as the occlusion adjustments advice from Prof Tipton, really interesting. So much so, that I have already implemented these ideas into my daily practice."

Dr Neil Bremner, also an associate at Shawlands Dental Care, said: "At the moment, dentistry is evolving from traditional techniques to 21st-century digital planning and high-tech treatment options from surgery to laboratory. We must move our dentistry forward or be left behind, which is why events such as this are so important.

"For me, the main things I took away from the event centred on the idea that the treatment of occlusal disease is under utilised. Time is needed to identify and treat patients who would otherwise suffer unnecessarily."

Neil also said that he is flourishing in the environment that the L&T Dental Group has created. He said: "Since I've been working at Shawlands, the standard of my clinical dentistry has been pushed forwards – there are always new challenges and opportunities available for us.

"What sets L&T apart are the constant academic challenges and high clinical standards aspired to by everyone, from the partners to the nurses, therapists and associates. We can all improve ourselves, our attitude, skills and knowledge."

As well as hosting their events, Adam works with the group's partners to enhance the reputation of the company and provide strategic support. He said: "The culture at L&T Group is very different to that of other practices or groups of practices, which is one of the main reasons I have become so involved with them. The team are treated like friends and there is a strong emphasis on having fun and treating every team member and patient like the most important person in the world.

"As a group of dentists, we meet every six weeks to train and study cases together – not only clinically, but also to see how we could have communicated better, planned better or given the patient an even better experience at one of our practices."

MORE INFORMATION

L&T Dental Group has clinics throughout Scotland and was founded by two long-time friends Abid Faqir and Arfan Ahmed. If you think you would like to join the team at L&T, please feel free to email theirs operations manager alex@lantdentalgroup.co.uk – they would love to hear from you.

TOP TEN

ADAM MORGAN EXPLAINS THE BENEFITS ASKING THE RIGHT QUESTIONS CAN HAVE IN BUILDING STRONGER AND MORE PROFITABLE RELATIONSHIPS WITH YOUR PATIENTS

ADAM MORGAN

Asking good questions – and by good, I mean the person who is replying to you gives more than a superficial answer – is actually pretty tough. When you are in the heat of the moment, have a patient in your chair and are ready to roll, it is so easy to get into the groove of asking the same questions over and over again, just to different people throughout the day.

There are so many missed opportunities to speak about alternative treatments, create stronger relationships with people or create moments of personal connection with patients. We get so busy with our routine that it can be hard to break out of that cycle. For others, it can be hard asking personal questions as we are afraid of not being "professional" or being seen as rude or invasive. When it comes to the way people create bonds with you as their healthcare professional – this personal connection is truly vital and the only way to get it is by asking great questions that do more than skim the surface.

UNCOVERING THE TRUE MOTIVATION

This is one of the easiest ways to visualise the impact our questions have and how best to direct them to uncover what is truly important to someone. This not only helps to build strong relationships, but also helps uncover what a person's motivation is for choosing a particular treatment.

Before we get into asking questions, there are two types of needs that people have – those we can see (above the waterline on our iceberg) and those we can't. Often we ask questions to what we can see, which is usually the easiest place to start. The trouble is, most people only ask questions to the obvious needs a person may have and they do not go below the surface to find the real issues, desires or wants – and this is where the real value is.

CONVERSATION STARTERS

So, to begin my top 10 questions, you should start off your conversation with a good open ended question that will get the ball rolling. Some of the best conversation starters are:

1. "WHAT DO YOU LIKE MOST ABOUT YOUR TEETH?"

I prefer this question to the negative alternative "What do you not like about your teeth?" because, when building relationships and trust, research shows us that people usually feel happier sharing things they like about themselves than things they don't. When this is asked in a positive and caring way, the patient and dentist relationship is strengthened.

2. "HOW IMPORTANT IS YOUR SMILE TO YOUR DAY-TO-DAY LIFE?"

This question, when asked in the right way, can open a very deep and personal conversation with the patient.

