RRP £4.50

SEPTEMBER 2015

SCOTTISH DENTAL

ESSENTIAL KNOWLEDGE FOR DENTAL PROFESSIONALS IN SCOTLAND

TACKLING FRAUD IN THE DENTAL PROFESSION

CLINICAL: EARN UP TO FIVE HOURS OF VERIFIABLE CPD IN THIS ISSUE

LIAM LYNCH

ANDREW CROTHERS

NICHOLAS BEACHER

PETRINA SWEENEY

GILLIAN HOWIE

MICHELE WEST

GARRY SIME

MADELEINE MURRAY

TECHNOLOGY IN PRACTICE

An innovative approach to teaching clinical skills to undergraduates

Evolved

The new A-dec 300

Designed as a modular solution, A-dec 300 is a whole system that lets you pick and choose the features you want, within the price point you need. And we didn't skimp on comfort. With pressure mapped, contoured surfaces and virtual pivot back, patients are relaxed and supported. Ergonomic and economic just got better.

Experience the New A-dec 300 at one of A-dec's Premier Dental Showrooms. To book your appointment, please call 0800 233 285 or email info@a-dec.co.uk. Alternatively visit a-dec.co.uk/300 to explore all of the possibilities.

a-dec®

Now Backed By a-dec 5 YEAR WARRANTY* *Terms and conditions apply

A-dec Dental UK Ltd
Austin House, 11 Liberty Way, Nuneaton, Warks, CV11 6RZ. Tel: 024 7635 0901 Fax: 024 7634 5106 Email: info@a-dec.co.uk Web: www.a-dec.co.uk

Contents

SDMAG.CO.UK | @SCOTTISHDENTAL | FACEBOOK.COM/SCOTTISHDENTAL | SEARCH FOR SCOTTISH DENTAL | SDSHOW.CO.UK | SDAWARDS.CO.UK

TARGETING TAX CREDIT FRAUD

NHS Scotland Counter Fraud Services has launched a new scheme to help save the health service £3m a year

09

DEMAND FOR SCOTS REGULATOR

SDPC survey has revealed the extent of the crisis in confidence in the General Dental Council's performance

12

FRAUD IN DENTISTRY

Dr Liam Lynch looks at the definitions of fraud in dentistry and outlines his plans to stamp it out

24

TECHNOLOGY IN TEACHING

Andrew Crothers from Glasgow Dental School talks about its use of new technologies for clinical skills teaching

30

SAFEGUARDING THE VULNERABLE

Dental professionals have a key role to play in helping to prevent the neglect and abuse of vulnerable adults

42

LATEST SDCEP GUIDANCE

An overview of the new advice on managing patients taking anticoagulants or antiplatelet drugs

47

GETTING THE RIGHT PEOPLE ON BOARD

Mark Fowler explains that recruiting staff is like a bus journey – get the right people and you will be on your way

63

34

> This isn't pay restraint, it's a pay cut. If this trend continues it will inevitably have an impact on dentists' ability to deliver NHS services
>
> **DR MICK ARMSTRONG**

21

CONTACT DETAILS

Managing editor: David Cameron
david@connectcommunications.co.uk
Editor: Bruce Oxley
Tel: 0141 560 3050
bruce@sdmag.co.uk
Advertising sales manager: Ann Craib
Tel: 0141 560 3021
ann@connectcommunications.co.uk
Design: Renny Hutchison, Raymond Francis
Sub-editor: Wendy Fenemore
Subscriptions: Lauren Adger
Tel: 0141 561 0300
info@sdmag.co.uk

PHILIP FRIEL
ADVANCED DENTISTRY
@ HYNDLAND DENTAL CLINIC

Philip Friel Advanced Dentistry is based in Hyndland Glasgow. The clinical team accept private referrals for:

- Dental Implant treatment - Drs Friel, Clare
- Bone grafting/Sinus Augmentation - Dr Friel
- Cone Beam CT scanning - Dr Friel
- Cone Beam CT reporting - Dr Neil Heath, Consultant Radiologist
- The treatment of Peri Implantitis - Dr Friel
- Endodontics - Dr Will McLean
- Orthodontics - Dr Imran Shafi
- Oral Surgery - Mr Craig Wales, Consultant Oral/Maxillofacial Surgeon
- Intravenous sedation - Dr Stuart McLaren
- Hygiene therapy

Referrals can be made securely on line via our clinic website www.philipfriel.com or alternatively, please contact the clinic for a referral pack.

We understand there are many options when referring patients and appreciate you trusting us with your referral. All new referrers are invited to arrange an initial visit to the clinic to view the facilities and discuss any specific wishes they may have for specific referral types.

We operate a very much open door policy at the clinic and run a number of informal courses, bespoke referral programmes and training/education for referring dentists. In addition, referring dentists in many cases will visit the surgery to observe the treatment of their patients. Any adjunctive work is returned to the referral source for completion as part of the treatment plan.

We are delightled to introduce 2 new members to our clinical team:

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.

Philip Friel Advanced Dentistry
154 Hyndland Road, Hyndland, Glasgow, G12 9HZ
Tel no: 0141 339 7579 **Website:** www.philipfriel.com

Editorial

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

CREATING A COUNTER FRAUD CULTURE

Not everyone's favourite subject, but important nonetheless

In the current climate, where any number of perceived misdemeanours can see the GDC knocking on your door, it is no wonder that dental fraud is such an uncomfortable subject.

High-profile cases such as Stuart Craig from Ayrshire or Joyce Trail in Birmingham may make the headlines and get patient's tongues wagging, but the fact is they remain few and far between.

The vast majority of dental professionals are honest, hardworking individuals and fraud is something they only read about in the papers and probably never see in their own practices. However, according to conventional wisdom, around 10 per cent of the healthcare budget is lost to "fraud, waste and abuse" – a not insignificant amount of money.

Now, as Liam Lynch explains on page 24, terms such as "inappropriate", "waste" and "abuse" are often lumped in with these estimates, making a definition of fraud and an estimation of the cost to society, fiendishly difficult to arrive at. But despite all this, it needs to be acknowledged and it needs to be tackled, however uncomfortable it might make us.

For right-minded members of the profession, the obvious question is not if it exists, but why? Why would a highly-educated and well paid dentist risk everything by trying to "fiddle" the system? There are always a few dishonest people in all walks of life, but just pointing to greed and dishonesty is overly simplistic. As with everything in life, it is often a combination of situations and circumstances, some of which may be beyond the individual's control. Bad investments, health problems and the breakdown of relationships could all, in theory, contribute to a situation where dentists might find themselves in financial difficulties, thus making fraud seem like a plausible "way out" for some.

Lynch argues that despite the reasons that offenders use to justify their actions, a different approach needs to be taken to prevent fraud happening in the first place.

Rather than just a peer review or a statistical method of countering fraud, he recommends a multi-faceted approach to create what he refers to as a "counter fraud culture". Food for thought for Counter Fraud Services and the Government?

Elsewhere in this issue, Michele West provides an overview of the new guidance from the Scottish Dental Clinical Effectiveness Programme (SDCEP) on page 48. With more than half a million people in Scotland taking anticoagulants or antiplatelet drugs, most readers will come across such patients at some point in their career.

The topic was highlighted as a priority within oral health and, while many dentists are confident in treating patients taking warfarin and other antiplatelets, there was found to be a gap in knowledge around the newer drugs, which this guidance aims to bridge.

WE COULDN'T HAVE DONE IT WITHOUT...

1

ANDREW CROTHERS
(ON TECHNOLOGY AND TEACHING)
Andrew Crothers is head of second year and teaches clinical skills to second and third year students at Glasgow Dental School.

2

LIAM LYNCH
(ON FRAUD IN DENTISTRY)
Cork GDP Liam Lynch has more than 30 years' experience in publicly funded dentistry and has written a book on occupational fraud in the profession.

3

NICHOLAS BEACHER
(ON SAFEGUARDING)
Nicholas Beacher is a clinical lecturer and honorary specialty registrar in special care dentistry at Glasgow Dental Hospital and School.

4

MICHELE WEST
(ON SDCEP GUIDANCE)
Michele West is a research and development manager at SDCEP and was project lead on the new anticoagulant guidance.

Scottish Dental Magazine adheres to the Editor's Code of Practice and we are regulated by the The Independent Press Standards Organisation (IPSO).
Complaints about content in the magazine or on www.sdmag.co.uk should be referred to:
Alan Ramsay, Managing Director, Connect Publications (Scotland), Studio 2001, Mile End, Paisley PA1 1JS or email info@connectmedia.cc
If a resolution cannot be reached, contact IPSO at inquiries@ipso.co.uk or IPSO, Gate House, 1 Farringdon Street, London EC4M 7LG

Dental Associate

We are seeking a conscientious and friendly colleague to join us as our practice goes from strength to strength.

Partnership opportunity for the right candidate.

Argyll Smile DENTAL CARE

Would you like to join us in beautiful Argyll, in our spectacular coastal location, just over an hour from Glasgow?

Following our practice expansion and complete renovation we are a modern, bright and airy, 3 surgery practice, We offer private dental treatment for adults and children are generally treated under the NHS

Dunoon and surrounding areas have a huge potential for further private / NHS growth.

We believe in the highest standards of treatment and patient care, and as such have invested in latest equipment and treatment techniques such as digital radiographs, intra-oral cameras, Reciproc rotary endodontics and SonicFill composites.

In addition we work with award winning dental labs to produce the highest standard of fixed and removable prosthesis.

For more information email our practice manager shona@argyll-smile.com or phone 01369 702755. If you would like to see more of our practice go to www.argyll-smile.com

---

DenComp Systems

Dental Compressor Specialists

Keeping Up The Pressure

- ✓ Scottish based
- ✓ Service Plans
- ✓ Supply
- ✓ Installation
- ✓ Repairs
- ✓ Filtration
- ✓ Inspection & Certification

Contact: Les Ferguson les@dencompsystems.co.uk
Mobile: 07885 200875 **Office:** 01786 832265
www.dencompsystems.co.uk

Insider

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

ADVICE FOR OUR MEDICAL COLLEAGUES

General practice is apparently facing a shortage of practitioners. Sound familiar? Can we use our own experience to help our medical peers?

After crossing the Antarctic in the expedition which resulted in the untimely deaths of Scott, Wilson and Bowers, Apsley Cherry-Garrard wrote: "I do not believe anybody on Earth has it worse than an Emperor penguin." I wonder if the UK's General Medical Practitioners (GMPs) would presently agree.

GMPs are in crisis. Almost one in four GMPs are close to retirement age. They are complaining of a lack of new graduates in general, and few of them wishing to enter general practice. A survey of nearly 400 doctor's surgeries revealed 92 vacancies for permanent doctors, and 68 for locums[1]. There has been a real-term drop in GP investment of £1.1 billion since 2005/2006[2]. The RCGP also note that demands on general practice have increased by 11 per cent over the last decade. As dentists, we have been here before. Can we offer any advice to our beleaguered colleagues?

We can all remember the television pictures of queues around the block when any new dental practice opened in the 1990s.

Politicians bemoaned the poor access to NHS dental practice, and solved this by introducing bursaries for dental students, and offering the Scottish Dental Access Initiative grants to encourage practices to expand, move (to also comply with the need for an LDU), or to open. Student numbers increased at Glasgow and Dundee dental schools, and Aberdeen dental school opened.

Indeed, the access problem was so comprehensively solved that we now have under-employment of dentists. Recent graduates can struggle to find an associate position. Once again, NES have had to email round dental practices to see if anyone is willing to take on a VDP at short notice, due to what is apparently yet another unexpected shortfall in places. This happens every year, yet NES cannot get it right.

The removal of the superannuation incentive has played a part but who has the capacity to take on a foundation dentist? Most of us have quiet enough appointment books without losing a substantial part of our list. I hear of young dentists who are employed purely to see emergency patients. Even dentists who have successfully completed VT are under-employed, with many working only three days a week.

Vocational trainers and practice principals are complaining that new graduates are no longer "safe beginners", and simply have not had enough experience to carry out simple procedures. We all know we have greater gaps in our appointment books than ever before. Many dentists now find the reduced income and increased bureaucracy overwhelming, and are selling out to the corporates. Our financial position is only going to get worse as compulsory pensions for staff come in as well as the living wage. And no consequent uplift in the SDR on which the majority of us are dependent.

"The removal of the superannuation incentive has played a part but who has the capacity to take on a foundation dentist?"

Frustration at the lack of parity between those who received grants and those who did not is becoming apparent (Scottish Dental July 2015, p17). Some health boards are more stringent than others in checking whether conditions have been adhered to. Recently, I heard of a crazy situation whereby a practice has been forced to close after a health board-owned access centre opened nearby.

I can see two solutions. One is to look at changing the ill-fated Aberdeen dental school to a post-graduate accelerated medical school. Willing dental students could be automatically accepted onto a course. However, I would caution against GMPs readily accepting an increase in numbers, or 10 years down the line they too will be sitting with empty offices.

And the other? The average dentist in Scotland now earns £68,000 per year, and a recent report shows London Tube drivers have a starting salary of £49,673 (after three to four months' training) and rising to as much as £60,000. You do not require a degree to be a train driver, so no risk of paying Andy Burnham's graduate tax, or student loans to repay! Tube drivers also get 43 days of paid annual leave. No run-ins with the GDC, or PSD. If I were a medical or dental undergraduate, I know which I'd pick.

1. Scottish Labour survey of GP practices. www.scottishlabour.org.uk/blog/entry/scotland-is-facing-a-looming-crisis-in-family-doctors

2. RCGP, A blueprint for Scottish general practice, July 2015

A real alternative to amalgam has arrived...

DUAL CURED COMPOSITE!

Fill-Up!™

DEEP
- 10mm guaranteed curing

FAST
- Light cures in seconds
- Chemical cure in 3 mins

PERFECT
- Minimal shrinkage due to dual cure
- Perfect marginal seal

Suitable for all posterior restorations

Guaranteed curing, even in cavities 10mm & deeper & no capping

'Fill-Up! has excellent handling and is simple to use. I am very pleased with the results I have been achieving with this product. Fill Up! is a brilliant material to use when working in less than ideal conditions. I would thoroughly recommend Fill-Up! to my colleagues' - **Andrew Osafo BDS Dip Sed**

20-25 Restorations per kit

Intro Kit
Art No. 6001 9342
Kit includes:
2 x 4.5g Fill-Up! Universal
1 x 2.5g Etchant Gel S
2 x 3ml Parabont Adhesive A+B
6 x Mixing Tips Short SF, 8 x Mixing Tips Short F

Intro Kit £79.95 or less!

Contact us today to book a demonstration!

For further information, call:

01444 235486 Ext. 224 Chris

info.uk@coltene.com | www.coltene.com

COLTENE

www.facebook.com/coltene.uk @coltenеukltd Supporting dentaid

See Fill-Up! on **STAND G45**

BDIA DENTAL SHOWCASE
Putting innovation into practice

22-24 October 2015, NEC Birmingham

Free registration now on:
www.dentalshowcase.com

PAGE 24

Another example of neutralisation might include viewing the oral healthcare delivery system as culpable

DR LIAM LYNCH

TARGETING TAX CREDIT FRAUD

New scheme to abolish fraud and errors in dental exemption claims to be piloted in NHS Forth Valley

A new scheme that aims to stamp out fraud and errors in dental exemption claims, saving the health service more than £3 million per year has been launched.

The NHS Scotland Counter Fraud Services (CFS) pilot scheme will focus on preventing fraudulent and erroneous patient claims for exemption from dental treatment costs under the NHS Tax Credit category. This area of exemption was highlighted by CFS after more than £3.25 million was lost nationally to fraud or error in 2014 alone. This figure represents 28 per cent of the overall payments made by NHS Scotland under this exemption category last year.

Fraser Paterson

The initiative will be piloted in NHS Forth Valley and will see members of the CFS team visit dental practices to reinforce the important role that practice staff can play in reducing claims made wrongly by patients. The CFS training support events will focus on prevention rather than monitoring and enforcement.

Fraser Paterson, national counter fraud prevention manager at CFS, said: "This initiative is all about deterrence. When you think that every fourth person who claims exemption under the NHS Tax Credit category does so either mistakenly or fraudulently, you can understand why our pilot work with NHS Forth Valley dental community is so important.

"We believe that a well supported, planned and co-ordinated venture of this type can reduce the amount wrongly paid to patients for this type of dental claim exemption."

NEW SCHEME TO GIVE DENTISTS MORE CLOUT

A new NHS Scotland-run procurement scheme is being launched to help dentists save money on dental products.

Denpro aims to combine the buying power of up to 400 practices and negotiate better deals. The scheme will initially focus on general hygiene and safety products, instruments, impression materials, cements and general consumables. If successful, then it could be extended to include other products.

Paul Cushley, NHS National Services Scotland (NSS) director of dentistry, said: "This is an opportunity for dentists to get greater clout in terms of buying power and drive down the cost of the products they use. When we consulted on the scheme earlier in the year, it was very popular. We are already assessing the best prices from the major suppliers and would like to have as many NHS practices ready to participate to help our leverage when negotiating with the suppliers."

Jim Miller, NHS NSS director of strategic sourcing, said: "We already manage around 300 collaborative purchasing solutions on behalf of NHSScotland worth about £1.3 billion a year, so we are well placed to offer this service."

REFORMED SALDC IS UP AND RUNNING

Arabella Yelland

Submissions to the DDRB and tackling stress in the profession were on the agenda at the first meeting of the re-formed Scottish Association of Local Dental Committees (SALDC).

The new group, whose reformation was proposed and passed at the 2014 Scottish Conference of LDCs, has elected Largs practitioner Arabella Yelland as chair and Gordon Morson from Forth Valley as vice chair. Kate Morrison from Lanarkshire has been appointed secretary and John O'Donnell from Glasgow and Clyde as treasurer.

Arabella said: "The first meeting included a review of our constitution, and the main issues we feel are facing the profession. We, of course, have to limit this to issues we can deal with at present.

"We have set up a working group to consider a submission to DDRB which will reflect actual dentist earnings and we are considering ways to support the profession and combat stress."

The group hopes to liaise with NHS Education for Scotland's TRaMS (Training, Revision, Assessment, Mentoring and Support) team and have invited Martin Morrison from Practitioner Services Division to speak at the next meeting in October.

Arabella continued: "We're hoping to find out exactly what PSD expects from practitioners. If we know what it wants, we can disseminate this through our LDCs which we hope will reduce stress.

"We are also planning on sending GDPs a questionnaire to evaluate the causes of it."



A FRESH APPROACH TO DENTAL DESIGN & CONSTRUCTION






Concept Design | Space Planning | Detail Design | Project Management | Construction

0845 548 9860
www.nvdc-dental.co.uk
enquiries@nvdc.co.uk

NVDC dental

RECORDINGS ADVICE

MDDUS urges dentists to accept the possibility of patients covertly recording consultations

Scots dentists have been advised to avoid confrontational or defensive reactions to patients who covertly record their consultation.

Defence organisation MDDUS has said there is increasing use of smartphones by patients to make an audio, or in some cases video, recording of a dental appointment.

However, MDDUS dental adviser Rachael Bell believes dentists should not resent patients who record consultations and instead accept that it is simply a product of the digital age.

"The law offers little or no protection from patients covertly recording consultations," says Bell.

"A dentist may think that a patient would require their permission and that any recording made covertly was illegal. However, patients don't need a dentist's consent to record the consultation

Rachael Bell

as section 36 of the Data Protection Act 1998 considers that the information in the recording belongs to them.

"Therefore, patients are within their rights and could use the information obtained to challenge the dentist's actions. Conversely, dentists always require patients' permission to record consultations, with the resulting data being subject to a number of protections.

"Any covert recording would seem inherently intrusive and a breach of trust in a patient-dentist relationship. Even if obtained covertly, courts may view the recording, if relevant to the case, as admissible."

Dentists are warned that the accuracy of their records could be challenged if they do not match the recording of any consultation.

"By keeping clear, comprehensive and accurate records of consultations, dentists can justify their actions in court if necessary."

While sometimes the patient may try to use the recording to challenge the dentist, it is our experience at MDDUS that the majority of recordings support the practitioner's actions and confirm that they acted in an appropriate manner.

"There will be occasions when a dissatisfied patient uses a recording to pursue a complaint or claim but dentists acting professionally should have nothing to fear from recordings, covert or otherwise," says Bell.

NOW TRENDING

£43M

FACT

*The estimated worth of the UK tooth whitening market **

** British Dental Health Foundation*

SCOTS DENTISTS' MORALE PLUNGES TO NEW LOW

Morale among Scottish dentists has plunged to an unprecedented low, a new report has revealed.

And the figures show that dentists in Scotland are the most demoralised in the UK.

The data on the depth of the morale crisis is contained within a report from the HSCIC Dental Working Hours, 2012/13 & 2013/14.

Commenting on the findings, the chair of the British Dental Association's Scottish Dental Practice Committee (SDPC), Robert Donald, said: "These figures are shocking, but come as no surprise.

"Ever falling incomes and rising expenses make general practice a stressful environment to operate in.

"The SDPC believes this is a situation that requires action now.

"We call on the Scottish Government to recognise the heavy demands placed upon general dental practitioners and start addressing the causes of poor morale."

The report states that its main findings in Scotland for 2013/14 are:

- Associate dentists report higher levels of motivation than principal dentists.
- A 'motivation index' has been calculated for each dentist based on their answers to the motivation questions. The index exhibits a negative relationship with age and the proportion of time dedicated to NHS work. For example, it is predicted that switching from all private to all NHS work would decrease the 'motivation index' of Principals by 18.2 percentage points.
- Annual leave has a positive relationship with motivation for dentists and is associated with higher motivation.

FIND OUT MORE AT
www.hscic.gov.uk/catalogue/PUB18272

DENTISTS STEP UP DEMAND FOR SCOTS-ONLY REGULATOR

Scottish survey found nine in 10 don't believe the GDC is fit for purpose

Demands for a break away independent Scots regulator have been reinforced by a new survey of dentists north of the border.

A Scottish Dental Practice Committee (SDPC) survey has revealed the extent of the crisis of confidence among Scottish GDPs in their professional regulator with nearly nine in 10 respondents saying that the General Dental Council (GDC) is not fit for purpose to regulate the dental team and protect patients.

In addition, more than 92 per cent of respondents have called on SDPC to increase its efforts to establish the Scots-only regulator by carrying out a formal investigation into the how it could be established.

Commenting on the survey results, SDPC Chair Robert Donald, said: "Scottish GDP's have given an emphatic vote of no confidence in the GDC.

"They know that they are being regulated by the worst health regulator in the UK. The GDC is responsible for regulating over 100,000 registrants including dentists and other dental care professionals. Those organisations representing patients should be concerned about the survey results and the implications of the PSA's annual report.

Robert Donald says his colleagues are fed up waiting for improvements

"My colleagues are fed up waiting for improvements to be made to address these serious failings and have given their representative committee a mandate to investigate establishing a Scottish based regulatory body which is fit for purpose.

"We have today asked for an urgent meeting with the chief executive of the GDC and the Scottish health minister to discuss the survey's findings."

The findings come on the back of a number of serious failings raised about the GDC in the last few weeks. These include the Professional Standard Authority's (PSA) assessment of the performance of the GDC in its most recent annual report.

The GDC failed to meet a total of seven of its standards of good regulation and only fully met one of the 10 standards on fitness to practice. In it's assessment of nine healthcare regulators, the GDC came bottom of the league.

Other serious concerns have also been raised.

TAKE PART IN THE NEXT SURVEY

Between 21 July and 21 August 2015, Scottish GDP's were surveyed about their views on the GDC and whether SDPC should investigate establishing a Scotland based regulatory body.

A total of 541 GDPs responded, 46 per cent of those invited to participate.

- 88 per cent of those who responded believe the General Dental Council is not fit for purpose to regulate the dental team and protect patients.
- 92 per cent of respondents believed that SDPC should investigate establishing a Scotland based regulatory body which is fit for purpose.

The SDPC are now planning to carry out more GDP surveys and if GDPs wish to take part, they can add their name to the database by emailing Robert Donald at scottishdpc@gmail.com

AUDIT SCOTLAND CONTACTED TO INVESTIGATE ALLEGED MISMANAGEMENT OF DENTAL GRANTS BY HEALTH BOARD IN GRAMPIAN

NHS Grampian could be at the centre of an investigation into alleged mismanagement of dental grants after Aberdeen dentist Ross McLelland raised his concerns with Audit Scotland.

He is claiming that at least £1 million of grants awarded to dental practices in Grampian could be lost to the public purse due to mismanagement by the health board.

The principal of Waverley Dental Health Practice has been asking questions of NHS Grampian for more than three years after discovering a rise in new practices opening up in the region funded by the Scottish Dental Access Initiative (SDAI).

He said: "Grampian has the highest SDAI spending on new practices in Scotland. There have been legitimate concerns raised around multiple breaches of terms and conditions and the lack of scrutiny for many years, with a lack of action by NHS Grampian.

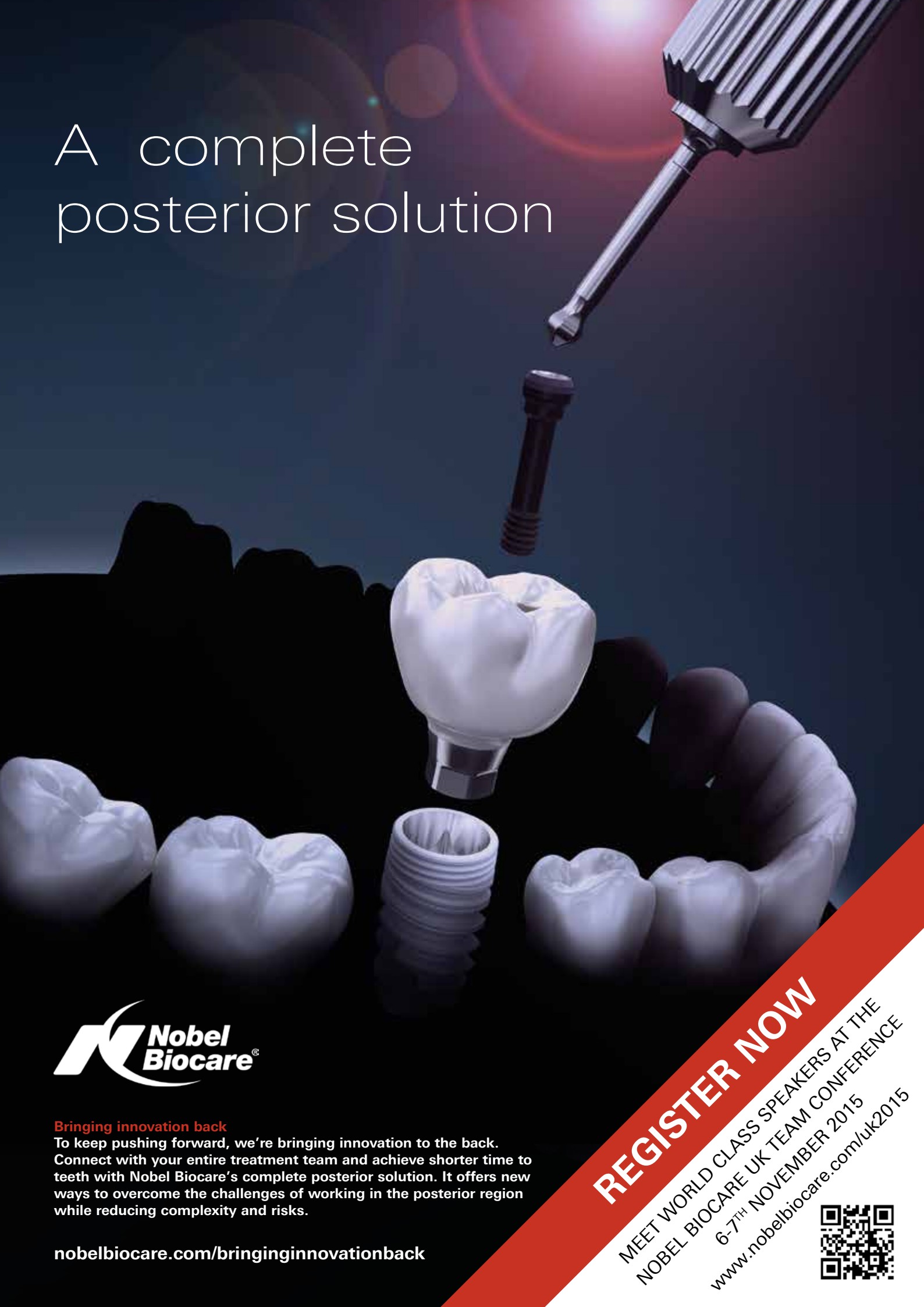
"In my view there is an air of mismanagement and collusion about the whole process in this region, with an attitude of 'the means justifying the ends'. I believe it's time an alternative authority had a close look at the process in Grampian in order to ensure full value to the public purse."

An Audit Scotland spokeswoman said: "We have received correspondence relating to the Scottish Dental Access Initiative. We will consider the points raised by the correspondent and respond in due course."

In July, the health board investigated five practices that received SDAI grants totalling in excess of half a million pounds for potential non-compliance.

A spokesman for NHS Grampian refused to comment on the specific allegations made by Mr McLelland, instead saying: "The SDAI Grant scheme is estimated to have led to about 115,000 patients being registered with a NHS dentist in Grampian.

"Seven out of 10 people in Grampian are now registered with a NHS dentist and registration has been consistently on the rise since 2007. This is a significant achievement given the historical challenges we faced and given the higher than average number of residents who are treated privately."


A complete posterior solution
Nobel Biocare
Bringing innovation back
To keep pushing forward, we're bringing innovation to the back. Connect with your entire treatment team and achieve shorter time to teeth with Nobel Biocare's complete posterior solution. It offers new ways to overcome the challenges of working in the posterior region while reducing complexity and risks.
nobelbiocare.com/bringinginnovationback
REGISTER NOW
MEET WORLD CLASS SPEAKERS AT THE NOBEL BIOCARE UK TEAM CONFERENCE
6-7TH NOVEMBER 2015
www.nobelbiocare.com/uk2015

ACQUISITION OF DPAS SHOOTS WESLEYAN INTO THE TOP SPOT

Financial services company Wesleyan has announced the acquisition of dental plan provider DPAS, making it the second largest provider of membership plans in the UK.

The Birmingham-based company already owns Practice Plan and its latest purchase is expected to go ahead following regulatory approval.

Craig Errington, Wesleyan Group chief executive, said: "We can now take the best of both Practice Plan and DPAS to deliver a first class customer service."

Gary Anders, DPAS Managing Director, said: "Wesleyan is an established player in the dental market and has a deep understanding of it. It's also good to know DPAS will be part of a strong financial mutual with a great heritage and a reputation for customer service and product performance."

NEW NHS PRACTICE FOR LERWICK

After four years without an independent NHS dentist, during which time the waiting list in Shetland has increased to more than 1,500, a new practice is finally opening in Lerwick later this year.

NHS Shetland has announced the development of a new four-surgery dental practice, which the owners predict will attract a list of 6,000 patients once it is fully operational. Because of the historic access issues on Shetland, the new business was able to take advantage of a Scottish Dental Access Initiative (SDAI) grant with the chief executive of NHS Shetland, Ralph Roberts, insisting there is sill room for another NHS-committed practice.

He said: "We are extremely pleased that a new independent dental practice will now be opening in Shetland.

"This should provide adequate capacity to address the current waiting list. We would still welcome at least one further Independent NHS committed practice in Shetland.

"Key to this and the continued effective provision of the Public Dental service will remain our ability to attract dentists to live and work in Shetland. We believe this provides great opportunities for a high quality of life in a beautiful setting and in a vibrant community with excellent facilities."

NHS Shetland took over the patient list and staff of the former NHS practice when it closed in Autumn 2011 after the principal retired and was unable to find a successor. Mr Roberts explained: "In reviewing our dental strategy at the time, we agreed that we should not expand the number of chairs in the salaried dental service but should concentrate on trying to attract new Independent NHS practice to Shetland and new dentists to work in what is now the public dental service."

NOW TRENDING

48%

FACT

*Nearly half of respondents to a recent survey had received verbal abuse in their practice**

* Dental Protection survey of 497 members

Working together on the day

FUNDRAISING NURSES' COOKING CHALLENGE

Dentists, nurses, patients and carers joined forces at a recent charity event to raise awareness of mouth cancer

A team of Edinburgh dental nurses who helped raise £5,000 for mouth cancer charity the Ben Walton Trust were put through their paces at a cook school event recently.

Emily Weir, Diane Alexander, Kirsten Banks and Robert MacNeil from Vermilion in Edinburgh joined cancer patients, carers and representatives from NHS Greater Glasgow and Clyde as well as charities such as Macmillan Cancer Support and Chest, Heart and Stroke Scotland at the Tennants Training Academy in Glasgow.

The event, which consisted of an interactive cookery demonstration and focused discussion, was wholly funded by the proceeds of Vermilion's 'Ben for Ben', a fundraising initiative which saw 15 staff members from the Corstorphine practice climb Ben Lomond in June.

A patient cook book resource will be produced as a result of the event, which featured dishes designed for mouth cancer sufferers and other patients with swallowing problems or eating disorders.

Liz Grant, project manager at the Ben Walton Trust, said: "It was a unique initiative and, as far as I am aware, there has not been one like it. It was very fortuitous that Vermilion did their 'Ben for Ben' when they did because we had talked about doing this for a while but didn't really have the resource to do it. So it all dovetailed nicely.

"It was great to see the health board (NHS GGC), the voluntary sector, Macmillan and a private dental practice all involved and working together. So, it just shows that public, voluntary and private sectors can all work together for the benefit of the patient."

And Emily Weir, who was responsible for thinking up the 'Ben for Ben' idea, said: "It was about raising money but the most important factor for us was raising awareness of mouth cancer.

"Being in the dental profession, we all realise that something as seemingly common or insignificant as a mouth ulcer can manifest into something devastating."

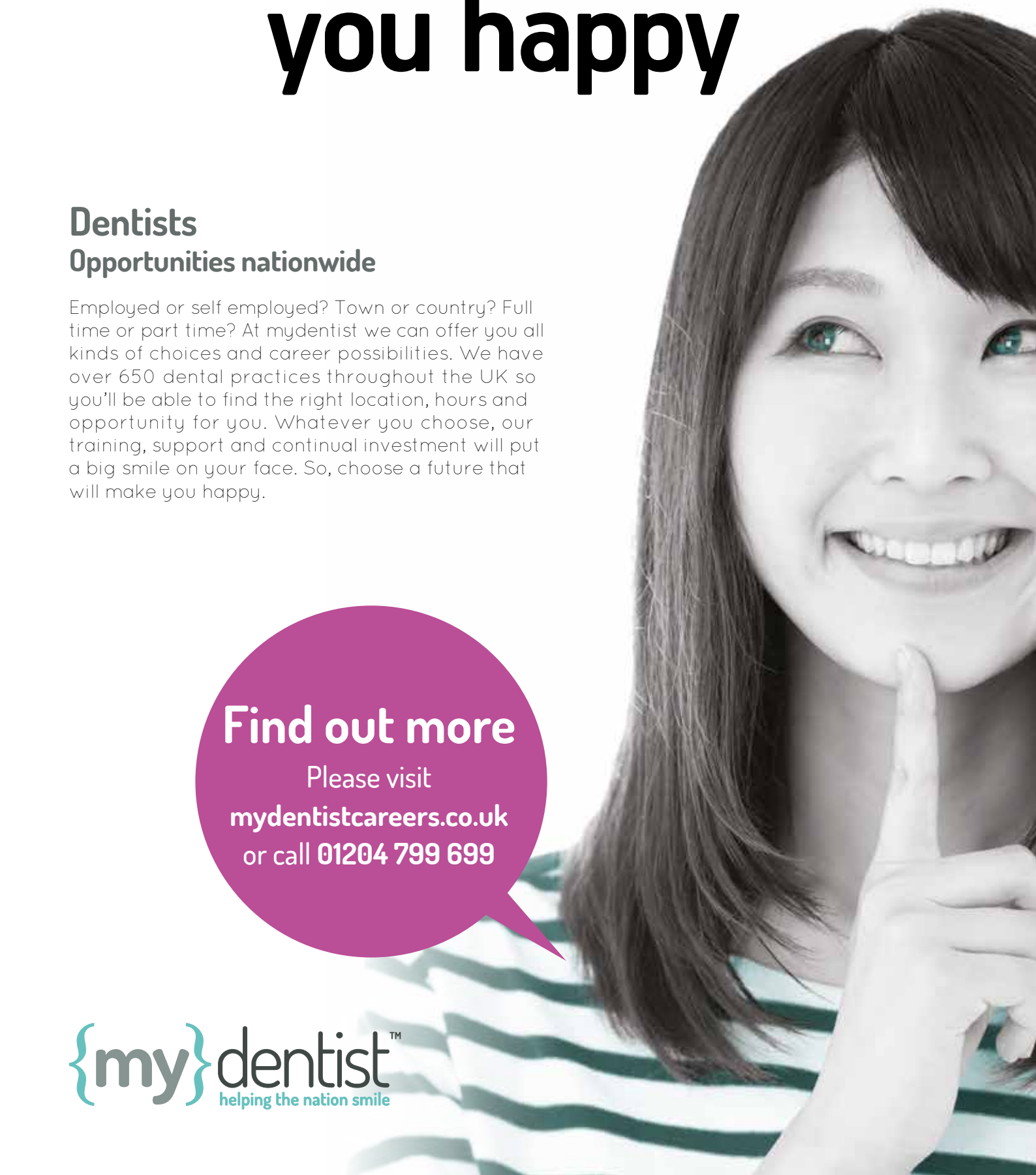
The Ben Walton Trust was set up 20 years ago by Michael Walton, whose son Ben died from mouth cancer at the age of 22, a year after being diagnosed.

choose what makes you happy

Dentists

Opportunities nationwide

Employed or self employed? Town or country? Full time or part time? At mydentist we can offer you all kinds of choices and career possibilities. We have over 650 dental practices throughout the UK so you'll be able to find the right location, hours and opportunity for you. Whatever you choose, our training, support and continual investment will put a big smile on your face. So, choose a future that will make you happy.



Find out more

Please visit

mydentistcareers.co.uk

or call **01204 799 699**

{my} dentist™

helping the nation smile

THE COUNTDOWN TO 2016 BEGINS

The Scottish Dental Show is returning to Braehead Arena in May 2016 and next year's event will be offering up to nine hours of verifiable CPD from some of the biggest names in the business

The scientific line-up for the 2016 Scottish Dental Show is shaping up to be the best yet, with some of the biggest names in Scotland and the UK confirming their attendance.

The event, on 13 and 14 May, will be returning to Braehead Arena for the third time after the 2015 show saw nearly 1,800 people through the doors – an increase of more than 30 per cent on the previous year.

Registration for the show is now open at www.sdshow.co.uk

FAMILIAR FACE

The keynote lecture will be presented by Cardiff dental dean Professor Mike Lewis, a Dundee graduate and former Glasgow lecturer who will be a familiar face to many north and south of the border. He will be presenting two, one-hour lectures on mouth cancer on Friday 13 May.

A professor of oral medicine at Cardiff University, Prof Lewis is also clinical board director for dentistry at the Cardiff and Vale University Health Board.

He is the honorary president of the British Society for Oral and Dental Research and past dean of the Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow.

He has published more than 200 scientific articles and co-authored six medical textbooks as well as delivering more than 450 postgraduate lectures around the world. He is a past president of the British Society for Oral Medicine and has served as a dental member of the Advisory Council for Misuse of Drugs (Home Office) and dental member of the Scientific Advisory Committee on Antimicrobial Resistance and Healthcare Associated Infection (Department of Health).


Prof Mike Lewis


Prof Brian Millar


Prof Jan Clarkson


Prof Peter Mossey

THAT'S NOT ALL...

Also confirmed at the show so far are:

- Professor Jan Clarkson, co-director of the Dental Health Services Research Unit at the University of Dundee and director of the Effective Dental Practice Programme.
- Professor Peter Mossey, honorary consultant in orthodontics and director of the WHO Collaborating Centre at the University of Dundee.
- Professor John Gibson, professor of medicine in relation to dentistry and honorary consultant in oral medicine at the University of Glasgow Dental School.
- Professor Brian Millar, professor of blended learning in dentistry and a consultant in restorative dentistry at King's College London Dental Institute at Guy's, King's and St Thomas' Hospitals.
- Robbie Lawson, specialist orthodontist and partner at Edinburgh Orthodontics. He graduated from Dundee University in 1990 and completed his specialist training in Cardiff in 1996.
- Steve Bonsor, GDP and tutor on the University of Edinburgh's MSc in Primary Dental Care and honorary clinical senior lecturer leading the applied dental materials teaching at Aberdeen Dental School.

MORE CORE FOR 2016

Professor Lewis' talks on mouth cancer won't be the only CORE CPD topics covered at the show as all the recommended CPD topics will be featured. Christine Park from Glasgow Dental School will be presenting on 'Safeguarding and child protection for dental teams' and Laura Wilson from NHS Education for Scotland will give an 'Infection control and decontamination update'.

There will also be a session on radiography presented by the ever popular Barbara Lamb and talks on legal and ethical issues and complaints handling will be given by Aubrey Craig from the MDDUS and Stephen Henderson from Dental Protection.

Professor StJohn Crean will return to the 2016 show with a talk entitled 'Risk assessment for medical challenges in dental patients' and he will be joined on the podium by Ian Robertson from Glasgow Dental School who will give an update on resuscitation guidelines.

GETTING DOWN TO BUSINESS

The business of dentistry is becoming more and more important and the business stream at the Scottish Dental Show reflects this. From lawyers

Barbara Lamb speaking at the 2014 show

NOW TRENDING

3/4 FULL

FACT

The exhibition space at the 2016 show is already more than three quarters full as the dental industry shows its enthusiasm for the event

and accountants to business coaches and financial advisors, there will be something of relevance for practice managers, principal dentists, associates and other members of the team.

CONFIRMED SO FAR:

- Adam Morgan, communications and business growth training solutions
- Jonathan Gibson, A+B Wealth chartered financial planners
- Ian Main, Stark Main and Co Dental, specialist dental accountants and tax advisors
- Michael Royden, head of Thorntons Law's specialist legal team
- Davidson Chalmers LLP, specialist legal advice for dentists
- Martin Aitken & Co Chartered Accountants
- Turcan Connell, legal, wealth management and tax advice for dentists.

WORKSHOPS

As well as the lecture programme there will be a busy programme of workshops taking place in the atrium, on the show floor and in the hospitality suite next to registration.

Glasgow dentist Philip Friel will be presenting two day-long practical workshops covering an introduction to basic surgery as well as atraumatic extraction and implant placement. There will also be workshops covering facial aesthetics, medical emergencies and much more.

Details on these and all the other lectures will be released in the coming weeks. Keep an eye on www.sdshow.co.uk for updates or follow @ScottishDental on Twitter for all the latest news.

Prof John Gibson

TOP TIPS

DEVELOPING DENTAL EXPERTISE

SYMPOSIUM **5 CPD CREDITS APPROVED**

JOIN IN

#rcpsgevents

Top tips for dental care professionals

Saturday 7 November 2015

Royal College of Physicians and Surgeons of Glasgow

232 - 242 St Vincent Street, Glasgow, G2 5RJ

Why attend?

- Hear from a range of expert speakers
- Gain lots of practical hints and tips
- Network with professionals in your field

Who should attend?

- Dental Hygienists
- Dental Therapists
- Dental Nurses
- Dental Technicians
- Clinical Dental Technicians
- Orthodontic Therapists

View full event programme online

Book Now:

http://rcp.sg/events

Call: +44 (0)141 241 6210

Email: alexis.ferguson@rcpsg.ac.uk

ROYAL COLLEGE OF PHYSICIANS AND SURGEONS OF GLASGOW

DENTISTRY

CS 3500

Carestream DENTAL

ALL YOU NEED FOR THE **PERFECT RESTORATION**

Quality and Accuracy

The CS 3500 intraoral scanner creates highly accurate, true colour 2D images and 3D models of teeth without conventional impressions.

- Truly handheld, portable with no trolley and plug and play
- Powder-free with slim scanner head for comfortable, custom-fit restorations
- Unique light guidance system for more patient-focused scanning
- Part of a flexible and open system

SCAN DESIGN MILL

Unrivalled UK Based Support Service

At Carestream Dental we pride ourself on our UK based support team here to aid your smooth transition to using CAD/CAM technology in your practice. The UK team is trained on all aspects of CS Solutions covering our support desk and our field service team.

Service Support from a name you can **TRUST**, a company committed to building a **PERSONAL** relationship with you, and a network of experts with a **PROACTIVE** approach and a deep **RESOLVE** to ensure **your** success today and in the future.