The patient can answer in any way and you will get a whole host of replies. I often hear people say: "I really want a nice smile to look and feel younger" and "My smile is very important to me because I am dealing with people all day long".

3. "IF YOU COULD CHANGE ANYTHING ABOUT YOUR SMILE, WHAT WOULD IT BE?"

Once the conversation is flowing and the patient is sharing how they feel about their teeth, it is now the right time to ask what they would like to change. If this question is asked too soon, patients can often feel under pressure and say "nothing," or feel like they are being sold to. We have all been in that situation when someone has asked "What don't you like about it?" and then proceeds to say "Well I have this new shiny solution that will solve all of your problems?!" – no one likes that!

4. "IF MONEY WERE NO OPTION, WHAT WOULD YOU LIKE YOUR SMILE TO LOOK LIKE?"

This is another good question that opens the conversation up to finding out what the patient likes and dislikes about the look or functionality of their teeth in a non-threatening way but can open avenues that can be explored later on.

WHAT TO DO

With these big picture questions, be sure to sit close to the patient, ideally to one side or in front and, if possible, try to ask these questions when the patient is not in the dental chair. If you have space in your surgery, put two individual seats in there that are the same height and use these for your conversations – these should be your 'talking chairs'. Patients feel much more relaxed and in control when they are at eye level with you and do not have the same levels of anxiety as when sat in the dental chair.

When you are asking questions, make sure you have a notepad and pen to hand and make notes as the patient is answering you. This serves two purposes:

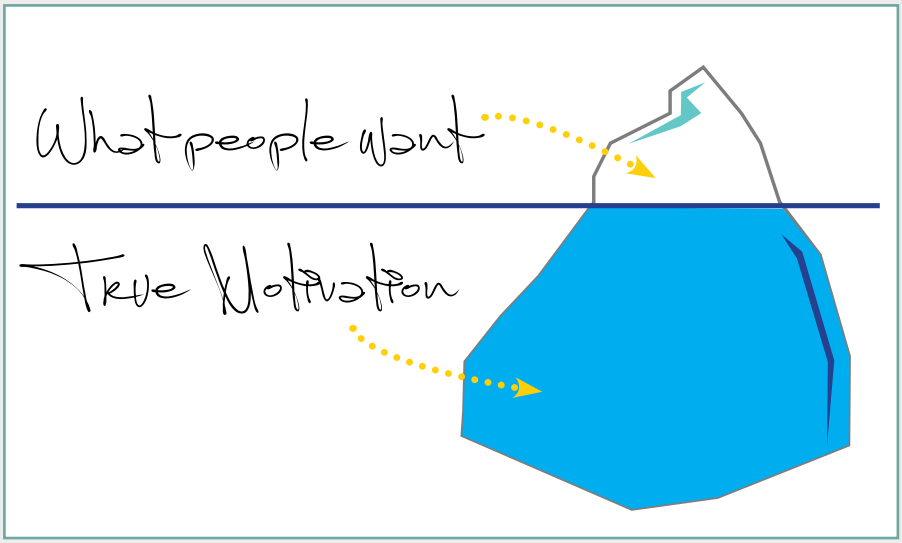
1. To give you a record of what is being said, so that you can refer to it as you continue to talk. Let's face it, some of us forget what has just been said within seconds! So make sure you write exactly what they are saying down – in their own words not yours.

2. It shows the patient that you care enough about them that you are taking the time to write down what they are saying – this is very powerful in building trust.

GET SPECIFIC

Once you have got the conversation started with these open questions, it is time to get specific and find out exactly what someone means by what they are saying. This might sound obvious, but this is the most frequently missed part.