Carestream DENTAL
CS Solutions Compatible

For more information or to place an order
in the UK please call **0800 169 9692**
in Ireland please call **+44 1438 245000**
email **sales.uk.csd@carestream.com**
or visit **www.carestreamdental.co.uk**

Follow us on:

Dispatches

WITH DR MICK ARMSTRONG →
Chair of the BDA's Principal Executive Committee
dispatches@sdmag.co.uk

STRESS AND A DEMORALISED PROFESSION

Stress is at record levels, earnings have plunged since 2009 and the red tape keeps piling up. So what will it take before our Governments act?

I'm embarrassed on our respective governments' behalf. We've warned them all before – and we're almost certainly going to have to do so again. There are worryingly low levels of morale amongst dentists, in Scotland and across the rest of the UK. Stress is at unparalleled levels in all areas of dentistry and this cannot be good for dentists or our patients.

One in five principals in Scotland reported very low levels of morale, compared to around one in 17 associates, according to a study published last month on the working hours, motivation and morale of primary care dentists in England and Wales, Northern Ireland and Scotland in 2013/14.

Frustratingly, these figures from the Health and Social Care Information Centre are not an anomaly. They more or less mirror findings from research carried out by the BDA last year. Our survey of members found that dentists were almost twice as likely as the general population to feel dissatisfied with life. They also reported higher levels of anxiety. Do our governments actively want dental professionals to be the most stressed sector of society? I would hope that that is not official policy, but the question then arises: "What is the government doing about it?"

Our survey of members found that dentists were almost twice as likely as the general population to feel dissatisfied at life

It's predictable that principals and associates would differ in their levels of morale since the former have to bear the brunt more directly of falling incomes and rising expenses in running an NHS practice. They have also generally had to bear the burden of a stressful professional life for longer. However, it's not all plain sailing for associates either because, in the past, GDPs could reasonably expect to follow a well-trodden career path from being an associate to practice owner, but for most young dentists that reliable path is now a morass of quicksand. The outlook for more established dentists is no better, as more dentists contemplate leaving the profession early, due to unfulfilling careers, or ill health.

It's no surprise to me that dentists are demoralised – just providing good dental care for our patients and managing their increasing expectations within a shrinking budget is challenging in all parts of the UK.

Inevitably, job satisfaction suffers when you also factor in the multiple layers of unnecessary bureaucracy set by politicians. If that wasn't enough, dentists now practise under the shadow of litigation, arcane, over-zealous regulation and ever-tightening financial scrutiny.

These challenges pervade not only general practice but also our community clinics, hospitals and dental schools.

The NHS would do well to heed these warning signs and provide the resources to assist dentists in delivering high-quality care to their patients and to provide understanding and support where difficulties arise.

Unsurprisingly, pay is a major bone of contention. In March, we expressed our disappointment with the Review Body on Doctors' and Dentists' Remuneration's recommended 1.6 per cent award, and warned that body that it would do nothing to address the low morale among dentists in Scotland (and indeed across the UK). In fact, it only reinforces our growing belief that no one cares for dentists.

From 2009 to 2013 there has been a massive drop in taxable income for Scottish GDPs, according to the government's own figures. This equates to a pay cut of over £16,000. It would take a pay rise of 23.5 per cent just to bring GDP earnings back to 2009 levels. This isn't pay restraint, it's a pay cut. If this trend continues it will inevitably have an impact on dentists' ability to deliver NHS services for patients.

Practices simply cannot continue to provide the high quality of care that patients deserve and that GDPs wish to provide

Without action, practices simply cannot continue to provide the high-quality care that patients deserve and that GDPs wish to provide. None of us came into this business for our own health, but to improve the health of others. That we should be suffering actual harm in trying to do our best is nothing short of scandalous.

The Scottish government must recognise the heavy demands placed upon GDPs and start addressing the causes of poor morale – and it's not just the funding for practices, it's lifting the threats to our livelihood from regulation and red tape. If they lack the will – or the power – to act, then we must be prepared to find our voice and inform our patients and their voters that, while dental health may be improving, the health of dentists certainly is not.

ABOUT THE BDA
Visit www.bda.org for more information

DÜRR DENTAL AG · Höpfigheimer Straße 17 · 74321 Bietigheim-Bissingen

The VistaScan Mini View: X-ray images with maximum resolution.

The DÜRR DENTAL VistaSystem brings digital diagnostics from a single source. With the compact image plate scanner VistaScan Mini View, for instance, your diagnostics will become even faster, surer and more convenient. Scan radiographs in all intraoral formats in just seconds, and with maximum resolution. Monitor the results directly on the large touch display. And, thanks to an integrated WLAN function, stay fully flexible.

More at www.duerrdental.com

DÜRR DENTAL

In depth

24
DENTAL FRAUD
Dr Liam Lynch explains that fraud control in healthcare is a "miserable business" but there are solutions

30
CLINICAL SKILLS
Tim Power talks to Andrew Crothers about how technology is assisting his teaching at Glasgow Dental School

34
WHOSE RESPONSIBILITY?
The issue of vicarious liability is expected to become an increasing area of concern for dental litigation

ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

BAD NEWS
DEFINING FRAUD AND FINDING WAYS TO STAMP IT OUT

See page 24

DENTISTRY'S WHITE-COLLAR CRIME

IT'S AN ISSUE NOBODY WANTS TO HEAR ABOUT, BUT FRAUD EXISTS IN THE PROFESSION AND DENTISTS DO COMMIT IT FOR A NUMBER OF REASONS. BUT THERE ARE SOLUTIONS TO STAMP DOWN ON THE PROBLEM

DR LIAM LYNCH

Dentists rarely like to talk in public about occupational fraud involving fellow dentists. Such discussion seems to make most dentists uncomfortable. One reason may be the inhibitory effect of collegiality.

We all recognise the cultural biases (for example bonds of loyalty and friendship) that accompany membership of a profession and the difficulty in achieving absolute detachment from these perfectly legitimate bonds. Another is the fact that fraud is not a pleasant business. Fraud control can be a difficult field.

As Sparrow[1] says of his own wide experience: "Fraud control is a miserable business. Failure to detect fraud is bad news; and finding fraud is bad news, too. Senior managers seldom want to hear any news about fraud, because news about fraud is never good. Institutional denial of the scope and seriousness of fraud losses is the norm. Fraud control policies tend to be scandal driven."

> "FRAUD CONTROL IS A MISERABLE BUSINESS. FAILURE TO DETECT FRAUD IS BAD NEWS; AND FINDING FRAUD IS BAD NEWS, TOO"
>
> MALCOLM SPARROW

A third reason may be that dentists do not feel they are equipped with the necessary tools – semantic and legalistic – to contribute in a meaningful way in the discourse. After all, occupational fraud studies are rarely taught at undergraduate level and are difficult to find in CPD lectures.

The purpose of this article is to describe the main issues in the field of provider fraud in dentistry. The focus is on fraud carried out by dentists in the course of their professional activities. The term Dental Provider Fraud (DPF) will be used and is defined as: "Fraud committed by a dentist when he or she submits, or causes someone else to submit, false or misleading information for use in determining the amount of fees or benefits payable, that could result in some unauthorised benefit to the dentist, or to another person or entity."

Dr Liam Lynch

The dentist may bill the patient directly, may be paid by a publicly funded delivery system or may be paid via a private insurance carrier.

FRAUD

Developing a definition of fraud is the first step in considering the problem. Vasiu, Warren and Mackay touch on one of the difficulties in defining fraud: "Fraud is a concept that seems to have a perfectly

obvious meaning until we try to define it. Fraud is a deep concept, and few use common definitions."[2]

In its broadest terms, "fraud means obtaining something of value or avoiding an obligation by means of deception"[3]. Black's Law Dictionary defines fraud as "theft by the intentional use of deceit or trickery"[4]. Two other terms, "corruption" and "abuse", require definition. Corruption and fraud are often linked together, partly because in both cases the recipient is seeking to obtain some covert financial advantage[5].

Corruption is "the abuse of entrusted power for private gain"[6]. Healthcare abuse is produced when either the provider practices are inconsistent with sound fiscal, business or medical practices, and result in an unnecessary cost or in reimbursement of services that are not medically necessary or that fail to meet professionally recognised standards for healthcare.

LEGISLATION

In the UK, an Act to make provision for, and in connection with, criminal liability for fraud and obtaining services dishonestly (2006 c.35) came into effect in January 2007. Its territorial extent is England, Wales and Northern Ireland.

In the Republic of Ireland, the Criminal Justice (Theft And Fraud Offences) Act 2001 is the legislation covering DPF.

DECEPTION

According to Guerrero, Anderson and Afifi[7] the five primary forms of deception are as follows:

1. Lying: making up information or giving information that is false, the opposite or very different from the truth.
2. Equivocation: making an indirect, ambiguous, vague or contradictory statement.
3. Concealment: omitting information that is important or relevant to the given context, or engaging in behaviour that helps hide relevant information.
4. Exaggeration: overstatement, embellishment or stretching the truth to a degree.
5. Understatement: minimisation or downplaying aspects of the truth.

The presence of intent differentiates between deception and an honest mistake. For example, ticking the wrong box or honest misinterpretation of a rule.

MENS REA

Mens rea, "the state of mind required to be criminally liable"[8], is one of the necessary elements defining a crime such as DPF. The standard common law test of criminal liability is usually expressed in the phrase "actus non facit reum nisi mens sit rea", which means "the act does not make a person guilty unless the mind be also guilty".

Thus, the general rule is that there must be an actus reus accompanied by some level of mens rea to constitute the crime with which the defendant is charged. Mens rea refers to the mental element of the offence that accompanies the actus reus. Under the traditional common law, the guilt or innocence of a person relied upon whether they had committed the crime, actus reus, and whether they intended to commit the crime, mens rea.

TYPES OF DPF

Twelve broad categories of dental provider fraud have been identified. Rocke[9] provides a good working typology of the different types of dental practitioner fraud of interest.

TYPOLOGY OF THE DIFFERENT TYPES OF DPF

Nonrendered service
This is the easiest type of fraud to identify, investigate and pursue. It encompasses situations in which a dentist bills for services that were never rendered or for supplies that were never received by the patient (for example: charging for a radiograph when none was taken).

Upcoding
This involves situations in which some legitimate service has been rendered; however, the appropriate Current Procedural Terminology (CPT) code is not indicated on the submitted claim form. Instead, another CPT code is used that does not accurately describe the service rendered and results in enhanced compensation to the dentist. An example would be charging for the surgical removal of a tooth when, in fact, the tooth was extracted in a conventional manner.

Unbundling
In cases of unbundling, the dentist chooses not to submit claims for reimbursement using a global or general CPT code that fairly and accurately describes the services rendered, but instead breaks down the various components that make up the global fee into individual parts, thereby increasing the reimbursement received.

Mischaracterisation
This occurs when dental services that would not ordinarily be covered are falsely described with the intention of obtaining coverage. An example of this is describing a root treatment in a premolar tooth (which may not be covered) as having been carried out on the adjacent canine tooth (which may be covered). Another example might be claiming for a domiciliary visit when the treatment took place in the dentist's surgery.

Unnecessary dental services
Almost all claim forms contain both the explicit and implicit representation that all services rendered by a dentist were deemed to be medically necessary and for the benefit of the patient. Any services that were rendered and known not to be medically necessary could thus result in a false claim. An example of unnecessary dental services is billing for radiographs that are of no diagnostic value.

Routine waiver of co-payments
Co-payments are designed to reduce the growth in healthcare spending by making consumers bear some of the cost of the care so that they have an economic interest in the services rendered. In addition, co-payments give patients an immediate interest in avoiding fraudulent and abusive situations (due in part because they will not want to pay for services that are not needed).

Although co-payments may be waived occasionally because of dire financial circumstances, any routine waiver of co-payments can be characterised as creating false claims, since a routine waiver may mean that the provider is misrepresenting his or her customary and ordinary fees.

Informal payments
Also termed "under the table payments"

CONTINUED OVERLEAF>

IN ITS BROADEST TERMS, 'FRAUD MEANS OBTAINING SOMETHING OF VALUE OR AVOIDING AN OBLIGATION BY MEANS OF DECEPTION'

Dental Protection

MORE THAN DEFENCE WITH YOU EVERY STEP

Things change. Your career is no different

At Dental Protection we do not penalise you for taking a break in your membership – so whether you are at dental school, taking a career break or buying or selling a practice, we have a package of support to suit your needs

FIND OUT MORE
Discover the benefits of membership or join today

VISIT
dentalprotection.org

1933: 08/15

FROM PREVIOUS PAGE>

or "brown envelope payments". Patients are charged and pay unofficial fees to gain access to health services that are supposed to be free of charge at the point of use.

Quackery and sham cures
Formally defined as "the fraudulent misrepresentation of one's ability and experience in the diagnosis and treatment of disease or of the effects to be achieved by the treatment offered"[10]. The terms imply over promotion of false or unproven health claims in dentistry for profit, including questionable ideas, products and services.

Misuse of modernisation-type funds
Funds provided for a specific purpose wrongly diverted to another use.

Double-billing
Practitioner submits claim(s) to more than one payment agency for the same item of service.

Kickbacks
An inducement to encourage the use of services paid for by the delivery system.

Altering dates of service
The correct date on which a procedure is performed must be used. It is fraudulent to knowingly send a claim for a treatment using a date other than the actual date of service in order to receive payment not otherwise entitled to. *(Adapted from Rocke, 2000)*

WHY FIGHT DPF?

Five reasons are advanced why DPF should be counteracted. These are that DPF represents:

1. A malum in se
2. Harm to individual patients.
3. Harm to society in general
4. Harm to the profession of dentistry
5. Harm to the transgressing dentist.

The Latin phrase malum in se, widely used by jurists, means wrong in itself. It refers to conduct assessed as inherently wrong by nature, independent of regulations governing the conduct.

EXTENT OF DPF

Different methodologies have been used to estimate the level of provider fraud in dentistry[11]. Estimating levels of DPF is a difficult exercise. One difficulty is that this type of crime is not self-revealing.

Another major problem with estimates is that terms such as "abuse", "waste" and "inappropriate" are lumped in with fraud. Therefore, caution should be used in interpreting these estimates.

Feldman states: "The conventional wisdom is that as much as 10 per cent of this [the healthcare budget] is lost to fraud, waste, and abuse."[12]

As regards a publicly funded delivery system, Oral Care Consulting states that, in the Dental Treatment Services Scheme operating in Republic of Ireland, "at least 10 per cent of payments are likely to be inappropriate"[13]. Depending which country is surveyed, estimates of losses to healthcare provider fraud range from 1 per cent to 15 per cent. It is likely that DPF lies within this range.

I want to emphasise that I believe most dentists are professional, caring, ethical and honest. Most do not perpetrate any type of dental fraud, abuse or scam. There is strong evidence to support this view, for example from Lynch[14] and Schanschieff[15].

The profession of dentistry has worked long and hard to achieve its high status. However, it is clear that some dentists do perpetrate DPF, as can be seen from the number of cases described in the media. It is also clear that it is a serious problem for all stakeholders.

WHY DO DENTISTS ENGAGE IN DPF?

Three factors are hypothesised by Ramos[16], to influence whether an individual engages in fraud. These are rationalisation, opportunity and pressure. This hypothesis is described graphically in the well-known Fraud Triangle in Figure 1 (above).

Duffield and Grabosky[17] discuss what they term the "psychological factors in fraud".

They state that at first glance: "A psychological explanation for fraud would appear simple – greed and dishonesty. Such an explanation is, however, overly simplistic. There are many in society who are aggressively acquisitive, but generally law abiding. Moreover, they are also associated with entirely legitimate forms of human endeavour. Technologies of prediction remain imperfect. Not all dishonest people commit fraud. To date, behavioural scientists have been unable to identify a psychological characteristic that serves as a valid and reliable marker of the propensity of an individual to commit fraud."

When discussing motivation, Stotland[18] points out that: "…sometimes individuals' motivation for crime may have originally been relative deprivation, greed, threat to continued goal attainment and so forth. However, as they found themselves successful at this crime, they began to gain some secondary delight in the knowledge that they are fooling the world, that they are showing their superiority to others."

There is also the gratification obtained from the mastery of a situation. He terms this motivation "ego challenge".

In 1940, Edwin Sutherland[19] coined the phrase "white-collar crime". Sutherland's concept of white-collar crime had a ground-breaking polemical impact. Sutherland discredited widely held theories of his

CONTINUED OVERLEAF>

Figure 1

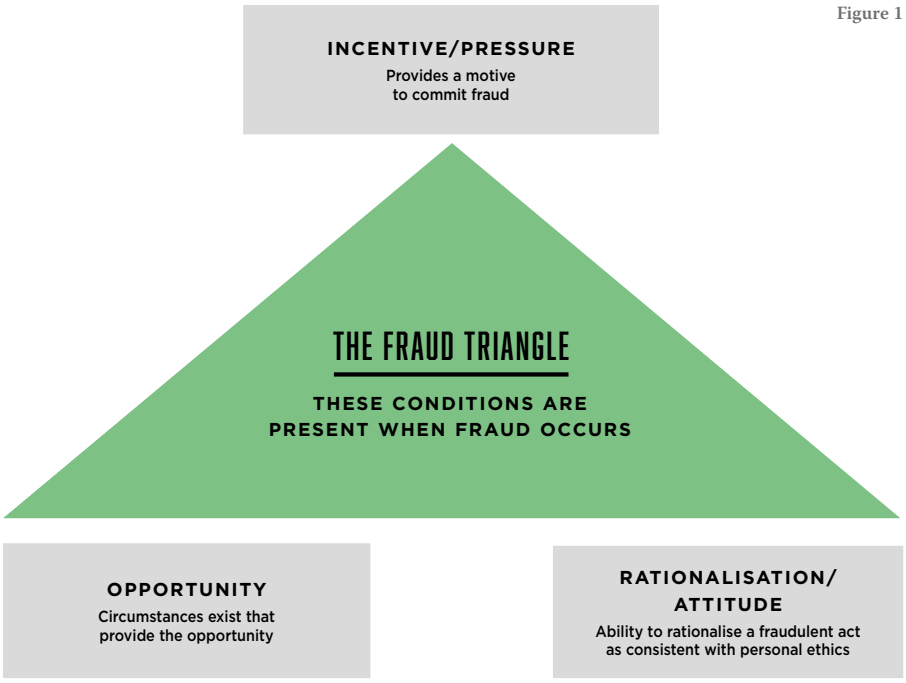


Figure 2

CREATING A COUNTER-FRAUD CULTURE
Deterrence
Prevention
Detection
Investigation
Sanctions
Redress
Monitoring performance

SUCTION & COMPRESSED AIR

High quality products, delivering unbeatable performance and leading-edge technology
Fantastic reputation for providing technical support and a professional, rapid and reliable after-sales service

Control the Power Generate the Power

Reliable and Powerful solutions from single to multiple surgeries

CATTANI AIR TECHNOLOGY

Call us: 01527 877997

info@cattaniesam.co.uk www.cattaniesam.co.uk

CATTANI AIR TECHNOLOGY

Models shown: C300DH Compressor (013250), Turbo-Jet 1 (029625), Micro Smart (035060), & Turbo Smart (035115)

*subject to terms and conditions of servicing schedule, only valid on goods supplied from the UK.

FROM PREVIOUS PAGE>

day that attributed criminal behaviours to poverty and its associated pathologies.

Sutherland described the white-collar criminal as one who is "respected", "socially accepted and approved" and "looked up to".

He later refined his definition of white-collar crime to "crime committed by a person of respectability and high social status in the course of his occupation"[20]. Fraud committed by dentists in the course of their profession is a perfect example of white-collar crime.

As well as positive motivations for white-collar crimes such as fraud, there are also "weak restraints" that lessen the inhibitions to commit these crimes. In most types of fraud, a majority of offenders may seek to justify or rationalise their activity as hypothesised in the fraud triangle.

In doing so, they will use vocabularies of extenuation[21] that manufacture rationale and extenuating circumstances and remove the perception of criminality from the act. For example, frauds against large organisations i.e. insurance companies are often rationalised with the excuse "they can well afford it".

Another example of neutralisation might include viewing the oral healthcare delivery system as culpable in some respect by not paying an adequate professional fee. Still another is the perception that everyone engages in DPF as part of astute professional practice. In this way, those individual dentists who do not participate are seen as naïve.

Stotland states that white-collar criminals appear to be motivated by money, avoidance of threats to goal attainment, sense of superiority, mastery, the admiration of others and conformity pressures. Psychological restraints on their criminal behaviour are weakened by their jungle view of society, the perception of the moral ambiguity of white-collar crime, the lightness of punishment, the view of victims as being morally culpable, and a belief in their own beneficence.

Stotland concludes that fraud is more likely when remuneration is made from a distant anonymous payment agency rather than from an individual patient.

COUNTERING DPF

Professional fraud in medicine has received considerable attention in the literature, for example Whiting[22], Feldman[23], and Faunce, Urbas and Skillen[24]. There was an awareness of the existence of this type of crime by medical practitioners, including dentists, before Sutherland.

A body of literature, perhaps not overly extensive, exists on professional fraud carried out specifically by dentists, for example Pontell, Jesilow and Geis[25], Schanschieff, Shovelton, and Toulmin[26], Bloomfield[27], Welie, 2004b[28] and Steele[29]. A typology of this type of crime was produced by Rocke[30].

A conceptual model, developed from the literature, suggests the presence of eight distinct thematic dimensions in countering fraud. These are presented in Figure 2.

Using this model as a framework, we make eight suggestions that may help to counter DPF.

1. As part of developing a counter-fraud culture, and to emphasise the criminality involved, we should use the term fraud rather than the softer euphemisms such as scamming, milking the system or playing the system.
2. As a deterrent, a robust system of pre-enrolment verification, ensuring that the dentist is familiar with the rules and regulations and the terms and conditions of the delivery system, should be in operation.
3. To prevent fraud, a proportion of payments to dentists should be manually checked before payment in an automatic payment system.
4. As an aid to detection, patients should be randomly selected for a clinical peer review examination.
5. As part of the investigation process, failure of the dentist to produce a patient record on request should be routinely followed through.
6. Sanction: all possible sanctions – regulatory, civil and criminal – should be considered in cases of DPF.
7. Redress: the delivery system should have a clear written policy on the recovery of losses incurred to DPF.
8. Monitoring the counter fraud system: the delivery system should regularly review the effectiveness of its counter fraud work against agreed performance indicators.

ABOUT THE AUTHOR

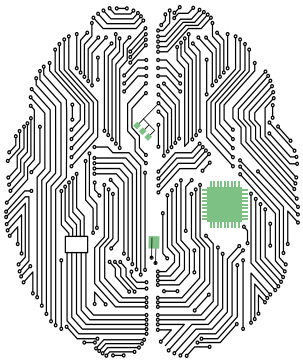
Liam Lynch BDS MDPH PhD is a dentist practising in Cork City, Ireland. He has more than 32 years' experience of active involvement in publicly funded dentistry. He lectures on the topic of healthcare fraud to MSc students in Healthcare Law and Ethics at the Royal College of Surgeons of Ireland in Dublin. He has published and lectured internationally on probity assurance systems in oral healthcare.

In 2013, he was awarded a PhD from The National University of Ireland for his thesis *The Counter Practitioner Fraud in Publicly Funded Dentistry Index – A New Dental Instrument*.

His new book, *Occupational Fraud in Publicly Funded Dentistry – The Elephant in the Room*, addresses the main issues in countering this type of fraud. The book was launched at the European Healthcare Fraud and Corruption Network conference in Athens, in November 2014.

REFERENCES

1. Sparrow M. License to Steal: Why Fraud Plagues the American Health Care System. Boulder: Westview Press, 1996.
2. Vasiu L, Warren M and Mackay D. Defining Fraud: Issues for Organizations from an Information Systems Perspective. Proceedings of the 7th Pacific Asia Conference on Information Systems, 10-13 July 2003, Adelaide, South Australia, pp.971-979.
3. Duffield G and Grabosky P. The Psychology of Fraud. Crime and criminal justice trends and issues, No.199. Canberra: Australian Institute of Criminology, 2001.
4. Black H. Black's Law Dictionary, 2nd edition. New Jersey: The Lawbook Exchange Ltd, 1995.
5. Doig A. Fraud. Devon: Willan Publishing, 2006.
6. Transparency International. How do you define corruption? 2011. Available at: www.transparency.org/whoweare/organisation/faqs_on_corruption[Accessed 6 April 2014].
7. Guerrero LK, Andersen PA, and Afifi WA. Close Encounters: Communication in Relationships, 3rd edition. Thousand Oaks: Sage, 2011.
8. Hall DE. Criminal Law and Procedure, 5th edition. New York: Cengage Learning, 2008.
9. Rocke S. The War on Fraud and its Effect on Dentistry. Journal of the American Dental Association, 2000: 1(131): pp.241-245.
10. Dorland W. Dorland's Illustrated Medical Dictionary, 28th edition. Philadelphia: WB Saunders Co, 1994.
11. Lynch L. A review of assessments of inappropriate payments in the DTSS. Journal of the Irish Dental Association, 2011:57(5): pp.252-255.
12. Feldman, R. An Economic Explanation for Fraud and Abuse in Public Medical Care Programs. The Journal of Legal Studies, 2001:30(2): pp.569-577.
13. Oral Care Consulting. A Report on Probity Assurance Within the Dental Care Sector. Dublin: Department of Health and Children:2009. Available at: http://health.gov.ie/blog/publications/a-report-on-probity-assurance-within-the-dental-care-sector/ [Accessed 18 March 2015].
14. Lynch L. Results of a peer review process: the distribution of codes by examining dentists in the Republic of Ireland 2006-2007. Journal of the Irish Dental Association, 2009: 55(1): pp.38-40.
15. Schanschieff SG, Shovelton DS and Toulmin JK. Report of the Committee of Enquiry into Unnecessary Dental Treatment. London: Department of Health and Social Security:1986
16. Ramos M. Auditors' responsibility for fraud detection. Journal of Accountancy. 2003. [online]. Available at: www.journalofaccountancy.com/Issues/2003/Jan/AuditorsResponsibilityForFraudDetection jofa/jan2003/ramos.htm [Accessed:23 March 2015].
17. Duffield G and Grabosky P. The Psychology of Fraud. Crime and criminal justice trends and issues. Canberra: Australian Institute of Criminology, 2001.
18. Stotland E. White collar criminals. Journal of Social Issues 1977; 33(4): 179-196.
19. Sutherland E. White-Collar Criminality. American Sociological Review 1940; 5(1): 1-12.
20. Sutherland E. White Collar Crime. New York: Holt, Rinehart and Winston, 1949.
21. Krambia-Kapardis M. Enhancing the Auditor's Fraud Detection Ability: An Interdisciplinary Approach. Frankfurt am Main: Peter Lang, 2001.
22. Whiting AD. The Professional Organizations, Training and Ethical Codes of Physicians, Dentists, Nurses and Pharmacists. Annals of the American Academy of Political and Social Science, 1922; 101: 51-67.
23. Feldman R. An Economic Explanation for Fraud and Abuse in Public Medical Care Programs. The Journal of Legal Studies 2001; 30(2): 569-577.
24. Faunce TA. Urbas G. and Lesley Skillen L. (2011). Implementing US-style anti-fraud laws in the Australian pharmaceutical and health care industries. The Medical journal of Australia 2011; 194(9): 474-478.
25. Pontell H, Jesilow P and Geis G. Policing Physicians: Practitioner Fraud and Abuse in a Government Medical Program. Social Problems 1982; 30(1): 117-125.
26. Schanschieff SG, Shovelton DS and Toulmin JK. Report of the Committee of Enquiry into Unnecessary Dental Treatment. London: Department of Health and Social Security, 1986.
27. Bloomfield K. Fundamental Review of Dental Remuneration. London: Her Majesty's Stationary Office, 1992.
28. Welie J. Is Dentistry a Profession? Part 2. The Hallmarks of Professionalism. Journal of the Canadian Dental Association 2004; 70(9): 599-602.
29. Steele J. An independent review of NHS dental services in England. London: Department of Health,2009.
30. Rocke S. The War on Fraud and its Effect on Dentistry. Journal of the American Dental Association 2000; 1(131): 241-245.



TEACHING MANUAL

ANDREW CROTHERS MASTERED DELICATE HAND SKILLS WHILE BUILDING MODEL AIRCRAFT AS A BOY BUT, AWARE THAT FEWER STUDENTS NOW POSSESS SUCH DEXTERITY, THE CLINICAL SKILLS TEACHER ADOPTED A NEW APPROACH

TIM POWER MARK JACKSON

Andrew Crothers is old enough to remember enjoying constructing Airfix kits of aircraft and fighting vehicles as a boy. Making models and enjoying handicrafts is not something that many young people do anymore and, as senior clinical skills teacher at Glasgow Dental School, Andrew sees the lack of experience with dexterity as a challenge to many of his dental students.

He explained: "People don't use their hands as much as they did before and don't have the skills when it comes to handling equipment. That's why it's so important for our students to get as much hands-on coaching in our pre-clinical practice labs before they go on to practise on patients."

Andrew is head of second year and teaches clinical skills to second and third-year students, at the dental school's clinical skills facility. To help give his students the maximum time to perfect their manual skills, Andrew developed a virtual learning environment and launched it last year to his second-year students to provide them with everything they need to master the theory beforehand so they can spend their lab time developing their practical skills.

Within teaching circles this approach is known as the 'flipped classroom' – direct instruction, such as that relating to the theory or background of a subject, is carried out in the students' own time, through online lectures, collaborative online discussions or research, so that the time in the classroom can be spent exploring topics or developing skills in greater depth.

Andrew quotes a well-known teaching saying "from sage on the stage to guide on the side".

He explained: "It is a much more appropriate way of teaching when you are developing students' skills and it means that one member of staff can have a much more individual approach to a smaller number of students rather than talking to everyone all at once."

> "IT IS A MUCH MORE APPROPRIATE WAY OF TEACHING WHEN YOU ARE DEVELOPING STUDENTS' SKILLS"
>
> ANDREW CROTHERS, SENIOR CLINICAL SKILLS TEACHER

Andrew has developed three sets of resources that his second-year students can access at any time and from any device via the University of Glasgow's 'Moodle' intranet.

The first is a list of all the practical skills they need to obtain during the year; the second is individual lesson plans which tell them everything they are going to do with lots of images that guide them through the procedures; and the third resource consists of video presentations which Andrew has produced himself, introducing the work to be done on that day with a demonstration of the appropriate techniques.

Andrew said: "In the past, the students would not have had any of this material and would have come into the classroom and spent the first hour having a presentation from a lecturer – effectively wasting a third of the three hours of laboratory time that could be better spent developing practical skills."

The emphasis is on the students to

CONTINUED OVERLEAF>

MANY STUDENTS HAVE NOT WORKED WITH THEIR HANDS BEFORE AND ARE USED TO DOING THINGS ON SCREEN

FROM PREVIOUS PAGE>
familiarise themselves with the theory and procedures before they enter the labs so that they can maximise their time on the practical aspects of the study.

Andrew added: "The responsibility for learning is put firmly on the student because we are trying to encourage them to be independent learners.

"These resources are platform independent and are accessible at any time so students can read and watch them on either their laptops in the evening before or on their tablet or smartphone on the way in on the bus... the choice is theirs.

"It makes for a much better use of the resources and time we have, but most importantly it allows the staff in here to personalise the learning experiences for the individual students.

"Many students have not worked with their hands before and are used to doing things on screen. Translating that into three dimensions can provide quite a challenge for some. By being able to offer one-to-one coaching it allows us to model their behaviours through a personalised learning experience."

It also allows other students who are making good progress with the techniques to move on ahead at their own pace once they satisfy their lecturer that they have reached the appropriate skill level.

"As the resources are available online, the large majority of students bring their own tablets and smartphones into the lab with them," explained Andrew, "so if they want to revisit some piece of information they can just simply access it via our WiFi system. And it makes a great revision resource in the run-up to exams."

Next year, Andrew is launching an electronic response system that will allow him to ask questions to students during the practicals or to receive them back to bring much more interactivity into the lessons.

One of the things Andrew admits that he was initially worried about was whether his students would prepare fully before the lab work.

He said: "It was interesting as the few that did not prepare before soon realised how far they were behind the others by the end of the lesson. There was also a lot of peer pressure not to fall behind so everyone made sure that they came fully prepared next time.

"You have to bear in mind that our students are all enthusiastic about what they are learning so they are keen to make the effort beforehand."

Now that the system is bedding in for the second-year students, Andrew is developing further resources that will be invaluable for his third-year students. They will cover more advanced

clinical work such as crowns, bridges, endodontics and occlusion.

In addition to developing its own online learning resources, the team at Glasgow Dental School has also been working on the Scottish Dental Educational Online project (SDEO) – an NHS Education for Scotland (NES) national collaboration of dental schools which aims to provide a repository of learning resources for dental students and staff.

Robert McKerlie, clinical university teacher, said: "We're interested in the student learning experience and always looking to improve and that's why we've been supporting SDEO. Rather than reinventing the wheel we are pooling resources to not only share research with our academic staff but also to provide learning resources that students can tap into as an addition to the standard curriculum."

Andrew has already provided links to SDEO on his virtual learning system, such as resource on tooth morphology to help students with restorations if they can't recall their lessons from first year. "It's a great way for them to upskill themselves again," he added.

The SDEO resource was reviewed by Glasgow Dental School fifth-year students last year as an academic study and provided useful feedback to the SDEO team about areas that could be improved.

Robert added: "This year we are about to embark on a specially selected study module which six of our final-year students have opted to take to specifically look at 'e-learning' and develop learning resources for the School.

"Although this work will not be examined, it's been created to generate general interest in research and add value to their course. They are looking back over the last five years of the course at areas that have either been problematic to them or that they feel would benefit from the addition of a learning resource.

"They will be supported with the development of the learning resource by an academic member of staff in a relevant area of specialism and once it has been showcased to the Dental School and approved, it will be available for use by students.

"The students get valuable experience in research, teamwork and presentation skills and get the opportunity to give something back to the School that will help other students in their journey to become professional dentists."

Andrew added: "These learning resources and research exercises are all aimed at developing our students to become self-directed learners. This is vital, as qualified dentists have a commitment to continued professional development so I believe these new models of teaching through e-learning will help give them the skill sets to develop professionally as well as giving them the technical skills."

RESPONSIBILITY OR LIABILITY?

WHEN IT COMES TO COMPLAINTS OR CLAIMS OF NEGLIGENCE, DO PRACTICE PRINCIPALS HAVE A LEGAL RESPONSIBILITY FOR THE ACTIONS OF THEIR ASSOCIATES?

STEWART McROBERT

Dental practice owners are often proud to take responsibility for those who work in their establishments. However, when it comes to the issue of negligence, that obligation can become a matter of contention. Some argue that the complex topic of 'vicarious liability' will become increasingly relevant to the dental profession.

Vicarious liability is where, under certain circumstances, one party becomes liable for the actions of another. For example, an employer may be held civilly or criminally liable for the negligent or unlawful acts of an employee, even though the employee can be shown to have wilfully disobeyed the express instructions of the employer.

Neil Taylor of Taylor Defence Services (TDS), who is qualified in both dentistry and law, believes that vicarious liability is an area where most litigation in dentistry will exist in years to come. "The issues have always been known to lawyers and those dealing with law," he said. "In dentistry, there is the conception that associates are self-employed and provide services on the basis of no contract or contracts that suggest an associate is not employed."

He suggests this throws up several issues. Namely, are associates employees of owners or principal dentists when working in dentistry? What are the contractual rights and obligations between three parties: the patient, the principal dentist/owner and the associate dentist? What recourse does the patient have in law to seek damages for negligent acts?

According to Taylor, the issue is whether an associate is employed, not what type of indemnity they have; however, TDS urges principal dentists to consider their associates have in place "claims made" policies with retroactive cover and indemnity to principles clauses rather than discretionary "claims occurring" memberships.

DETAILED EXAMINATION

Although the law regarding vicarious liability has been known for many years, it seems that until April 2014, there was a grey area in some minds as to why it should apply in dentistry.

The absence of case law made it difficult for dentists to predict the court's reaction to any attempt to impose vicarious liability for the actions of associates. The judgment of HHJ Richard Seymour QC in Whetstone v Medical Protection Society Ltd [2014] in the England and Wales High Court on appeal contains the first detailed examination of this issue.

Between 1998 and 2009, Mr Whetstone, the principal dentist, engaged Mr Sudworth as an associate dentist. A contract was drawn up in 2008 which stipulated the associate was self-employed. Allegations by patients of negligent treatment by Mr Sudworth were made in early 2009. The patients intimated claims against Mr Whetstone on a vicarious liability basis. Mr Whetstone sought indemnity from the MPS (Dental Protection Ltd).

In considering if Mr Whetstone was vicariously liable for the actions of Mr Sudworth, the judge examined the contractual relationship between the two dentists. He observed: "... there was a degree of artificiality about the Sudworth contract. It had been carefully constructed so as to ensure that, as between themselves, Mr Whetstone and Mr Sudworth were not in an employment relationship. However, to the outside world, unaware of the actual terms of the Sudworth contract, how some

of those terms worked was likely to create a different impression."

Judge Seymour cited clauses of the contract which, among other things, determined the policies Mr Sudworth was to follow, the uniform he was required to wear, the hours he was to keep, his holiday entitlement, how fees were fixed, collected and distributed, how he would not be able to treat his own patients wherever he liked, and not be able to treat his own patients after the termination of the contract.

Concluding the relationship was one "akin to employment," Judge Seymour observed: "In no meaningful sense was Mr Sudworth an independent dental practitioner merely taking advantage of premises provided by Mr Whetstone. Mr Sudworth could not decide of his own choice when to work, or what to charge for his services. When the Sudworth contract came to an end, he could not take 'his' patients or their records with him."

Taylor said the issue is becoming more prevalent as pursuing solicitors will not care who has caused the alleged negligence – they will stipulate that their client, the patient, contracted with the surgery or the limited company. Pursuing solicitors have begun to plead in court that the patient's recourse in damages is against the surgery, owner or limited company as the associate is employed.

He maintains the solution is simple: all associates ought to have an indemnity to principals clause inserted into a policy of insurance such that if a patient decides to sue an owner or principal, then it falls back on the associate or the person deemed to have caused the negligent act. If the patient sues a limited company separately from the principal or the associate, then the company ought to look at corporate liability cover to protect the company.

CAREFUL CONSIDERATION

Vicarious liability is an issue that has been carefully considered by organisations that offer dento-legal advice and professional indemnity. MDDUS is one such and its chief executive, Chris Kenny, said: "While all dentists have a legal and professional responsibility to maintain appropriate indemnity, principal dentists cannot afford to take this at face value. They should ensure that indemnity arrangements are maintained for any and all associates, partners and other staff employed or engaged in their practice."

He emphasised that this can be a problem for principals where a partner or associate dentist has 'claims-made' indemnity (which is typical for most insurers), since a certificate of insurance becomes invalid if premiums are not maintained, and insurers will usually only pay if a claim is notified to them within a tightly prescribed period.

"Principals who are members of MDDUS can rest assured they have access to indemnity for their vicarious liability in relation to practice managers, nurses and other ancillary staff. Confirmation that any associate dentists are also members of MDDUS will provide principals with reassurance of adequate indemnity for claims arising, even after associates leave the practice."

MDDUS welcomes the spotlight being shone on this area, he added. "While the legal issues are important to appreciate, our message to our members is that we remain abreast of these developments and have continued to innovate and build in features to their membership, so they can rest assured that we will continue to provide

BOOK NOW

22–24 October 2015, NEC Birmingham

Putting innovation into practice!

Meet 350+ suppliers - Enjoy exclusive offers - Gain vCPD

• The UK's leading B2B dental trade show • Discover and trial what's new • Meet and share ideas with friendly experts for the benefit of your practice and patients • Learn new skills and techniques • Benefit from hands-on demonstrations • Network with colleagues and industry thought-leaders

Save the date and register now for your free ticket

www.dentalshowcase.com

BDIA DENTAL SHOWCASE

Putting innovation into practice

Registration Sponsor

Colgate

Headline Sponsor

Oral-B

BDIA Dental Showcase 2015 is organised by the British Dental Industry Association (formerly the BDTA), Mineral Lane, Chesham, Bucks, HP5 1NL Tel: +44 (0)1494 782873 Email: admin@bdia.org.uk

FROM PREVIOUS PAGE>

adequate and appropriate indemnity.

"The developments in this area of law have come thick and fast over the past few years and we see this trend continuing as claimant law firms seek to use this to their advantage. Unfortunately, this is likely to mean that more of our members are involved in claims relating to their employed staff."

DIFFERING EXPOSURE

Meanwhile, Kevin Lewis, director at Dental Protection, said: "Practices vary greatly and, as a result, their potential exposure to vicarious liability will differ. For this reason, we encourage our members to contact us directly if they have any specific questions regarding vicarious liability and their practice."

He went on to offer general advice to practice owners to help minimise their potential exposure to vicarious liability claims. This included making sure that all members of the dental team operate within the limits of their competence and/or legally permitted scope of practice, and having a written agreement with registered and non-registered personnel they employ, and any other registered health professionals with whom they work.

He advised that it should be a condition of employment or any other contractual relationship that adequate and appropriate professional indemnity is maintained by every registered healthcare professional at all times.

Echoing this, Chris Kenny said that whenever possible professional indemnity should be occurrence-based, and that if the indemnity takes the form of 'claims-made' insurance, it should include 'run-off cover' in perpetuity, without this depending on further premiums.

It is important to see documentation confirming that professional indemnity has been renewed annually and payments have been honoured. Equally, owners should keep copies of documentation that show these checks have taken place and the necessary indemnity was in place at all times.

Finally, he added that practice owners should "Do everything possible to reduce the likelihood of complaints and claims being made against themselves, or the person in respect of whom they might be held to be vicariously liable."

The GDC Standard 1.8 of Standards for the Dental Team states: "You must have appropriate arrangements in place for patients to seek compensation if they suffer harm." The onus is on practitioners, principal practitioners, limited companies and corporate bodies to decide if the cover they purchase is sufficient to meet that test.

WHEN AN ASSOCIATE BECOMES AN EMPLOYEE

The issue of when an associate can be deemed an employee is central to the issue of vicarious liability. This is a topic that has been considered by Dawn Dickson, Employment Partner at Davidson Chalmers in Edinburgh.

She said: "A common assumption made by those working in dental practices is that a written agreement between the practice and associate dentist saying the associate is self-employed is enough to protect the practice from any claims that the associate is indeed an employee.

"Unfortunately, that is not the case and it is not just what is written down (although a good associate agreement is needed) but the day-to-day treatment of the associate that is important; many different factors determine if a dentist is in reality employed or self-employed.

"It is only when something goes wrong in the relationship that the status of an associate is put to the test, so the key thing is to ensure that the relationship practices intend to create at the outset is the one that is actually created."

Dawn outlined key legal principles that need to be taken into account in deciding whether an associate dentist is employed or self-employed:

- personal service
- control
- the written contract
- mutuality of obligation, and
- the right of substitution (someone truly self-employed should be able to send along a substitute to fulfil the terms of their contract.)

She recommended that practices and individuals review their associate agreement and working practices.

"People need to be clear on the type of relationship they wish to create and that should be reflected in a well drafted contract. Practices must adopt working practices to suit each relationship.

"Think about matters such as how dentists are paid, the degree of say they have in how and when they work, the degree of a dentist's integration into the business, the provision of equipment, the responsibility for providing a substitute, the financial risk taken by their associates, the management of the performance and conduct of their associates, and the payment of professional costs."

Effective dental plans for patients & practices

CELEBRATING 20 YEARS 1995-2015

indepenDent

Your dental care plan provider

01463 223399

www.ident.co.uk

Dutch Heiress, the winning horse in the IndepenDent Care Plans 20th Anniversary Stake

Macdonald Marine Hotel

20 YEARS OF INDEPENDENT

SCOTLAND'S LARGEST DENTAL CARE PLAN PROVIDER RUN BY DENTISTS FOR DENTISTS CELEBRATES LANDMARK WITH DAY AT THE RACES

This year, IndepenDent Care Plans celebrates its 20th anniversary in business, supporting independent practitioners with high-quality, tailored dental membership plans for their patients.

Kevin Leeming, chairman of IndepenDent Care Plans, said: "We set up ICP in 1995 because, as dentists, we knew the level of care and support we required from a plan provider. We wanted to create a business that focused more on the needs of its clients, rather than a corporate machine run by shareholders, and sought to offer support to the many independent practitioners across the UK."

RACE DAY CELEBRATIONS

In order to mark the occasion of ICP's 20th anniversary, a celebratory day at Musselburgh races was organised for member dentists and their partners. The day out was followed by an evening reception at the Macdonald Marine Hotel, North Berwick, East Lothian.

Luckily, the weather on 7 August was stunning and perfect for a day at the races. In fact, it was actually the sunniest and warmest day of the year so far!