OFTEN, WE DO NOT ASK THESE TYPES OF QUESTIONS FOR FEAR OF SEEMING INVASIVE, BUT THE TRUTH IS THAT YOU DO HAVE THE ABILITY TO CHANGE SOMEONE'S LIFE FOR THE BETTER



Have you ever heard the saying "The issue is never the issue?" It is so true! We all interpret things and say things that have completely different meanings all the time. For example, if I asked you what does good customer service look and feel like to you? You could reply with a whole host of answers: to feel special, to listen to what I need, to be quick and efficient, to be kind and friendly, to smile, etc – the list goes on. However, we often assume to know why someone wants a treatment, service, or product, but unless we ask "why" the truth is, we really don't know – we assume to know – and that is dangerous ground. When we know and discover what the real motivation is, the patient then feels like you understand them and are able to give them what they want.

So, once the conversation has started and the patient has answered our first open question(s), it is time to get specific and find out "why".

5. "WHAT DO YOU MEAN BY…?"

When anyone says they want, like or dislike something, I ask them what they mean by that. For example: "What do you mean by wanting straighter teeth?" At this point the patient will usually point or show you the teeth they are unhappy with and my next question would be:

6. "WHAT SPECIFICALLY ABOUT THIS BOTHERS YOU?"

This is a very good question that digs deeper and gets the patient talking about their personal motivation for wanting to have treatment. Make sure you make a note of exactly what the patient says here, as this will form the basis for how they will either go ahead or not go ahead with any treatment you talk about at a later stage.

7. "WHY IS THAT IMPORTANT TO YOU?"

Asking why something is important to someone is a great way of taking the conversation to a deeper level very quickly. If possible, always tie in the answer to the question before, such as: "Why is it important to you to have no space after having this tooth taken out?" This not only shows the patient you are listening, but it also shows that you care and understand what is important to them personally after they have left your surgery.

8. "WHAT IMPACT WILL CHANGING THIS HAVE ON YOU?"

This is a very personal question that must be asked in a caring and thoughtful way. I would encourage you to ask this whenever you feel it is appropriate. I call this a "bonding question". It stops being about the treatment, product or service and now is all about them as an individual and what is most important to them and their lives. Often, we do not ask these types of questions for fear of seeming invasive, but the truth is that you do have the ability to change someone's life for the better and talking about this not only builds strong levels of trust but may allow a patient to overcome any anxieties they may have about proceeding with their chosen treatment.

THE RECAP

Once you have dug deeper and uncovered what is most important to someone, what their biggest concerns are or why they truly want to have a treatment, it is then time to summarise and recap what the patient has told you. At this stage your notes come in extremely handy! Unless you have an incredible memory, this is where I would utilise my notes to summarise everything the patient told me. Do this using recap questions such as:

9. "SO, FROM WHAT YOU'VE SHARED WITH ME, I UNDERSTAND THAT YOU WANT TO HAVE STRAIGHTER TEETH AND THE REASON YOU WANT TO HAVE THESE TEETH STRAIGHTENED OUT A LITTLE IS BECAUSE YOU FEEL THIS WILL HELP BOOST YOUR CONFIDENCE GOING FOR JOB INTERVIEWS – IS THAT RIGHT?"

This question recaps everything the patient told you and their reason for wanting the straight teeth – that is the most crucial part as it now flags what is important to the patient and also strengthens the bond between you both. You have now demonstrated that you care and understand how you can truly help them. At this stage you can start to discuss the individual treatment options. I will cover this in more detail in my next article.

10. "BASED ON EVERYTHING WE HAVE TALKED ABOUT, WHEN WOULD YOU LIKE TO START THIS?"

At the end of your fact finding conversation, always ask when the patient would like to start their treatment journey. Most often, patients will be happy to start treatment soon after their appointment if you have uncovered their real motivation for wanting treatment. Other patients will be unsure and want to think about all of their options at home. In that case, ask the patient if they would like you to call them a few days later to answer any questions they may have. Again, this goes a long way in building trust and respect.

Asking these 10 questions will unlock much deeper levels of conversation with your patients and will create more opportunities, increase treatment uptake and solidify relationships between you both. It is so true that the simplest of things are often the most powerful, but often the hardest to master – and for me, asking great questions falls into this category. Go for it, ask great questions and talk to your patients on a deeper level. The reward is well worth it.