Guests of ICP were treated to a champagne reception in an exclusively reserved suite situated in the Queen's stand. The first race of the day, The IndepenDent Care Plans 20th Anniversary Stake, was

From left to right: Kevin Leeming (chairman), John Jamieson, Margaret Behrendt, jockey Chris Catlin, Millar Hunter and Bill Longstaff

sponsored by ICP and won by Dutch Heiress. Margaret Behrendt and her fellow ICP directors presented the prize to winning jockey Chris Catlin.

The ladies picked more winners than the men, several of whom were glad to be transported back to the hotel at 5pm before further damage to their pride (and wallets) ensued.

After a short respite between proceedings, guests enjoyed a prosecco and canapés reception in the Bass Rock foyer at the Marine Hotel followed by dinner.

Robert Donald, original chairman of ICP, delivered grace prior to the meal. Current chairman Kevin Leeming delivered a short speech and a vote of thanks, both of which were well received.

Perhaps due to the excitement at the races, the evening was a relatively tranquil affair but everyone certainly had a thoroughly enjoyable time.

"Thanks ICP, for our wonderful day at Musselburgh Races and the Marine Hotel. It was an event that we both eagerly anticipated and it lived up to expectations."

Leslie & Colin Campbell, Campbell & Timmons Dental Care

"Really enjoyed the races, the reception and dinner after – a very happy occasion. Roll on the next ICP event!"

Dr Sarah Thomson

"Thank you for a wonderful day that passed by all too quickly!"

Stephen Mackenzie, Harper Bell Limited

BESPOKE PLANS WITH GREAT SUPPORT

IndepenDent Care Plans provides bespoke membership plans for members, including full care plans, maintenance plans and children's plans. It offers all new clients zero per cent admin fees for the first nine monwths of their plan and doesn't charge patients a joining fee. ICP provides a switching service to make it even easier to move practices across from an existing plan supplier.

Our many partners offer a huge range of support products and services, all with exclusive member offers and discounts.

HISTORY IN BRIEF

- IndepenDent Care Plans (ICP) was formally launched on 17 September 1995, by dentists, run by dentists, for the benefit of dentists
- Originally based in Ness Bank Dental Practice, Inverness, they moved to the current offices at River House, Inverness, in 2008
- Previous chairmen have included Robert Donald, a leading figure in UK dentistry and Kevin Leeming is the current chair.
- In January 2015, ICP acquired Dental Maintenance Plan as part of an expansion of the group.

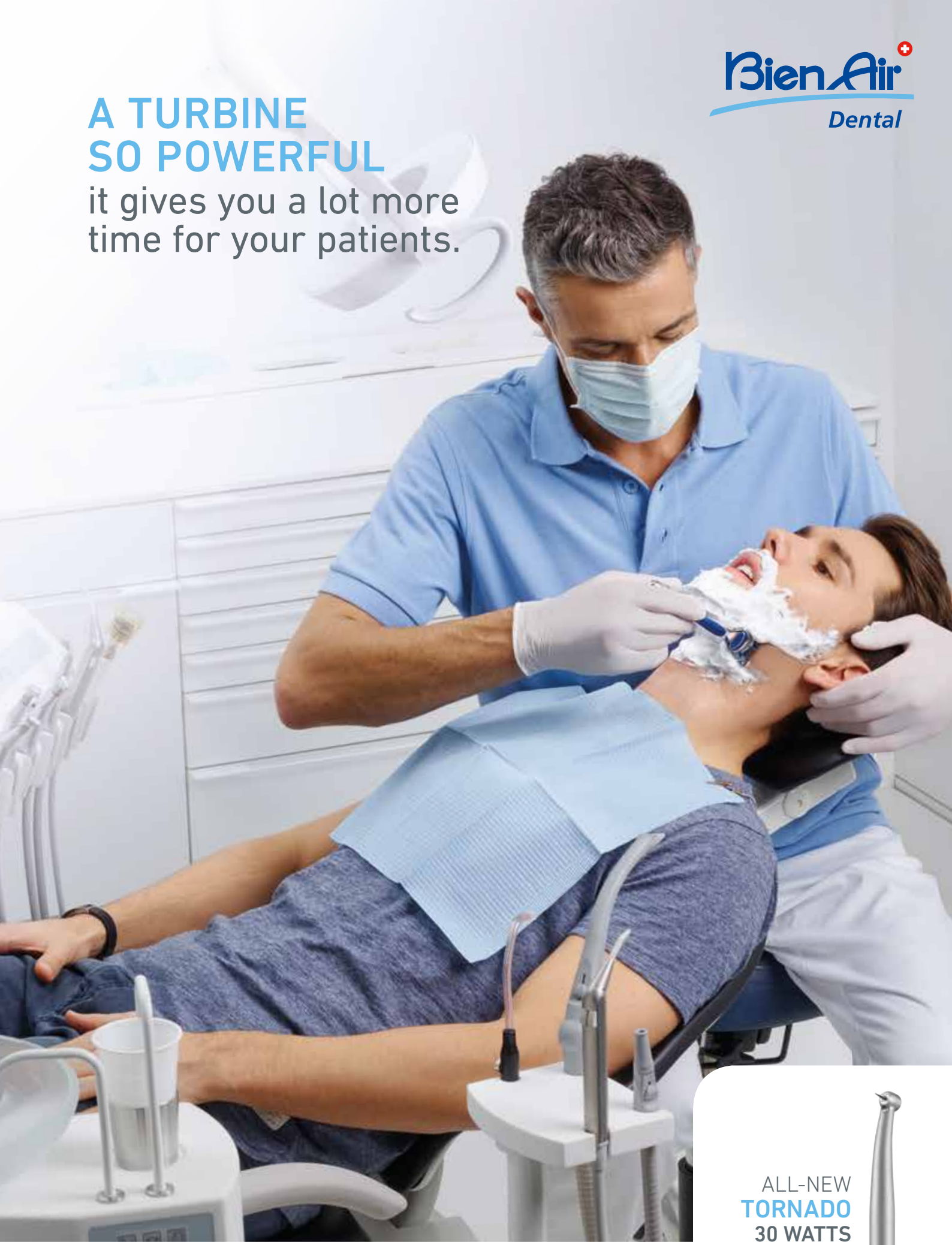
MORE INFORMATION

If you would like to discuss your dental plan needs then please contact Gary Moore, ICP's business development manager, on 01463 223 399, by email at garymoore@ident.co.uk or by visiting www.ident.co.uk

Bien-Air Dental

A TURBINE SO POWERFUL

it gives you a lot more time for your patients.



ALL-NEW
TORNADO
30 WATTS

Bien-Air UK Limited Arundel House Unit 1 - Ground Floor Amberley Court Whitworth Road
Crawley RH11 7XL England Tel. +44 (0)1293 550 200 ba-uk@bienair.com

SWISS MADE

BIENAIR-TORNADO.COM

Clinical

42
SAFEGUARDING
The neglect and abuse of vulnerable groups needs to be a priority for education and training in the profession

47
ANTICOAGULANT GUIDANCE
New guidance from SDCEP provides advice on new drugs on the market and managing the patients taking them

52
PERIODONTAL PROBLEMS
Madeleine Murray considers the implications of starting advanced restorative work on patients with periodontitis

THE SAFEGUARDING OF VULNERABLE ADULTS

VULNERABLE ADULTS

NICHOLAS BEACHER, PETRINA SWEENEY, GILLIAN HOWIE

With each turn of the wheel of time the societal prejudices of the western world have slowly been eroded away. The ethos of pioneering equalitarians from Abraham Lincoln to Emmeline Pankhurst and Martin Luther King Jnr. has begun to resonate within our modern society to include vulnerable adults. As a privileged profession charged with the duty of caring for our patients, the holistic healthcare practice we undertake must endeavour to include safeguarding to protect and promote the welfare of vulnerable people.

The population of Scotland is ageing[1] and the number of people living with chronic medical conditions requiring treatment is rising.[2] This is in part due to medical advances, whilst environmental and social changes including improvements to living and working conditions have also contributed. Prolonged life can come at a cost as, with pre-term birth rates increasing, there is also a resultant poorer long-term health outlook for these individuals[3] whilst those nearing death later in life are kept alive as a result of advanced medical intervention and current ethical beliefs. There is predicted to be a future explosion in the rate of dementia diagnoses burdening our already stretched health and social care systems.[4] One to three people in every 100 suffer from bipolar disease or schizophrenia[5] and while often they manage well with their condition they may go through periods of being acutely unwell. Collectively, these points illustrate the number of people within our society who are likely to be vulnerable at some stage in their life.

The neglect and abuse of many vulnerable people has been brought to light in multiple arenas including The Francis Report[6] which has propelled the issue of adult protection into the foreground of healthcare. Appropriate multi-level measures must now be put in place to ensure these events are never allowed to happen again. This neglected issue must now become a priority for education and training to ensure the profession is able to perform its important role in safeguarding.

Safeguarding

Safeguarding involves a spectrum of measures with the purposes of:

1. Preventing harm and promoting welfare
2. Protecting individuals from harm

Safeguarding is more than an acute response to abuse or neglect. It incorporates anticipatory methods which actively seek to improve the welfare of individuals potentially at risk and prevent harm. This role is inclusive of the dental profession as many vulnerable adults experience poor oral health.[7] Addressing oral health and its common risk factors in order to promote welfare requires input at all levels, from government policy to the essential practices of the clinician.

Protecting Vulnerable Groups Scotland

The Protection of Vulnerable Groups Scheme (PVG) came into existence in 2011.[8] Its purpose was to improve the disclosure process to better protect both children and vulnerable adults. This measure, whilst not foolproof, is a worthwhile system and plays a vital role in preventing predators and those willing to abuse positions of trust from gaining access to vulnerable groups.

Application to the scheme is necessary for anyone who takes part in regulated work with children or protected adults. This includes dentists and dental care professionals.

The neglect and abuse of many vulnerable people has been brought to light in multiple arenas

PRINCIPLES TO BE FOLLOWED

The Act aims to protect people who lack capacity to make particular decisions, but also to support their involvement in making decisions about their own lives as far as they are able to do so. Anyone authorised to make decisions made on behalf of someone with impaired capacity must apply the following principles:

PRINCIPLE 1 - BENEFIT

- Any action or decision taken must benefit the person and only be taken when that benefit cannot reasonably be achieved without it.

PRINCIPLE 2 - LEAST RESTRICTIVE OPTION

- Any action or decision taken should be the minimum necessary to achieve the purpose. It should be the option that restricts the person's freedom as little as possible.

PRINCIPLE 3 - TAKE ACCOUNT OF THE WISHES OF THE PERSON

- In deciding if an action or decision is to be made, and what that should be, account must be taken of the present and past wishes and feelings of the person, as far as this may be ascertained. Some adults will be able to express their wishes and feelings clearly, even although they would not be capable of taking the action or decision which you are considering. For example, he/she may continue to have opinions about a particular item of household expenditure without being able to carry out the transaction personally.

PRINCIPLE 4 - CONSULTATION WITH RELEVANT OTHERS

- Take account of the views of others with an interest in the person's welfare. The Act lists those who should be consulted whenever practicable and reasonable. It includes the person's primary carer, nearest relative, named person, attorney or guardian (if there is one).

PRINCIPLE 5 - ENCOURAGE THE PERSON TO USE EXISTING SKILLS AND DEVELOP NEW SKILLS

Fig.1 Principles of The Adults with Incapacity Act [9]

It is essential as employers, dental practitioners and health boards are actively involved in ensuring all employees are registered with the scheme.

For the purposes of PVG a protected adult is defined as an individual aged 16 or over who is provided with a type of care, support or welfare service and includes health services.

Application to the scheme instigates a search of registers to determine if the applicant is barred from working with vulnerable groups. Further vetting information is acquired from agencies to determine if the individual has any convictions, cautions, children's hearing findings or if there is any other additional police information of interest. On receipt of this information, Disclosure Scotland decides on the suitability of the person to perform a role with at-risk groups. One of the benefits of this new disclosure system is that it will be continually updated. Thus any new information which may affect an individual's position will be recorded and employers informed.

Adults with Incapacity Act

As users of health services we have an expectation that our choices in relation to the treatment we receive will be respected and honoured. Some people are unable to make decisions or communicate their decisions as a result of dementia, learning disability, acquired brain injury, mental illness or severe sensory impairment.

Yet, they still have a right to healthcare which ensures their wellbeing is protected. As a profession we must respect these basic human rights and utilise the existing processes which seek to protect vulnerable adults in relation to the provision of medical and dental treatment.

While this article cannot cover every aspect of the Adults with Incapacity Act nor its clinical applications, it must be touched upon to allow the reader to appreciate its role in the safeguarding of individuals who lack capacity.

The Adults with Incapacity Act was passed by Scottish Parliament with the intention of "safeguarding the welfare and managing the finances of adults who lack capacity due to mental disorder or inability to communicate due to a physical condition".[9] Part 5 of the Act specifically relates to medical treatment and research. It plays an essential role in the safeguarding of patients who lack the capacity to make decisions about healthcare and are reliant upon others to make a decision on their behalf.

For the purposes of the Act, incapacity is defined as being incapable of:

(a) Acting; or
(b) Making decisions; or
(c) Communicating decisions; or
(d) Understanding decisions; or
(e) Retaining the memory of decisions,

It must be reinforced that capacity is not an all or nothing entity and each decision must be made on an individual basis. Equally, the stigmatisation of every person with a learning disability or other medical disease affecting cognitive ability being unable to consent is completely wrong; we must assume capacity until proven otherwise ensuring it is an active process. Each decision in relation to capacity is procedure specific. It may be that a patient is able to consent for certain procedures but not others – if a procedure were complex, or involved multiple risks, then a patient may not be able to consent despite the ability to do so for something more straightforward.

It is the responsibility of the dental practitioner to initially assess capacity. The process is not always black and white but can be established using a simple question and answer conversation. The patient must have the ability to understand what the procedure will involve, why it is required, the benefits and risks of that procedure, and the consequences of having no treatment. The patient must then be capable of making a decision based on the information they have been given, and communicate that decision (with aids if required). Asking your patient to explain to you in their own words their understanding of information you have given them about the procedure or treatment is one way of doing this. It is also worth remembering that some adults who lack capacity one day may not be in the same condition the next. Fluctuation in capacity necessitates continual reassessment.

If the person is deemed not to have capacity, and treatment is being considered, it is important that the principles of the Act are followed (Fig.1).

The next stage in the process would be for the practitioner to determine if the person without capacity has in place a welfare power of attorney, welfare guardian or person appointed by an intervention order (proxy) who should be consulted prior to the provision of any treatment. Where none of these individuals are in place a nearest relative should be consulted. Only if consent is given on the individual's behalf should an Adults with Incapacity (Scotland) Act section 47 form be completed prior to the provision of

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

treatment. An exception to this rule is the provision of essential emergency care, whereby as long as the principles are observed it may be correct to provide treatment without undertaking the capacity process described. These situations are few and far between in dentistry and should subsequent treatment be required an appropriate section 47 should be completed as required.

Only a few dental practitioners in Scotland have the training necessary to legally assess capacity and sign a section 47 form. However, every dentist must assess capacity before providing treatment. For the practitioner without this training there is a responsibility to contact the patient's general medical practitioner, who is able to assess capacity in the eyes of the law and sign Section 47 forms. The dental practitioner can provide a treatment plan to the patient's doctor listing the treatment intervention necessary and should the patient be deemed to lack capacity it can be signed off.

At present, dental treatment requires financial payment if an individual is not in receipt of exemption. A proxy involved in the consent process may also hold financial powers for an individual. If the proxy is refusing necessary treatment which is in the best interests of the person without capacity on financial grounds the intentions of that individual should be questioned. If the dental practitioner is certain that all the principles of the Act have been followed then it may be necessary to raise concerns with the local authority about the suitability of that legal guardian.

The importance of this Act to the safeguarding of vulnerable people should not be underestimated. Without education and training the profession cannot fully embrace the benefits of this Act and ensure the safety of those who lack capacity. There is a clear need for educators to disseminate their knowledge and skills at both undergraduate and postgraduate levels to improve the Profession's use of the Act and ultimately the safety of our patients.

Until then there must be an opening of the channels of communication, to remove the barriers to care, between dental practitioners without the necessary training and general medical practitioners who can assess capacity on their behalf. Equally, dentists with expertise in this area are most numerous in the Public Dental Service and must be open to discussing such issues with colleagues as we throw away the compartmentalisation of services and work together as a team for the benefit of patients and practitioners alike.

The Adult Support and Protection (Scotland) Act 2007

The Adult Support and Protection (Scotland) Act 2007,[10] is the core piece of legislation relating to the protection of potentially vulnerable adults in Scotland. Its role is to support and protect those members of society who are (or are likely to be) at risk of harm through their own conduct or that of others. The term harm when applied is specific to each individual but may include conduct which is physical or psychologically harmful, adversely affects property rights or interests and self-harm.

The Act defines adults at risk as persons aged 16 or over, who:

a) are unable to safeguard their own well-being, property, rights or other interests,

b) are at risk of harm

c) because they are affected by disability, mental disorder, illness or physical or mental infirmity, are vulnerable to being harmed than adults who are not so affected.

As a three-point test, all features must be present to say an adult is at risk. One of the fundamental themes of the Act is to ensure that where an individual is at risk any response should be multi-disciplinary necessitating the need for co-operation between bodies including health boards. Vulnerable individuals often interface with multiple services which may hold information of value in protecting that individual. When access to information is required during

TABLE 1

Types of abuse and examples of possible indicators (adapted from Social Care Institute for Excellence)[12]

Type of abuse	Definition	Example of possible indicators
Physical	The non-accidental infliction of physical force that results in bodily injury, pain or impairment	• Multiple bruising and/or welts on the face, lips, mouth, torso, arms, back and thighs • Cluster(s) of injuries or body marks including slap marks and finger marks
Sexual	The direct or indirect involvement of the adult at risk in sexual activity or relationships, which they: 1. Do not want or have not consented to 2. Cannot understand and lack the mental capacity to be able to give consent to 3. Have been coerced into because the other person is in a position of trust, power or authority (for example a care worker)	• Pregnancy in a woman who is at risk or is unable to consent to sexual intercourse • The uncharacteristic use of explicit sexual language • Overt sexual behaviour/attitude • Withdrawal (e.g. excessive fear/apprehension of, or withdrawal from, relationships) • Reluctance of the adult at risk to be alone with an individual known to them
Psychological / Emotional	Actions or behaviour that have a harmful effect on the emotional health and/or development of an adult who is at risk	• Alteration in the psychological state of the adult at risk (e.g. withdrawal or fear) • Low self-esteem or unexplained paranoia • Intimidation, use of threats, humiliation, bullying, swearing and other abuse
Financial	The use of a person's property, assets, income, funds or any resources without their informed consent or authorisation.	• Unexplained lack of money or inability to maintain lifestyle or withdrawal of funds from accounts, by any party • The person managing the financial affairs of the adult at risk being evasive or uncooperative • Abuse of position (e.g. exploitation of a person's money or assets)
Neglect and Acts of Omission	The failure of any person, who has responsibility for the charge, care or custody of an adult at risk, to provide the amount and type of care that a reasonable person would be expected to provide. Neglect can be intentional or unintentional.	• Poor physical environment or physical condition of the adult at risk (e.g. pressure sores or ulcers) • Malnutrition or unexplained weight loss • Untreated injuries and medical problems • Poor personal hygiene or provision of reasonable personal care
Institutional	Is the mistreatment, abuse or neglect of an adult at risk by a regime or individuals.	• Inadequate staffing levels or high turnover of staff • People being hungry or dehydrated • Poor standards of care with lack of personal clothing and possessions • An ongoing absence of visitors • Inappropriate use of restraints by staff • Loss of or failure to provide dentures; failure to ensure that the person's dentures are cleaned and reserved for their use

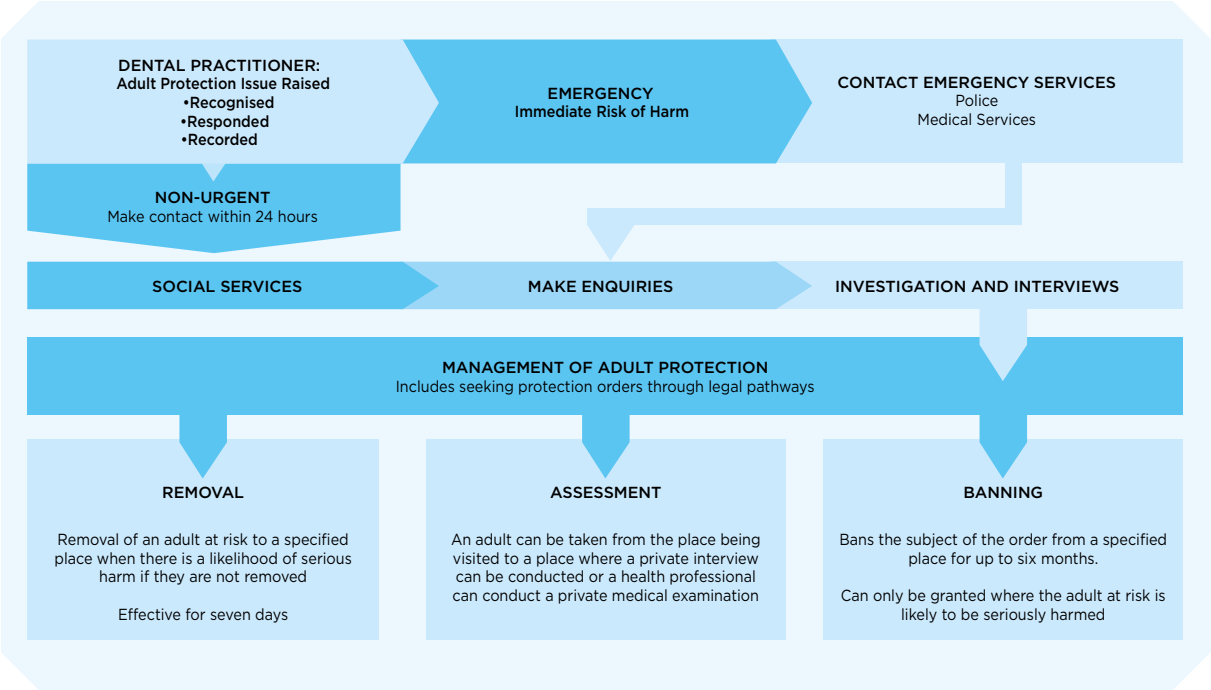


Fig 2. Process of actions in the protection of a vulnerable adult

an investigation under the Act, the oral health practitioner has a duty to co-operate. In rarer instances the oral health physician may be asked to perform an examination and provide evidence in cases of neglect or physical harm which include traumatic injuries to the head and neck.

Protection of adults

The very essence of humanity must be questioned when we read of the events at Winterbourne View Hospital.[11] People with a learning disability and autism were cold-heartedly abused by those they were dependent upon for care. This report has been succeeded by further discoveries highlighting a shameful lack of care including the neglect witnessed at a Mid Staffordshire hospital. Francis, in his seminal report, gave a framework from which the NHS could move forward into a brighter dawn and regain the respect it once possessed as the shining beacon of the world's healthcare services. As lessons are learned and grand plans are made to prevent further such instances, each and every dental practitioner has a role to play at the front line.

The dental practitioner may undertake domiciliary work visiting a patient's own home, care home or supported housing whilst other dentists may work within a hospital setting. Privileged access to these environments should never be taken for granted as they provide a vantage point from which concerns about the safety of an individual or group may come to light. Equally, such signs may present in the patient who attends the surgery.

Empowerment is important, both for the adult at risk but also for the practitioner who has concerns. We must have the confidence to be able to report concerns to ensure safety and provide a vital link in the chain. We often interface with care environments more often than other healthcare colleagues and have built up trusting relationships with our patients for years such that they are able to disclose concerns to us.

The types of abuse and indicators vary but the dental practitioner must always remain vigilant

The types of abuse and indicators vary but the dental practitioner must always remain vigilant and alert to potential signs. Table 1 provides some of the key types of abuse and the indicators which are most likely to be encountered.

Whilst being aware of the potential for abuse, we must appreciate that dental neglect, particularly in our older population, is complex. At face value there is no doubt that many older people resident in care homes have their oral health neglected and in no way can this be deemed acceptable. Yet, there are multiple barriers to the provision of oral care in this setting.

Work is currently being undertaken at The University of Glasgow Dental Hospital and School to gain a better understanding of these factors with the ultimate aim of improving oral health and quality of life for these people. At present, The Caring for Smiles Programme is being rolled out across the country as an intervention to improve the oral health for residents in care homes. The success of the programme is yet to be fully evaluated but the initial response appears promising, yet true success is dependent on high standards being maintained in the long term.

The Adult at Risk

The healthcare professional has a duty of care and a responsibility to report and record any concerns, suspicions or disclosures made by or about an adult who may need protection. Every dental practice and health board should have a protocol in place should such an event occur.

The role of the dental practitioner in adult protection is three-fold:

1. Recognise – Being able to identify an adult at risk
2. Respond – Manage the acute situation and inform other services as required
3. Record – Document and report in detail the information obtained and the actions taken

If concerns arise or a disclosure is made to the practitioner the following steps outline the initial management:

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

1. Remain calm and reassure the individual
2. Seek further information – obtaining who, what, when, where and why?
3. Record the information given
4. Inform person of the your next actions.

A non-judgemental approach is important while no attempt should be made to contact the alleged perpetrator nor should forensic evidence be removed. No promises should be made to the individual or assurances that you will keep any secrets.

Should there be concerns about the immediate safety of the individual the emergency services (police or ambulance services) should be contacted.

The capacity of the individual is not of primary importance in a life-or-limb situation and therefore, in an emergency, it is acceptable to contact services without the person's consent. When contacting emergency help, the practitioner should never put themselves at risk and should always undertake appropriate risk assessment ensuring they are in a safe environment from which to communicate.

Responding to issues which are not of immediate urgency should involve a line manager in the first instance. This should facilitate discussion around the information available, the capacity of the person to consent and what action, if any, should be taken. If action is required contact with social services should be made within 24 hours.

If the individual lacks the capacity to consent then in those circumstances a referral to the local social work department should be undertaken. However, if the individual has capacity, the only instances where referral can be made without consent are if:

- a person is, or may be, an adult at risk, and action needs to be taken in order to protect that person from harm;
- there is an issue of public safety.
- the person is/may be a service provider, and other people may also be at risk.

A referral should be made by telephone initially to the local social work department and followed up in writing by the practitioner. In such matters communication is essential, even if you are only seeking advice it is better to do so than neglect your duty. The process of actions undertaken by social services and associated agencies should an adult protection issue be raised are briefly outlined in Figure 2.

The recording of every aspect of adult protection is essential to ensure there is a contemporaneous record of events. The time taken to ensure these notes are of a high standard cannot be underplayed as they are important for services to establish if the adult is at risk but also for the dentist and their associated legal responsibilities.

Conclusion

The safeguarding of adults is a key area of practice for dental practitioners and is one of the few aspects of care which, if not acted upon correctly, could result in serious harm to an individual. Safeguarding affects many areas of practice which may not have been previously considered, including PVG and Adults with Incapacity. While this article provides an overview of safeguarding, further dedicated training is necessary for the dental community to ensure we are practicing safely and are able to promote welfare and protect vulnerable groups.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To gain an understanding of and be able to implement appropriate safeguarding practice for vulnerable adults
- To review the legislation and requirements related to the safeguarding of vulnerable adults
- To further develop the dental professional's understanding of and ability to assess capacity and appropriately manage the patient who lacks capacity to ensure they are protected
- To understand the importance of health promotion and prevention of harm in safeguarding
- To recognise and appropriately manage abuse and neglect in vulnerable adults

LEARNING OUTCOMES

- The dentist should be able to describe the legislation related to safeguarding
- The dentist should be able to understand the principles of the Adults with Incapacity Act, assess capacity and appropriately manage their patients who lack capacity
- The dentist should be able to identify an adult at risk of/or is experiencing neglect or abuse and take appropriate actions

EXAMPLE QUESTION

1. Which is the key piece of legislation related to the protection of Vulnerable Adults in Scotland?

a. The Adults with Incapacity Act 2000
b. The Adult Support and Protection (Scotland) Act 2007
c. The Protection of Vulnerable Groups Act
d. The Mental Capacity Act 2005

REFERENCES:

1. Office for National Statistics. Population Ageing in the United Kingdom, its Constituent Countries and the European Union. March 2012. http://www.ons.gov.uk/ons/dcp171776_258607.pdf
2. The Scottish Government. Scotland's National Dementia Strategy 2013-2016. http://www.gov.scot/Resource/0042/00423472.pdf
3. Boyle EM, Poulsen G, Field DJ, Kurinczuk JJ, Wolke D, Alfirevic Z, Quigley MA. Effects of gestational age at birth on health outcomes at 3 and 5 years of age: population based cohort study. BMJ. 2012 Mar 1;344:e896.
4. The Scottish Government .Living and Dying Well Living and Dying Well: A national action plan for palliative and end of life care in Scotland. 2008 .
5. Perala et al (2007) Lifetime prevalence of psychotic and bipolar I disorders in a general population Archives of general psychiatry, 64:19-28
6. Francis, R (Chair). Report of The Mid-Staffordshire NHS Foundation Trust Public Inquiry. London: The Stationery Office, 2013. http://www.midstaffspublicinquiry.com/report
7. Daly, B. Disability in Oral Health, Social Inequalities from evidence to action. ICOHIRP. Published: UCL. 2015
8. Disclosure Scotland. The Protection Vulnerable Groups Scheme. 2011. http://www.disclosurescotland.co.uk/disclosureinformation/pvgscheme.htm
9. Adults with Incapacity (Scotland) Act, 2000. http://www.legislation.gov.uk/asp/2000/4/contents
10. The Adult Support and Protection Act (Scotland), 2007. http://www.legislation.gov.uk/asp/2007/10/contents
11. The Department of Health, England. Transforming Care: A National Response to Winterbourne View Hospital. https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/213215/final-report.pdf
12. Social Care Institute for Excellence. Identifying the Signs of Abuse. http://www.scie.org.uk/publications/elearning/adultsafeguarding/resource/documents/Identifying%20the%20signs%20of%20abuse.pdf?res=true

ABOUT THE AUTHORS

Nicholas G. Beacher, BDS, MFDS (RCPSG) Clinical Lecturer and Honorary StR in Special Care Dentistry. University of Glasgow Dental School, School of Medicine, College of Medical, Veterinary & Life Sciences, Glasgow, UK

E-mail: Nicholas.Beacher@glasgow.ac.uk

M. Petrina. Sweeney, BDS, MSC(Med Sci), DDS, FDS (RCPSG) Senior Clinical Lecturer and Honorary Consultant in Special Care Dentistry. University of Glasgow Dental School, School of Medicine, College of Medical, Veterinary & Life Sciences, Glasgow, UK

Gillian C. Howie, BDS Longitudinal Dental Foundation Trainee, NHS Lothian.

MANAGING ANTICOAGULATED PATIENTS

GUIDANCE

Michele West and Garry Sime give an overview of new SDCEP guidance on managing and treating dental patients taking anticoagulants or antiplatelet drugs

MICHELE WEST AND GARRY SIME

More than 500,000 people in Scotland currently take one or more anticoagulants or antiplatelet drugs to treat or prevent thrombotic events[1]. It is, therefore, very likely that at some point most dentists will encounter such patients, under circumstances where they require dental treatment likely to cause bleeding.

The primary concern for those performing dental procedures on this patient group is likely to be the potential for bleeding complications due to the drugs' effects on clot formation, and the practitioner's aim will be to manage the bleeding risk through the use of appropriate treatment planning and haemostatic measures. However, given the variety of these drugs and the other factors that can influence bleeding risk, deciding on the best course of action for an individual patient is often not straightforward.

Various guidelines exist nationally and internationally, providing advice and recommendations for the dental treatment of patients taking the most commonly used of the drugs, including the oral anticoagulant warfarin and the antiplatelet agents aspirin and clopidogrel[2-7]. These drugs have been in use for a number of years, allowing for the accumulation of significant dental clinical experience and evidence to underpin best practice.

However, since 2008, several new anticoagulant and antiplatelet drugs have entered the UK market and are being increasingly prescribed for cardiac and thrombotic conditions. Dabigatran, rivaroxaban and apixaban belong to the group of so-called novel oral anticoagulants, or NOACs (also known as direct oral anticoagulants; DOACs, or target specific oral anticoagulants; TSOACs)[8]. These are a newer class of oral anticoagulants that act in a different way to warfarin, by directly inhibiting specific components of the anticoagulation cascade. New antiplatelet drugs prasugrel and ticagrelor also became available at around the same time and are usually prescribed in combination with aspirin as dual antiplatelet therapies.

The availability and increasing use of these new anticoagulants and antiplatelet drugs has driven the need for new guidelines to assist dental practitioners in

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

the management of patients taking them. Currently, local guidelines from different Scottish health boards make conflicting recommendations for the treatment of patients taking NOACs, with divergence of opinion on whether the NOACs should be interrupted for invasive dental procedures or not. This has the potential to lead to variation in dental treatment for the patients taking these anticoagulants. The conflicting advice is also a source of concern and confusion for dentists and has resulted in calls for a single national guideline on the topic[9].

New guidance

In response to the identification of this topic as a priority in oral healthcare, the Scottish Dental Clinical Effectiveness Programme (SDCEP) has developed new guidance on the 'Management of Dental Patients Taking Anticoagulants or Antiplatelet Drugs'.

The aim of the guidance is to provide advice covering both the new and the conventional drugs, with clear recommendations for the management of invasive dental treatment for this patient group. The guidance was published in August 2015 and printed copies have been distributed widely to members of the dental profession in Scotland.

The main guidance document includes information on each of the drug groups and provides practical advice and recommendations to inform the assessment of bleeding risk and decision making for treatment planning. A quick reference guide, which provides the main recommendations and advice in an easily accessible flow-chart format, is also available.

Additional tools have been developed to support the implementation of the guidance, including printable patient information leaflets specific for the different drug types. A form for recording the contact details of key medical, dental and emergency care contacts, which can be kept on hand by dentists for use should the need arise, is also provided.

The aim of the patient information leaflets is to make patients aware of the importance of informing their dentist about all medical conditions that they have and all of the medications they are taking, even if these are non-prescribed. Ideally, these leaflets should be provided to patients identified as taking anticoagulants or antiplatelet drugs before they require an invasive procedure.

Additionally, the leaflets provide information about how the patient's dental treatment may be affected by their drugs so as to manage their expectations with regards to the extra precautions that may be taken and to provide a basis for communication between the patient and their dentist. Also available are post-treatment advice sheets, with space for recording local emergency contact details, which can be adapted as required by dental practices and provided to patients.

The guidance and all of the supporting documents are freely available via the SDCEP website (www.sdcep.org.uk).

Development of the guidance

SDCEP's approach to the development of this guidance was to engage the clinical knowledge, expertise and experience of a multidisciplinary group of individuals with a wide range of perspectives to provide a balanced view on the clinical questions to be addressed.

This guidance development group was chaired by Garry Sime, a senior dental officer and specialist in special care dentistry based at Broxden Dental Centre in Perth. The other 17 members of the advisory group included dental consultants of various specialities, comprising oral surgery, oral medicine, special care dentistry, oral and maxillofacial surgery and restorative dentistry. A cardiologist, a haematologist, two senior pharmacists and a general medical practitioner provided medical and pharmaceutical expertise and opinion. Three primary care dental practitioners, including one from Orkney to ensure that issues relevant for remote and rural locations were fully considered, and a dental therapist represented the views of end-users.

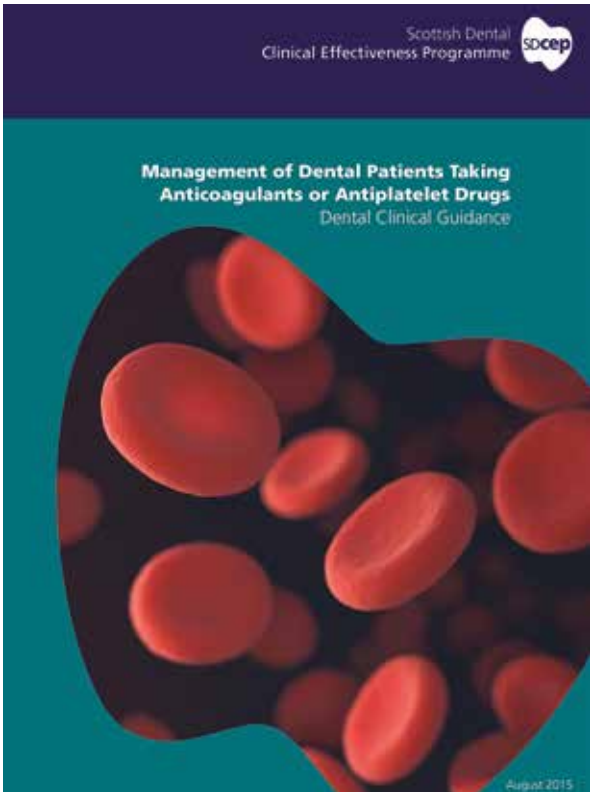
Importantly, the guidance development group also included a patient representative who, in addition to having personal experience of anticoagulant use, is a patient contact for the anticoagulation charity ACE (Anticoagulation Europe) and so was well placed to represent patient views and perspectives.

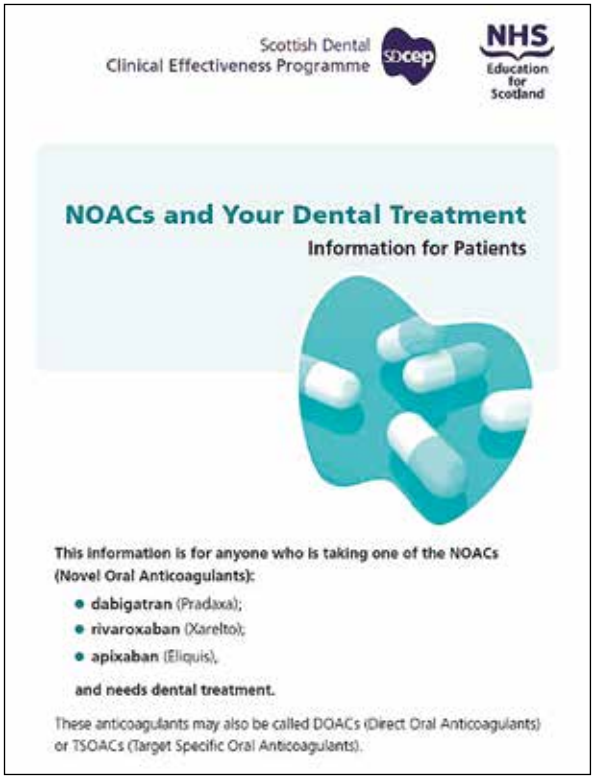
Scoping research with dental practitioners and patients was carried out at the outset of the project to explore their experiences and views to inform the development and content of the guidance. This research was carried out by TRiaDS (Translation Research in a Dental Setting; www.triads.org.uk), who work in partnership with SDCEP and have long-standing experience of carrying out research projects, within an established framework, to support and inform the development and implementation of SDCEP guidance[10].

The TRiaDS research confirmed that, while dental practitioners were generally confident in their approach to treating patients taking warfarin or the commonly used antiplatelet drugs, there was considerable variation in the dentists' knowledge and confidence for the treatment of patients taking the newer drugs. Variation in referral decisions was also identified. Furthermore, accurate medical history taking emerged as a significant issue from both the perspective of the dentists and the patients. Difficulties in obtaining accurate details were highlighted by dentists and uncertainty in whether this information had been collected and recorded was highlighted by patients.

The evidence to inform the clinical questions addressed in the guidance was obtained through systematic searching of the literature. SDCEP was fortunate to be able to employ the expert skills and experience of the Cochrane Oral Health Group for this task (www.ohg.cochrane.org).

The recommendations developed by the group were based on considered judgements of the evidence, where available, clinical experience and expert opinion, and on the perspectives of patients and practitioners. The balance of risks, the values and preferences of patients, and the





ABOVE: The new SDCEP guidance, and (below) NOAC patient advice

practicalities of the proposed treatment options were all taken into consideration. In line with an increasing number of national and international guideline developers, SDCEP uses the GRADE approach (Grading of Recommendations, Assessment, Development and Evaluation; www.gradeworkinggroup.org) for assigning evidence levels and developing recommendations.

Following this approach, the evidence quality and strength of each of the key recommendations presented in the SDCEP guidance are stated clearly, so that dental practitioners can be aware of how clear-cut the recommendations are when planning treatment on an individual patient basis.

Prior to publication, the guidance was scrutinised through a national consultation process and it is endorsed by the Dental Faculty of the Royal College of Physicians and Surgeons of Glasgow and the Faculties of Dental Surgery of the Royal College of Surgeons of Edinburgh and the Royal College of Surgeons of England. Public Health England also supports the guidance recommendations.

The relative seriousness of the different outcomes is a very important factor to be considered

The balance of risks

The overarching consideration when performing an invasive procedure on a patient taking any anticoagulant or antiplatelet drug is the balance of the risk of a bleeding complication if the medication is continued versus the risk of a thrombotic event if the patient's medication is interrupted. There is insufficient evidence from which to obtain an accurate measure of the relative risks of these events for each of the different anticoagulant and antiplatelet drugs or combinations. However, the relative seriousness of the different outcomes is a very important factor to be considered in the judgements leading to the development of recommendations.

Bleeding complications following a dental procedure are usually understood to mean excessive, prolonged or delayed bleeding, or bleeding that requires unplanned measures such as repacking and suturing. In extreme and rare cases, the patient may need to attend hospital for a medical intervention such as a transfusion. While it is acknowledged that a bleeding complication following dental treatment may be a worrying or distressing situation for both patient and practitioner, these events are rarely life threatening. In contrast, a stroke caused by a thromboembolism can have a catastrophic effect on the patient, with the potential to cause serious disability and even death.

Evidence reported over the last 50 years for patients taking warfarin was analysed in a recent review article[11]. Of more than 5,000 patients having in excess of 11,000 dental surgical procedures carried out without interruption of their

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

warfarin medication, only 31 (0.6 per cent) experienced a bleeding complication which required more than local haemostatic measures. In many of these cases, the patients had other medical complications such as being on combined anticoagulant/antiplatelet therapies or having excessively high post-operative INR levels which, in some instances, was attributed to antibiotic usage.

On the other hand, the records for more than 2,500 patients whose warfarin therapy was interrupted or reduced prior to a dental procedure reported that 22 (0.8 per cent) experienced a thromboembolic event, six of which proved fatal.

Furthermore, the majority of studies identified in a recent systematic review found no significant difference in bleeding complications following dental procedures when comparing patients who had continued taking warfarin with those who had modified their drug intake or were not taking any anticoagulants[12]. This evidence also supports the argument to not interrupt warfarin therapy for dental treatment.

Although some guidelines initially advocated warfarin interruption for dental procedures, it is no longer considered best practice to do so. Most current guidelines, including the new guidance from SDCEP, recommend that invasive dental treatments should be carried out without warfarin interruption, as long as the patient's INR is of an acceptable level. This recommendation is consistent with documented patient preference, with evidence suggesting that patients place a higher value on avoiding a thromboembolism than avoiding a bleeding complication following a dental procedure when considering the potential outcomes of each[13].

Accumulated data from studies of patients taking antiplatelet drugs also indicates that serious bleeding complications experienced while continuing their antiplatelet medication for dental procedures are rare (estimated at 0.2 per cent)[14]. As with warfarin, none of the bleeding complications have been reported to result in a fatality.

The evidence also indicates that there is an increased risk of a thrombotic complication if antiplatelet medications are interrupted[14]. The estimates vary and depend on the condition for which the patient is being treated and the duration of interruption. It is likely that the risk is highest for patients on dual antiplatelet therapy following a coronary stent.

What about the NOACs?

While the recommendations for dental patients taking warfarin or antiplatelet drugs can be informed by evidence and accumulated clinical experience, this is not the case for the newer drugs, particularly the NOACs. There is, as yet, no direct evidence reporting on the impact of the NOACs on bleeding outcomes following dental procedures. Instead, the likely effects on bleeding can only be indirectly inferred from the evidence that relates to other types of bleeding.

Large trials conducted by the manufacturers of apixaban, dabigatran and rivaroxaban found comparable rates of spontaneous bleeding events for each compared to patients taking warfarin[15-17]. However, how relevant these results are as predictors for bleeding following dental procedures is not clear.

Current advice from the manufacturers of the NOACs is to interrupt the medication for one to four days (depending on the drug and the patient) prior to any kind of surgical procedure. However, not all types of surgery will cause the same levels of bleeding or carry the same risk of bleeding complications.