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To find out more, call 0208 756 3300 or visit the website at www.nobelbiocare.com

BRAEMAR FINANCE LAUNCHES FAST TRACK FUNDING SOLUTION

Braemar Finance has launched its new funding solution, Fast Track, which enables dental customers to apply for a credit facility to finance a selected procedure, treatment or specific professional service.

Fast Track is designed both for sole practitioners/small partnerships and larger corporate groups who want to be able to offer a no-frills funding option to their clientele.

It is available online and consumers can either request funds while at the dental practice or at home at a time that suits them. End users will then be provided with an instant decision to their application.

Professional services firms can register for Fast Track by providing Braemar Finance with the relevant information about their business. They will then be offered choices that best suit the SME's business and their customers.

For more information and news from Braemar Finance, visit www.braemarfinance.co.uk

BRAEMAR FINANCE

VOCO'S WORLD FIRST

Admira Fusion from VOCO is the world's first purely ceramic-based universal restorative material. The innovative combination of tried-and-tested nanohybrid technology and ORMOCER technology means that silicon oxide forms the chemical basis for both the fillers and the resin matrix.

This unique Pure Silicate Technology brings a number of benefits. These include a high filler content, as well as extremely low polymerisation shrinkage and a particularly low level of shrinkage stress. At the same time, Admira Fusion is characterised by excellent biocompatibility and very high colour stability.

The launch of Admira Fusion Flow means there is now a flowable version. This material also demonstrates very low polymerisation shrinkage and a low level of shrinkage stress.

For more information, phone 07500 769 613, email info@voco.com or visit www.voco.com

A REVOLUTIONARY SURGICAL GUIDE

Safe, accurate and cost effective, the unique ImplantPilot system reduces the stress of placing implants for the surgeon and patient alike.

Patients are given the option of keyhole surgery with no stitches, reduced time in the chair and faster recovery times when compared to traditional implant placement.

A CT scan of the patient and STL scans taken in the laboratory are merged with the aid of a Lego block fiducial marker and integrated into a software planning system operated by 2ingis. The implants are then digitally placed.

The ImplantPilot guide is suitable for all implant systems. The software cost is £600 annually and the drill kits start from £2,200 plus VAT.

To find out more at www.implantpilot.co.uk

NEW COLTENE PRODUCTS-2015

ONE COAT 7 UNIVERSAL

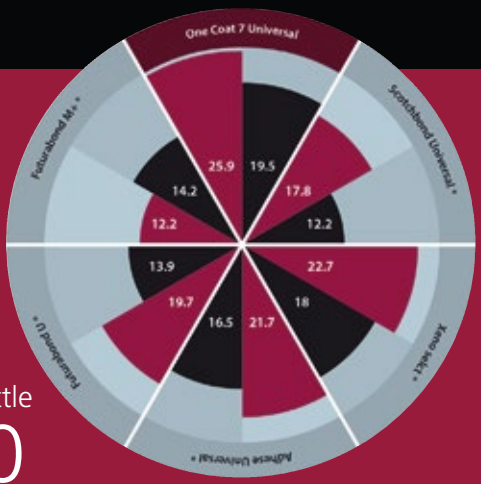
A new concept in Universal Bonding

Always the right choice...no tricks!

- One bond for all cases, direct or indirect restorations
- Excellent shear bond strength
- Bottle and single dose available
- Bonds to ceramic zirconium - no need for primer or silane

Comparison of the shear bond strength (SBS / MPa), Self Etch Technique
Source: Internal tests
* not a trademark of COLTENE

Dentine
Enamel



No waste
New Unique bottle

300 applications per bottle

RISK FREE Trial Kit

ART# 6001 9691
Intro Kit + Free Sample Kit

RISK FREE Single Dose Kit

ART# 6001 9690
Single Dose Kit (50 pcs. + 50 Brushes)
+ Free Sample Kit)

HyFlex™ EDM

New 5th generation of Niti Files

- Advanced production technique reduces breakage
- Controlled memory effect
- Saves time
- Saves money
- Less filing required for treatment success
- Reduced number of files