Although not yet the case for the NOACs, the distinction in terms of extent and controllability of bleeding between general surgical and dental surgical procedures is now acknowledged for warfarin. The product sheets provided by manufacturers of warfarin provide separate advice for surgery and dental surgery, with continuation of anticoagulation therapy recommended for the latter[18].

The SDCEP guidance recommendations

Key recommendations made by the new SDCEP guidance, in common with many other guidelines, are that neither warfarin nor antiplatelet drugs should be interrupted for dental procedures.

Because of the lack of evidence on which to base the recommendations for the NOACs, further deliberation was carried out by the guidance development group in formulating their advice. Particular emphasis was placed on the potential seriousness of the outcomes for bleeding complications versus thromboembolic events.

The outcome was that for the NOACs, the SDCEP guidance takes a dual approach and advises that drug treatment is: (i) continued for more minor dental procedures, which are judged to have a low risk of bleeding complications;

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To alert dentists and dental care professionals to the publication of SDCEP's new dental clinical guidance and accompanying tools
- To provide an insight into the background evidence and judgements that support the guidance recommendations
- To give a brief overview of the key recommendations in the new guidance.

LEARNING OUTCOMES:

After reading this article the reader should:

- Be aware of the newer anticoagulants and antiplatelet drugs
- Have gained an understanding of the evidence, clinical experience and other factors that influenced the guidance recommendations
- Be familiar with the key recommendations made in the guidance.

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

and (ii) briefly interrupted for more invasive and extensive dental surgery.

The opinion of the group was that the interruption of a patient's NOAC medication was justified, but only for dental procedures with a higher risk of bleeding complications, and as long as the drug interruption was kept to a minimum.

The recommendation given in the guidance is to advise patients to miss (or delay, depending on the drug) their morning dose of NOAC on the day of treatment, giving a window of 12-24 hours (drug dependent) of drug interruption prior to their dental surgery. Because of the short-half lives of the NOACs (~12 hours), levels of anticoagulation fall quickly and can also be reinstated quickly, minimising the length of time that a patient is sub-therapeutically anticoagulated.

For the relatively low-risk dental procedures, it was judged that, taking the balance of likely risk of a severe bleeding complication versus a thromboembolic event and all other factors into account, these procedures can be carried out without drug interruption. However, as a precaution, the guidance advises that for these dental procedures, initial treatment should be limited so that the extent and controllability of bleeding can be assessed before proceeding further with the treatment.

It is very important that any adverse events are recorded to inform future recommendations

Future research and recommendations

As with all guidelines, the recommendations for the new drugs will have to be reviewed in due course and revised if new evidence or experience emerges and indicates that this is appropriate.

It is very important that any adverse events occurring when providing dental treatment to patients taking the newer anticoagulant or antiplatelet drugs are recorded to inform future recommendations.

The national Yellow Card Scheme (www.yellowcard.mhra.gov.uk) collects data on adverse drug events, but this does, of course, rely on these being reported by practitioners and in sufficient detail. High-quality research studies are urgently required to investigate the impact of the drugs on bleeding complications after invasive dental procedures, and with longer patient follow-up, the effect on thrombotic events.

Another new oral anticoagulant, edoxaban, and an antiplatelet drug, vorapaxar, are now on the horizon, with both recently gaining EU marketing approval. Further drugs are also in the pipeline. Again, data on the impact of these for patients having dental treatment will be of great value to inform future guidelines for the management of such patients.

ABOUT THE AUTHORS

Dr Michele West is a research and development manager with the Scottish Dental Clinical Effectiveness Programme (SDCEP) based in Dundee at the Dental Education Centre. She was the project lead for the development of SDCEP's new dental clinical guidance for the 'Management of Dental Patients Taking Anticoagulants or Antiplatelet Drugs'.

Garry Sime is a Specialist in Special Care Dentistry. He is currently working in NHS Tayside as the Senior Dental Officer for Outreach at Broxden Dental Centre in Perth. He was the chair of the guidance development group for the recently published SDCEP guidance document 'Management of Dental Patients Taking Anticoagulants or Antiplatelet Drugs'.

To get in touch or for further information, email scottishdental.cep@nes.scot.nhs.uk

PLEASE NOTE

The information given in this article on the recommendations provided in the 'Management of Dental Patients Taking Anticoagulants or Antiplatelet Drugs' guidance is only a brief overview. For more detailed information about these recommendations and advice for following them, the dental practitioner should refer to the full guidance, which is available at www.sdcep.org.uk

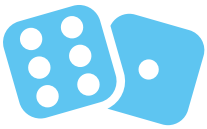
REFERENCES

1. Prescribing Information System, Information Services Division (ISD) Scotland, NHS National Services Scotland. (Extracted 25/08/2015)
2. Randall C. Surgical management of the primary care dental patient on warfarin: North West Medicines Information Centre. 2007; www.app.dundee.ac.uk/tuith/Static/info/warfarin.pdf.
3. Randall C. Surgical management of the primary care dental patient on antiplatelet medication: North West Medicines Information Centre. 2007; http://www.app.dundee.ac.uk/tuith/Static/info/antiplatelet.pdf.
4. Perry DJ, Noakes TJ, Helliwell PS, British Dental S. Guidelines for the management of patients on oral anticoagulants requiring dental surgery. Br Dent J. 2007;203(7):389-393.
5. Aframian DJ, Lalla RV, Peterson DE. Management of dental patients taking common hemostasis-altering medications. Oral Surgery Oral Medicine Oral Pathology Oral Radiology & Endodontics. 2007;103 Suppl:S45.e41-11.
6. Douketis JD, Spyropoulos AC, Spencer FA, et al. Perioperative management of antithrombotic therapy: Antithrombotic Therapy and Prevention of Thrombosis, 9th ed: American College of Chest Physicians Evidence-Based Clinical Practice Guidelines. Chest. 2012;141(2 Suppl):e326S-350S.
7. Armstrong MJ, Gronseth G, Anderson DC, et al. Summary of evidence-based guideline: periprocedural management of antithrombotic medications in patients with ischemic cerebrovascular disease: report of the Guideline Development Subcommittee of the American Academy of Neurology. Neurology. 2013;80(22):2065-2069.
8. Barnes GD, Ageno W, Ansell J, Kaatz S, Subcommittee on the Control of Anticoagulation. Recommendation on the Nomenclature for Oral Anticoagulants: communication from the SSC of the ISTH. J Thromb Haemost. 2015;13:1154-6.
9. Scott A, Gibson J, Crighton A. The management of dental patients taking new generation oral anticoagulants. Primary Dental Journal. 2014;3(4):54-58.
10. Clarkson JE, Ramsay CR, Eccles MP, et al. The translation research in a dental setting (TRiaDS) programme protocol. Implementation Science : IS. 2010;5:57.
11. Wahl MJ, Pinto A, Kilham J, Lalla RV. Dental surgery in anticoagulated patients – stop the interruption. Oral Surg Oral Med Oral Pathol Oral Radiol. 2015;119(2):136-157.
12. Kämmerer PW, Frerich B, Liese J, Schiegnitz E, Al-Nawas B. Oral surgery during therapy with anticoagulants – a systematic review. Clin Oral Investig. 2015;19(2):171.
13. Devereaux PJ, Anderson DR, Gardner MJ, et al. Differences between perspectives of physicians and patients on anticoagulation in patients with atrial fibrillation: observational study. BMJ. 2001;323(7323):1218-1222.
14. Wahl MJ. Dental surgery and antiplatelet agents: bleed or die. The American Journal of Medicine. 2014;127(4):260-267.
15. Connolly SJ, Ezekowitz MD, Yusuf S, et al. Dabigatran versus warfarin in patients with atrial fibrillation. The New England Journal of Medicine. 2009;361(12):1139-1151.
16. Granger CB, Alexander JH, McMurray JJ, et al. Apixaban versus warfarin in patients with atrial fibrillation. The New England Journal of Medicine. 2011;365(11):981-992.
17. Patel MR, Mahaffey KW, Garg J, et al. Rivaroxaban versus warfarin in nonvalvular atrial fibrillation. The New England Journal of Medicine. 2011;365(10):883-891.
18. Warfarin 0.5mg Tablets: Summary of Product Characteristics. Amdipharm Mercury Company Limited; 2014. (www.medicines.org.uk/emc/medicine/25626)

A RISKY BUSINESS?

PERIODONTITIS

Patients with periodontal problems can present particular challenges when carrying out advanced restorative work



MADELEINE MURRAY

Demand for dental implants is growing and patient acceptance of removable appliances is lower than in the past, as those who can afford to pay request restorations that are "fixed" in their jaws. Much of this demand, especially when multiple tooth replacement is considered, is from patients with a history of, or ongoing, periodontal problems.

This demand brings its own set of challenges, as many of the factors which put patients at risk of periodontitis and ongoing bone loss around teeth seem to apply to implants. What we are doing for many of these individuals is moving them from a state where periodontal disease has compromised tooth retention, one which they and their dentists have been unable to control, to a situation where they have complicated and expensive restorations, which need high degrees of skill to maintain, and which are susceptible to similar challenges in the medium and long term.

Our challenge as professionals advising and caring for these patients is to understand this and to plan and execute treatments to take their history into account. How can we reduce the likelihood that patients who had periodontitis, which caused them to lose their teeth prematurely, don't suffer the same fate five, 10 or 15 years down the line after they have implants placed?

The aim of this article is to outline periodontal considerations when planning for successful restorations and working with this challenging group of patients.

Risk assessment

In long-term studies looking at implant retention, patients with periodontitis affecting their natural dentition were more at risk of developing problems in an implant restored one, whether or not they retained some natural teeth[1,2]. Current research seems to support the contention that implants will fare less well in patients with a history of aggressive periodontitis[3,4]. These problems become more pronounced with time[1] and apply not principally in terms of absolute survival but in terms of problems which require intervention but may not result in implant loss, e.g. peri-implantitis. Key to success for patients with periodontal problems who are considering implants is assessing and then reducing this risk[5].

Using historical evidence relating to periodontitis in an individual can be a valuable assessment tool in terms of potential ongoing risk. This is done by considering the history with regard to periodontal disease and the presence of additional risk factors[6], which may contribute to implant-related problems.

For the purposes of this assessment, a thorough periodontal history and examination is required.

History

In the patient history the following factors may be indicative of higher risk:

- Smoking
- Systemic factors, particularly diabetes and stress
- Family history of early tooth loss that is related to periodontal disease
- History of tooth loss secondary to periodontal problems
- Poor outcomes of previous periodontal treatments.

Examination

In patients with complicated disease, as displayed by increased BPE scores, this examination will involve a full six-point pocket chart as well as an assessment of levels of oral hygiene and gingivitis. Radiographs should be assessed for the presence of periodontal bone loss (Fig 1).

Periodontal examination will highlight levels of periodontal attachment, the presence of areas of inflammation (as observed by bleeding on probing), areas

of infection (suppuration on probing) and levels of tooth mobility. This thorough assessment enables the clinician and patient to understand the level of disease present, quantify risk of inflammatory breakdown and plan comprehensively for potential restorations at an early stage.

Donos et al[7] categorised patients as low, medium and high risk for implant placement partially on the basis of these combined periodontal risk factors and clinical examinations:

High risk (Fig 2)

- Presence of aggressive or refractory periodontitis
- High plaque and bleeding on probing scores
- Smoking
- Systemic factors e.g. diabetes.

Medium risk (Fig 3)

- Previous periodontal disease overall successfully treated but still limited number of residual pockets >5mm and less than ideal oral hygiene.

Low risk (Fig 4)

- Systemically healthy
- Good response to periodontal therapy and displaying optimal oral hygiene
- Non-smoker.

Treatment modality selection

One of the fundamental questions when planning for this group of patients is the question of when to retain or extract teeth. The essential question is: will implants fare better, or even as well as, teeth in the medium and long term for the high-risk patient? A reasonable starting point may be that implants are a replacement for *no* teeth rather than a replacement for teeth.

Prior to removing teeth it is sensible to consider whether the patients' own natural implants, their teeth, could be retained by a specialist rather than be extracted. Many long-term studies[8,9] have shown that, following good-quality periodontal treatment and stabilisation of the periodontal tissues, it is possible to retain even severely compromised teeth for long periods of time.

This retention involves high degrees of skill and diligence by patients and support on a regular basis from a dental professional. However, this degree of required ongoing maintenance is not different with implants. Indeed, it is often much easier to maintain teeth than implant-supported restorations when one considers the morphology of restorations and the rough nature of many implant surfaces.

In high-risk patients, Donos et al.[7] suggested that implants should not be provided and, instead, that maintenance of teeth should be a priority and restoration based on removable and conventional dental restorations supported on teeth rather than implants. This concept challenges opinion when one considers that many perceive removal of teeth and placement of implants as a good option for periodontally compromised teeth.

Of course, the decision to remove teeth is not purely periodontal, often due to compromised aesthetics following periodontitis, for example drifting of anterior teeth, or as a result of other restorative failure a decision is made to remove teeth. This is often, in fact, what patients request. Even in these cases the long-term consequences of removing teeth

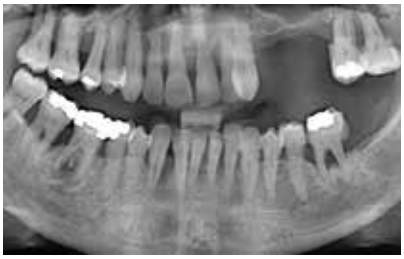


FIGURE 1
Radiographic presentation of aggressive periodontitis

FIGURE 2
Clinical features of aggressive periodontitis; high risk for implant restorations

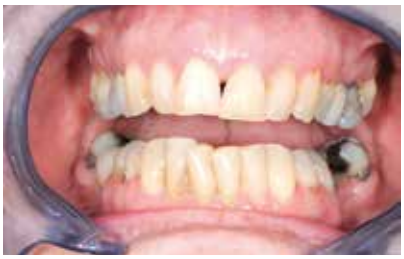


FIGURE 3
Controlled chronic periodontitis and good maintenance; medium risk for implant restorations

FIGURE 4
Patient with external resorption of central incisor, no evidence of periodontitis, good OH and non smoker; low risk for implant restorations

Loss of implants often leaves large tissue defects, which can be extremely challenging to restore at a later date

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

and rebuilding an aesthetic replacement, which will have to be retained and maintained, need to be carefully discussed with the patient. Loss of implants often leaves large tissue defects which can be extremely challenging to restore at a later date.

Patient preparation

If the decision has been made to provide an implant-retained restoration for a patient with a history of periodontitis, it is vital that the patient is fully prepared for the procedure.

Patients should understand what will be required to maintain their restoration and prosthesis design should be discussed in terms of the ease of maintenance of a fixed versus removable, semi-fixed option. They should be given the opportunity to learn the skills needed to maintain their restoration prior to the uncomfortable post-surgical phase that challenges them in this respect. If patients are having a mixed restoration, i.e. retained teeth and implants, these skills can be acquired around natural teeth (Figs 5-10).

In this preparation phase we are essentially trying to accomplish several things:

- Turn a previously "bad" patient, one who has lost teeth secondary to disease, into a "good" one, where disease is controlled and burnt out and the patient's risk is substantially reduced by their changed habits – i.e. good and regular OH, smoking cessation and attendance for regular and tight maintenance
- Establish conditions of periodontal health which reduce the risk to implants in the medium and longer term
- Allow the dentist some time to assess more fully what can and should be done to best restore the dentition. It may be possible to save teeth or a clearer picture may emerge as to what sort of restoration is best, if at all. Many patients function well on the shortened dental arch and the maintenance requirements are low.

Control of periodontitis

If patients have existing periodontitis, this should be controlled prior to implant placement. The aim is to reduce the risk of post-implant placement problems by reducing the likelihood of future periodontal problems. In practice, we should aim for:

- Probing pocket depths below 6mm
- High standard of oral hygiene
- Minimal BOP
- No pus on probing
- Smoking cessation
- Compliance with a regular supportive maintenance programme.

In a dentition where teeth are planned for retention, this will involve well-executed, non-surgical periodontal therapy[10,11] but, in more severe cases, may mean that specialist periodontal treatment is needed during that first phase. In many cases specialist periodontal treatment can save teeth which may be deemed hopeless and the need for implants reduced[8].

If that is the case then this should be accessed at an early stage to allow for healing of soft tissues and stabilisation of gingival margins prior to restoration. In patients who are to have all teeth extracted it is still worth investing time prior to extractions to control levels of inflammation and improve oral hygiene as a platform for future maintenance of implants[12].

Every patient is, of course, an individual but in general terms early periodontal treatment and stabilisation involves:

- Discussion with the patient of aetiology of periodontitis, their risk profile and the effect that may have on implant restorations
- Extraction of teeth with a hopeless prognosis and arrangements for transitional restorations
- Liaison to control any systemic factors contributing to increased tissue breakdown
- Establishment of high levels of oral hygiene as monitored in the medium term, on an objective basis
- Support for smoking cessation
- Scaling to remove supragingival calculus and ease OH
- Sub gingival instrumentation to provide clean, bio-compatible root surfaces and allow the establishment of healthy periodontal support
- In some cases antibiotics may be required if the patient has a more aggressive form of disease
- Opportunity to further discuss with the patient ongoing maintenance requirements and establish habits of attendance for supportive treatment around implants.

If pockets are persistent after non-surgical treatment then principle options will be:

- Surgery for pocket reduction prior to implant placement
- Extraction of non-responding teeth and incorporation into the planned restoration
- Tooth retention and the postponing or cancelling of implant work either until the tissues have stabilised at a later stage or altogether if control is not possible.

Consolidation after this pre-surgical phase allows the clinician to understand better what the longer-term outcome for the patient is likely to be. Any restorations subsequently planned are therefore more predictable. Cancelling or delaying planned implant work is disappointing, however it may be the best option for some patients where periodontitis is not fully controlled. Conventional restorations are less expensive and are often easier to adjust and add to if teeth fail at a later date. This may be the case particularly for those who are have multiple high-risk indicators, e.g. smokers or those with poorly controlled diabetes.

Prosthesis planning

When planning the prosthesis for a patient who has had periodontitis in their natural dentition, the priorities should be to:

- Allow ease of access for good oral hygiene
- Ensure retrievability of restorations so that implant fixtures can be directly assessed and maintained on a regular basis.

The following factors should be considered:

• Removable or fixed

Retrievable restorations are a good option as they allow for maintenance of periodontal tissues by patients and professional staff. This ability to remove a prosthesis and examine tissues directly gives reassurance that implants can be comprehensively inspected and, if problems occur, they can be addressed swiftly.

Establish conditions of periodontal health which reduce the risk to implants in the medium and long term

In terms of how this may be managed, restorations can be removable by patients, as is the case with e.g. a locator-supported denture, allowing for daily plaque control, or screw-retained and removable by the clinician for maintenance, perhaps annually or biannually. Cemented restorations are often used to allow for correction of implant angulation and to avoid screw holes in positions which are aesthetically compromising.

This type of restoration, as well as running the risk of excess cement around the fixture head and "peri-cementitis"[13], is extremely difficult to remove for routine maintenance without destroying the superstructure. Unless the patient can adequately access the peri-implant tissues, a cemented design will make maintenance extremely challenging.

• Flange design

Restorations may incorporate deep or ridge lap flanges designed to close space, improve aesthetics and limit air and fluid escape. In these cases a pontic becomes very difficult to clean for the patient. In addition, the clinician will have no access to peri-implant tissues at maintenance visits to allow for visual inspection or to clean the area unless the superstructure is removed. If this sort of restoration is, in addition, cemented in a patient with a history of periodontitis the risk of disease developing is potentially high due to the problems it creates with oral hygiene and the difficulty of maintenance. Flange design should take into account the patient's need to clean around the implants and beneath the pontic over the ridge and should allow for the use of interdental brushes or bridge floss in the area.

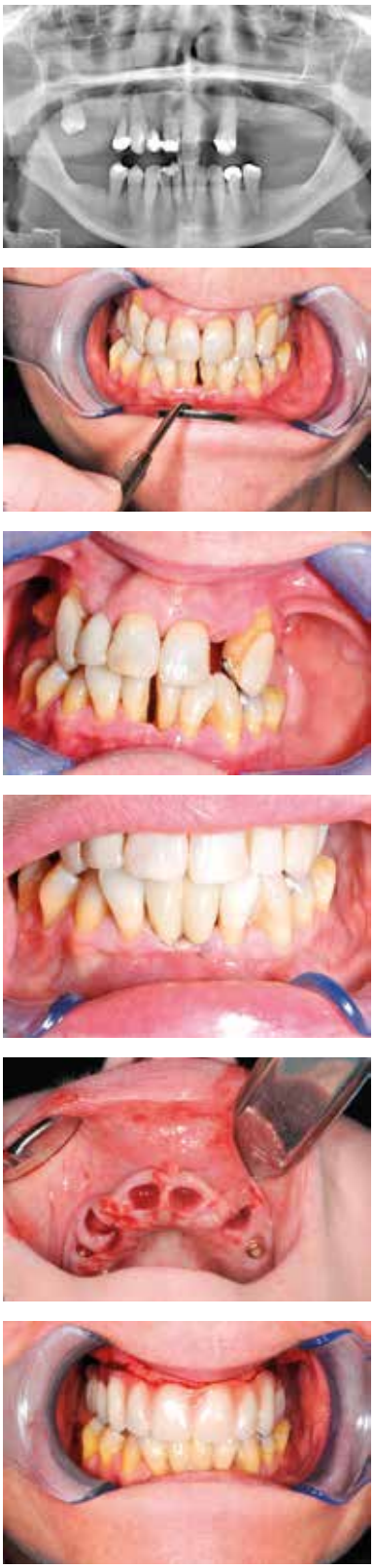
• Embrasure closure

Long and tight embrasures, designed to avoid black triangle spaces and fluid leakage, can make it extremely difficult to clean around implants when the spaces are too narrow to allow access for cleaning aids. This may be less of a problem if the patient is manually dexterous. However, if the patient is older and relying on help, for example if they are resident in a care home, the levels of oral care provided may be poor and implant health compromised.

Maintenance

Following delivery of the implant supported restoration it is essential that the patient is supported in their efforts of maintenance at home[9,14,15,16]. This applies whether there are remaining teeth or the dentition is implant-supported. At fitting of the prosthesis, all patients should have a good-quality periapical radiograph taken to establish baseline bone levels. If the patient has had periodontitis in the past then a comprehensive supportive care programme should be in place and can be modified to ensure adequate maintenance of the implants.