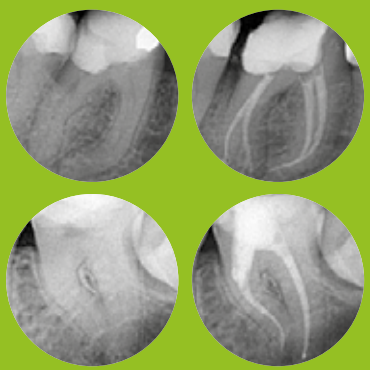
SEQUENCE STEP BY STEP

Glidepath File
10 /.05

HyFlex OneFile 25 / ~

"These files definitely know their way around curves. That's for sure. I love them!"

Dr. Antonis Chaniotis DDS, MDSC



Source - Dr. Antonis Chaniotis

FINISHING FILES
(optional)
40 /.04
50 /.03
60 /.02

Introkit Compact

ART# 6001 9660
Contents: 1x Hyflex Organiser
1x Hyflex EDM Shaping Set + 40/.04 Finisher File
1x Roeko Guttapercha Points
Greater Taper 0.04
Assorted 20-45

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EVEN BETTER ADHESION

All the benefits of the proven Provicol QM, but now with even greater adhesion. Thanks to its enhanced strength, the new temporary luting cement Provicol QM Plus is ideally suited to application in clinical situations requiring particularly high levels of adhesion.

The eugenol-free material contains calcium hydroxide and is indicated for the temporary luting of provisional and definitive restorations (crowns, bridges, inlays and onlays), as well as for the temporary obturation of small, single-surface cavities. With its increased strength, self-curing Provicol QM Plus is ideal for use in clinical situations that require a particularly strong hold. Provicol QM Plus and the corresponding Provicol QM give users the opportunity to select the ideal luting cement on a case-by-case basis.

For more information, phone 07500 769 613, email info@voco.com or visit www.voco.com

LAUNCH OF SCOTTISH NASDAL SECTION

The Scottish members of NASDAL (The National Association of Specialist Dental Accountants and Lawyers) are delighted to announce they have formed a Scottish section of the association.

Partner at Campbell Dallas LLP, Roy Hogg, said: "This formation will allow us to offer our clients in Scotland an even better service. We will still remain very active members of NASDAL as a whole and will continue to share all the benchmarking statistics and benefits that this brings our clients.

"We have set up the Scottish section to allow us to pool our knowledge and expertise on the many accountancy and legal matters that require a keen knowledge of Scottish practices and law. One of the key reasons to choose a NASDAL member is the specialist and expert knowledge that we can provide that others may not be able to. A Scottish section seemed a natural part of this remit."

MF DENTAL ARE SCHÜLKE TEAM OF THE YEAR

MF Dental in Airdrie received the 2015 schülke Infection Prevention & Control Team of the Year award at this year's BDIA Dental Showcase. The award was presented to the MF Dental team by Professor Andrew Smith of the University of Glasgow Dental School.

Speaking at the show Alison McGugan, MF Dental's practice manager, commented: "This award is for the whole team, Murray, Jennifer, Rachel and Lisa. We are a small practice in North Lanarkshire, but we work really hard – with a little help from Allan from schülke.

"All you can ever do is your best, and we do that every day to ensure that our practice is clean and safe for our patients."

Details of the 2016 awards will be announced shortly.

For more information, call 0114 254 3500, email mail.uk@schuelke.com or visit the websiet at www.schulke.co.ukAT

— UPCOMING EVENTS —

WE'VE GOT THIS COVERED

1-30 NOVEMBER
Mouth Cancer Action Month
Visit www.mouthcancer.org

3 NOVEMBER
MFDS Part 2 Preparatory Course
Royal College of Physicians and Surgeons of Glasgow
Visit www.rcpsg.ac.uk/events

12 NOVEMBER
SCED seminar: Update in endodontics
SCED, Glasgow
Email secretary@scottishdentistry.com to book.

13 NOVEMBER
NES CPD/SDPBRN/SDCEP Symposium – Drug Therapies in General Dentistry – Clinical Conundrums
West Park Conference Centre, Dundee
To register, visit https://portal.scot.nhs.uk/ or, email joanne.elwin@nes.scot.nhs.uk

15 JANUARY 2016
Inaugural Scottish Orthodontic Symposium
Royal College of Physicians and Surgeons of Glasgow
Visit www.rcpsg.ac.uk for more information on how to book.

2-4 FEBRUARY
UAE International Dental Conference
Dubai International Convention and Exhibition Centre
Visit www.aeedc.com

18-19 MARCH
BSSPD Annual Conference
Bridgewater Hall, Manchester
Visit www.bsspd.org

22-23 APRIL 2016
The Dentistry Show/Dental Technology Showcase
NEC Birmingham
To find out more, visit www.thedentistryshow.co.uk

13-14 MAY 2016
Scottish Dental Show
Braehead Arena
Visit www.sdshow.co.uk for more information, or follow @ScottishDental on Twitter for the latest updates.

16 MAY-16 JUNE
National Smile Month
www.nationalsmilemonth.org

26-28 MAY 2016
British Dental Conference and Exhibition
Manchester
For more information, visit www.bda.org

3 JUNE 2016
TC White Special Care Dentistry
Royal College of Physicians and Surgeons of Glasgow
Visit www.rcpsg.ac.uk for more information on how to book.

7-10 SEPTEMBER
FDI World Dental Congress
Poznan, Poland
www.fdiworldental.org

11-12 NOVEMBER 2016
Pandental Society Conference
ICC Birmingham
To find out more, visit www.pandental.co.uk

CONTACT US

To have your event featured in the *Scottish Dental* diary, email bruce@sdmag.co.uk

To advertise in future issues of *Scottish Dental*, contact Ann on 0414 560 3021 or email ann@connectcommunications.co.uk

PEOPLE HAVE PRIORITY

Have you seen Lisa?

KNOW&HOW

The all new Lisa vacuum B sterilizer is now even faster, offering a 30 minute B cycle for an average 2kg load and sterilizing unpacked instruments in under 14 minutes. The new Lisa is intuitive, easy to use, offers automatic load size detection and impressive connectivity.

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CDC PRODUCTS AND ASTEK INNOVATIONS
WORKING TOGETHER

See us at
FGDP(UK) Scotland Study Day
11 Dec 2015

inSafe

We'll keep you inSafe hands to avoid needlestick injuries

inSafe provides complete protection from the beginning of the medical procedure, through to the disposal of the needle. The specially designed syringe protects the needle at ALL times and its partnering sharps container removes the contaminated needle in complete safety.

inSafe Complete Surgery Kits

Get everything you need with an inSafe Complete Surgery Kit:

- **1 x Sharps Container**
- **1 x Sharps Container Base**
- **1 x 250 Needle Adaptors for 2.2ml Cartridges**
- **3, 4 or 5 Syringes**

Pro-Matrix®

One-stop solution for superior amalgam or composite restorations for use in all quadrants for every class

- Fully disposable, single product system - no assembly or application tools required
- Circumferential Band can be used for MO/OD/MOD/Cusp replacements
- High-tension mechanism for better compacting
- Easy contouring to tooth shape
- Narrow front section for better visibility and patient comfort
- Suitable for all quadrants
- Suitable for use with all restorative materials
- Suitable for use with wedges and rubber dams

TranSform™

A custom shape: created by you

Transform Impression Trays are made from a heat mouldable material which allows them to be moulded to create precise primary impressions which leads to increased quality in subsequent stages.

- Heat mouldable, single use impression tray
- Extremely strong
- Enhanced anatomical shape
- Facilitates impressions where unusual soft tissue, bone shape and tooth position exists
- Quick and simple to mould - can be moulded in less than 60 seconds at chairside
- Good retention slots
- Six Different Shapes: Upper and Lower trays available in 3 colour coded sizes (S,M,L) in dentate and edentulous

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