Once again plaque control was identified as a major risk for peri-implant mucosisitis in a recent systematic review[17]. As part of their completion review, patients should be given detailed instruction on exactly how to maintain their new restoration to avoid this. This will involve helping them to find the appropriate mechanical aids to access the peri-implant tissues and ensuring they can use them on a regular basis. At this stage, the benefits of the preparatory phase will become very apparent. Patients will already be used to and in the habit of



FIGURES 5-10
56-year old female presenting for implants. Long-standing severe periodontitis leading to multiple previous tooth loss. Staged approach to treatment tackling periodontal disease and extracting hopeless teeth at an early stage. Adhesive bridge placed in the lower anterior region. Once inflammation stabilised and probing pocket depth reduced, upper teeth extracted in stages and implants placed. Plan in place for an overdenture to allow for easy long-term maintenance of the upper arch

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

cleaning to a high standard and have the knowledge of why that is necessary.

They may have personal experience of the benefit of periodontal treatment and support. Ideally, post-placement review should be a matter of modifying an existing good technique rather than attempting at that late juncture to introduce an entirely new one. All patients then need to understand the importance of supportive treatment either with a dentist or hygienist in ensuring long-term success of their restoration.

It is usual for patients to have an annual implant review appointment when radiographs are updated to monitor peri-implant bone levels and restorations checked. For those with retained natural teeth or with a history of periodontitis this is not likely to be adequate. A programme should be followed which will support their periodontal tissues, control inflammation and reduce risk of implant problems as well as monitoring the implants directly. For periodontitis evidence is plentiful that those following and compliant will have considerably increased chance of stability[8,18].

Conclusion

In the current climate of using fixed implant-supported restorations to replace teeth, it is essential that patients are fully assessed prior to treatment. This is particularly important when considering the patient with a history of periodontitis who is at increased risk of peri-implant problems. If periodontitis is present it should be controlled prior to placement and the patient should be fully informed of their increased risk.

If periodontitis cannot be controlled then consideration should be given to a restoration not dependant on implants in a tooth/implant situation. Once placed, restorations need tight maintenance on a regular basis by both patient and dentist/hygienist. All those involved in planning and provision of implant treatment need to ensure they and their team have the skill to support their patients not only in the immediate surgical and restorative phases but in the longer-term life of the prosthesis.

VERIFIABLE CPD QUESTIONS

AIMS, OBJECTIVES AND LEARNING OUTCOMES

- To discuss the assessment of patients' periodontal status prior to implant placement
- To introduce the concept of periodontal and peri-implant risk
- To outline ways to manage risk when placing implants.

EXAMPLE QUESTION

Q. What factors are important in increasing a patient's risk of peri-implant problems?

a. Smoking
b. History of periodontitis
c. Poor oral hygiene
d. All of the above

ABOUT THE AUTHOR

Madeleine Murray, BDS, MSc, MPhil, FDS(Rest. Dent.) RCPS, MRD RCS Eng, qualified BDS from the University of Glasgow in 1984. She went on to train in the speciality of periodontics in London and then restorative dentistry in Glasgow and Manchester. Since the late 1980s, her principal clinical interest has been periodontology, especially the treatment of young individuals with aggressive periodontitis and, more recently, the management of patients with periodontitis who are having implant therapy. After specialist training, she taught on the Masters in Primary Dental Care in Glasgow and worked in specialist practice before moving with her family to Shanghai, China, for five years. She returned to Scotland in 2011 and is now based at the specialist clinic Vermilion in Edinburgh. She is an examiner for the specialist MRD in Periodontology at the Royal College of Surgeons in Edinburgh. She is married with two daughters.

REFERENCES

1. Schou S1, Holmstrup P, Worthington HV, Esposito M Outcome of implant therapy in patients with previous tooth loss due to periodontitis. See comment in PubMed Commons below Clin Oral Implants Res. 2006; 17 Suppl 2: 104-23.
2. Ong CT, Ivanovski S, Needleman IG, et al. Systematic review of implant outcomes in treated periodontitis subjects. Journal of Clinical Periodontology. 2008; 35: 438-462.
3. De Boever A, Quirynen M, Courke W, Theuniers G, De Boever J. Clinical and radiographical study of implant treatment outcomes in periodontally susceptible and non-susceptible patients: a prospective long term study. Clin Oral Implants Res 2009; 20: 1341-1359
4. Mengel R, Behle M and Flores-de-Jacoby L. Osseointegrated implants in subjects treated for generalized aggressive periodontitis: 10 year results of a prospective, long term cohort study. J Periodontol 2007; 78: 2229-2237
5. Jepsen S, Berglundh T, Genco R, Aass A-M, Demirel K, Derks J, Figuero E, Giovannoli J-L, Goldstein M, Lambert F, Oritz-Vigon A, Polyzois I, Salvi G E, Schwarz F, Serino G, Tomasi C and Zitzmann N.U. Primary prevention of peri-implantitis: Managing peri-implant mucositis. Journal of Clinical Periodontology. 2015; 42(S16) S152-S157
6. Paulander J, Wennstrom JL, Axelsson P, Lindhe J. Some risk factors for periodontal bone loss in 50-year-old individuals. A 10-year cohort study. Journal of Clinical Periodontology. 2004; 31: 489-496.
7. Donos N, Laurell L and Mardas N. Hierarchical decisions on teeth vs implants in the periodontitis susceptible patient: the modern dilemma. Periodontol 2000 2012; 59: 89-110
8. Graetz C, Dörfer CE, Kahl M, Kocher T, Fawzy El-Sayed K, Wiebe JF, Gomer K, Rühling A. Retention of questionable and hopeless teeth in compliant patients treated for aggressive Periodontitis. Journal of Clinical Periodontology 2011; 38: 707-14
9. Axelsson P, Nystrom B and Lindhe J. The long term effect of a plaque control program on tooth mortality, caries and periodontal disease in adults. Results after 30 years of maintenance. Journal of Clinical Periodontology 2004; 31: 749-57
10. Suvan JE. Effectiveness of mechanical nonsurgical pocket therapy. Periodontology 2000. 2005;37:48-71.
11. Eberhard J, Jervoe-Storm PM, Needleman I, Worthington H, Jepsen S. Full-mouth treatment concepts for chronic periodontitis: a systematic review. Journal of Clinical Periodontology. 2008; 35: 591-604.
12. Cortes AR, Cortes DN, No-Cortes J, Arita ES. Transition from failing dentition to full-arch fixed implant-supported prosthesis with a staged approach using removable partial dentures: a case series. J Prosthodont. 2014; 23: 328-32
13. Piñeyro A, Ganeles J. Custom abutments alone will not eliminate the clinical effects of poor cementation techniques around dental implants. Compend Contin Educ Dent. 2014; 35: 678-80, 682-6.
14. Carnevale G, Cairo F, Tonetti MS. Long-term effects of supportive therapy in periodontal patients treated with fibre retention osseous resective surgery. I: recurrence of pockets, bleeding on probing and tooth loss. Journal of Clinical Periodontology. 2007; 34: 334-341.
15. Tonetti MS, Muller-Campanile V, Lang NP. Changes in the prevalence of residual pockets and tooth loss in treated periodontal patients during a supportive maintenance care program. Journal of Clinical Periodontology. 1998; 25: 1008-1016.
16. Zangrando MS, Damante CA, Sant'Ana AC, Rubo de Rezende ML, Greghi SL, Chambrone L. Long-term evaluation of periodontal parameters and implant outcomes in periodontally compromised patients: a systematic review. J Periodontol. 2015; 86: 201-21.
17. Renvert S and Polyzois I. Risk factors for peri-implant mucositis: a systematic literature review. Journal of Clinical Periodontology. 2015; 42(S16): S172-S186
18. Tomasi C, Wennstrom J L and Berglundh T. Longevity of teeth and implants – a systematic review. J Oral Rehabil 2008; 35(Supplement): 23-32

FAIRDENT

experience, service and fair prices

All products have a 12 month guarantee

S1500 DTE Woodpecker D7 Ultrasonic Piezo Scaler

One of our top selling products!

- For Scaling, Periodontal and Endodontic procedures
- Detachable, Satelec compatible, Autoclavable Handpiece
- Digital Control
- Independent Water Supply
- Includes 8 Tips & Tip Holder – GD1, GD4, GD5, GD6, PD1, PD3, PD4D, ED1

£295.00 plus **VAT**.

£195.00 plus **VAT**.

A1042 Woodpecker III Apex Locator

- Clear bright LCD
- Different colour indication of the file trajectory
- Automatic calibrating ensures the measurements are accurate
- Based on advanced multiple frequency network impedance measurement technology
- The accessories can be autoclaved avoiding cross infection risks
- The battery is rechargeable
- Folds and is easy to adjust the visual angle.

NOW IN STOCK!

£115.00 plus **VAT**.

C1005 Woodpecker Lux E Curing Light

- Three working modes: Full, Ramping, Pulse.
- Time setting: 5s, 10s, 15s, 20s.
- Large capacity battery. A full charge can be used for more than 400 times continuously with 10s working time mode.
- Low standby power consumption with forty days standby time.
- Constant light intensity.
- Wireless.
- Power input - AC100V to 240V 50Hz/60Hz
- Light output - 1000mW/cm -1200mW/cm
- Net weight - 147g
- Dimensions - 260mm x 40mm x 50mm

Remember! You can now order and pay online using the website!

Tel: 01485 529363 & 07436 267935 or email: fairdent@btconnect.com

Now order and pay online at www.fairdent.co.uk

Clive and Stuart at the new distribution hub in East Kilbride

NO GIMMICKS

THE ONLY INCENTIVE YOU WILL FIND AT CDC PRODUCTS IS THE OFFER OF GREAT PRICES ALL THE TIME

While marketing gimmicks and special offers may seem attractive in the short term, how can you be sure you are getting the very best value for money for your dental products?

For Glasgow-based CDC Products Ltd, set up by dentists Clive Schmulian and Stuart Davidson, the important thing is offering consistently low prices on a wide range of dental products. You won't find 'Buy one get one free' or other special offers, just 'Dental supplies for dentists, by dentists.'

"We don't promote monthly special offers, loyalty points or free iPads. We simply focus on great prices," said Clive.

Set up in 2014, the company has gone from strength to strength and now offers more than 400 products from gloves and paper towels, through to washable keyboards and the award-wining InSafe needle stick prevention system.

As "wet-fingered" dentists, Clive and Stuart use all the products. "We have had to learn the hard way with some of the products in the early days," explained Clive. "With suppliers, sometimes you've got to kiss a few frogs, before you find a prince."

To this end, CDC Products is concentrating on a core selection of products and, in order to get the best value, they don't offer a dozen different colours of gloves, for example.

Clive said: "We've made the decision that the quality and cost of the products was more important than offering a wide range of choices of colours. If you want various colours then you'll have to look elsewhere.

"Our stainless steel kids crowns sell at less than half the price they can be found elsewhere. This means that cost is no longer a barrier for this technique to be provided on the NHS. Similarly, with packs of six NiTi files at £14.99, rotary endo becomes a financially viable option for all our patients."

He also explained that while some naysayers have called them "the Lidl of dentistry" he isn't concerned. He said: "To be honest, I take that as a compliment. We are not trying to compete with the big national supply companies. We are just trying to get the best deal for our like-minded colleagues."

CDC Products don't have any reps touring the country. By keeping overheads to a minimum, prices can be kept low.

With a new distribution hub in East Kilbride, the company has firmly established itself on the dental scene in Scotland and plans are in place to increase the range of products offered in the future.

Visit www.cdc-products.com and see for yourself.

INSAFE TESTIMONIAL

"Insafe has been a recent introduction to the practice and has been a very useful addition. As an associate in a very busy, high-paced NHS and private practice the health and safety of patients and staff is paramount regardless of the number of patients seen within the day.

"The Insafe sharps disposal has made that easier for everyone. Needles can be removed by the dentist chairside quickly and easily. The syringe also incorporates a lockable sleeve. This allows you to lock the syringe closed between uses covering the needle without the need to resheath it.

"The syringe is easily inserted into the opening of the accompanying sharps box while still covered by the lockable part of the syringe system. Then with a simple motion the needle is removed preventing needlestick injury.

"I would highly recommend the Insafe system to any colleagues."

Lara Paterson, dental associate, Helensburgh

Management

63
PRACTICE RECRUITMENT

Mark Fowler explains how making sure you recruit the right people, and how you do it, is essential for your business

65
FINANCIAL

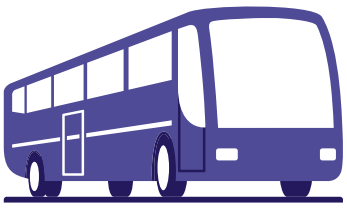
Tricia Halliday looks at the surprises that George Osborne's latest budget had in store for the dental profession

PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

ON THE BUS

RECRUITING THE RIGHT PEOPLE FOR YOUR BUSINESS

See page 63



HAVE THE RIGHT PEOPLE ON YOUR BUS

HAVING THE RIGHT PEOPLE ON BOARD YOUR BUSINESS, AND SITTING IN THE RIGHT SEATS, IS CRUCIAL. HIGH TIME, THEN, TO RETHINK HOW YOU RECRUIT

MARK FOWLER

Imagine your experience of practice ownership like a bus journey. You, as a practice owner (or manager) determine the direction of the journey and, throughout the trip, some people will get on the bus and some people will get off the bus. Some people will also move seats on the bus.

Research data supports the idea that having the right people on the bus, and in the right seats, will have a big impact on the quality of your journey, and in other words on the performance of your business. Radically, it suggests that only once the right people are on the bus, and in the right seats, can the destination of the journey be effectively established.

Importantly, it means that, contrary to popular business belief, it is more effective to recruit and retain good people, before you know what to do with them, rather than to be particularly prescriptive about where you are going and recruit people only towards that goal. In other words, a good team will help move your practice forward, even if the direction you do this in has not yet been established or changes with time as you evolve.

So how do you recruit good people to your team? Ultimately, this comes down to your in-house recruitment practices. Many practices fail to pay due care and attention to planning and preparing the recruitment process. It is time consuming, tedious and costly, however, consider the impact of bad recruitment decisions – the team becomes unsettled, the practice owner is unhappy and nothing moves forward.

The simplest way to begin an effective recruitment process is to consider that you are actually selecting a colleague for you and your team. Unless specific skills are absolutely essential for a position, you must hire first and foremost on attitude and then train the skills that you need.

Your team must contribute to this by brainstorming characteristics that they would like to see in an ideal team member and then divide them into two categories: characteristics that are essential for the position; and characteristics that are desirable for the position. This forms your Person Specification.

For example, if you wish to recruit a qualified dental nurse to your team, then a current GDC registration is obviously an essential characteristic, but being too rigid about the type of clinical software that they should be able to use is much more likely to blind you to an effective recruitment decision. The right people can learn to use new tools after all. Only you must be bothered to teach them how to do it.

Once your person specification is defined, you can use this to do two things:

1. Draw up the job advertisement
2. Use the characteristics to assess how you will measure them in an interview.

This is key to an effective interview process. For example, if your person specification includes someone who is friendly, then seriously consider a team interview where everyone gets a chance to speak to them and ask them questions in an informal setting, perhaps over coffee or as they take a tour around the surgeries.

If your team member needs to be able to think on their feet, consider posing a scenario-based question in your interview to see how they respond. Consider practical tasks to determine competency at certain skills such as email and telephone call handling. Once the interview concludes, immediately collect feedback from your team and your interview on each candidate to form an opinion and then act on your shortlist to offer the best candidate a position.

A good recruitment decision will pay dividends many times over. After all, people are your business.

IT'S MY WAY OR THE HIGHWAY

There are many leadership and management styles and as many names to label and identify them. While everyone has a dominant or preferred style of leadership, unfortunately, day-to-day life in the busy world of dentistry is not a one-trick pony. Different situations call for different management styles and the people in your team will respond to different leadership preferences.

Great leadership is about being committed to what you are doing and to cascade this belief to your team around you (remember there is no 'I' in team). This self-belief will carry your team and your business through difficult times and provide an anchor and point of reference for you and your team.

So, while there may be room for the 'It's my way or the highway' approach, don't make this your default position. It may be lonely at the top, but don't make your position up there any more lonely.

SUMMER SURPRISES

TRICIA HALLIDAY EXAMINES CHANGES CONTAINED IN THE CHANCELLOR'S SUMMER BUDGET AND WHAT THEY MEAN FOR DENTISTS IN SCOTLAND

TRICIA HALLIDAY

There were a number of announcements in the summer Budget on 8 July, many of which confirmed announcements which had been made previously and other initiatives which had been well trailed in the media before the Budget. If you missed the Chancellor's statement during the traditional Scottish summer holiday season, you can view the changes in full on www.maco.co.uk

Based on conversations I've had with a few dental practitioners since the Budget in July, I thought it worth highlighting a couple of recurring themes.

BUY-TO-LET?

Thinking about making a buy-to-let investment? You may want to give it a second thought.

Many of our dentistry clients have been considering other forms of investment over the past five years, especially in buy-to-let property, as the returns on investment generated have outperformed the more traditional investments in stocks and shares. One of the key attractions of investing in property as opposed to other assets is that the interest on borrowings to buy property is tax-deductible against the income generated. At current interest rates and yields, this has encouraged investors to borrow as much as possible, thereby increasing the size of their portfolio and/or reducing their tax bill.

Mr Osborne has now sounded a death knell for this technique by announcing that for individual investors, over the four years from April 2017, he will phase in a reduction in the rate of tax relief on interest

to basic rate. For higher and additional-rate taxpayers this could significantly increase their tax bill on buy-to-let investments – currently interest often offsets a large part of the rental income.

The other major change for buy-to-let – from 2016/17 onwards – will be the replacement of the 10 per cent wear and tear allowance for furnished lettings with a new relief that allows the actual costs of replacing furnishings to be deducted.

In practice, this relief will be worth less than the current allowance and will mean that the investor has to incur real pounds and pence expenditure to claim it.

> "FOLLOWING RECENT CHANGES TO SAVINGS TAXATION, IT IS TIME TO REVIEW WHETHER BUY-TO-LET IS STILL THE BEST FORM OF INVESTMENT"
>
> TRICIA HALLIDAY

Following recent changes to savings taxation, it is time to review whether buy-to-let is still the best form of investment. It is important that you consider your overall tax situation in the wakes of these recent developments. We expect further communication from the Chancellor and HMRC on these issues and we will update you in these pages.

ANNUAL INVESTMENT ALLOWANCE (AIA)

The current AIA is £500,000. From January 2016 it falls to £200,000, which is a significant reduction. If you are considering making an investment e.g. expanding the practice, refitting or purchasing expensive new equipment, and you want to make the best use of the AIA available, give me a call and I'll help you to calculate the savings you will make by doing it sooner rather than later.

THE £1M IHT EXEMPTION

The current IHT allowance is £325,000 per person, £650,000 for a married couple or civil partnership. A new tax-free 'main residence' band is being introduced from April 2017, however, it is only valid on a main residence and where recipients are direct descendants – children, step-children and grandchildren. The new main residence allowance will be phased in from April 2017 and will amount to a £1m IHT allowance per married couple (£500,000 for individuals) by 2020.

ABOUT THE AUTHOR
Tricia Halliday is a tax director at Martin Aitken & Co. To contact her, please email ph@maco.co.uk or phone 0141 272 0000.

Exit or entry? Get great advice for big decisions

CALLING UPON SPECIALISTS WITH YEARS OF EXPERIENCE AND EXPERTISE PAYS OFF WHEN SELLING OR BUYING A PRACTICE

IAN MAIN

We continue to be involved in a large number of practice disposals and acquisitions and it is clear that the market is highly active at present. There are a number of reasons causing this activity, including the relatively abundant availability of funding for the sector and the ongoing reduction in associate income sharing percentages, not to mention the ever-increasing compliance burden and reducing income levels causing some 'battle-worn' practitioners to consider making their exit.

We act for both buyers and sellers (although never at the same time due to the natural conflict that would cause) and are experts in achieving the optimal commercial outcome and lowest tax burden possible for our client.

With such a large number of considerations required when buying or selling a practice, it makes sense to tap into the expert knowledge of your advisers to ensure you do not fall foul of the various costly pitfalls that can occur if a deal is structured incorrectly or inefficiently.

Given that this could be the biggest financial decision undertaken in your career, or the culmination of a lifetime's work, it should not be undertaken lightly nor should choices be rushed into or made without the expert guidance that you need and deserve.

In terms of exit planning, we would highly recommend following a programme of advance planning.

A process of 'grooming the practice for sale' should take place over a number of years to achieve the smoothest transition for all parties and the best price.

Equally, forward planning for a practice acquisition makes good sense too, as the more prepared you can be for becoming a practice owner, the more chance you have of achieving your ambitions for the acquisition.

If you are considering an exit/entry and would like to chat through the finer details of how to achieve success, please do get in touch. I'd love to help you make a difference together.

STARK MAIN & CO DENTAL

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

Workplace pensions for Scottish practices

AUTO ENROLMENT HAS BEEN INTRODUCED TO ENCOURAGE EMPLOYEES TO SAVE FOR RETIREMENT BUT IS YOUR BUSINESS READY FOR THE ADMINISTRATIVE AND FINANCIAL CHALLENGES?

ROB TURNBULL

Have you heard or seen the public announcements about workplace pensions in the media? The UK Government has introduced a new mandatory workplace pension scheme for all UK employers. Known as 'auto enrolment', this has been created to encourage individuals to save for their retirement through having them automatically enrolled into a pension scheme by their employer.

So, how does this affect me as an employee? Auto enrolment will affect all employees who do not already contribute to a workplace pension such as the NHS pension. The employee has to be aged between 22 and the state pension age, plus they must earn more than £10,000 a year (this is for the 2015/16 tax year and is reviewed each year). The employee can choose to opt out of auto enrolment as it is not compulsory for them.

Employees who don't fit into the stated criteria might be eligible to contribute to a scheme, although the employer will not legally have to contribute.

How does this affect me as an employer? Employers are required to enrol their eligible employees by their individual staging date, this is set on a practice by practice basis, and could be any date before February 2018.

The smallest contribution that can initially be made is two per cent of the employee's gross annual earnings. This is made up of a contribution from the employee and from the employer. This will increase up to eight per cent by October 2018.

Any employers who are discovered to have not enrolled their staff will face substantial fines.

What should I do? By seeking advice from an Independent Financial Adviser you can learn more about auto enrolment and how it will affect you or your practice.

MORE INFO

Rob Turnbull is an independent financial adviser at Skyridge Financial Planning LLP. To contact Rob, email rob@skyridgefinancial.co.uk or call 07771 606 125. Skyridge Financial Planning LLP is an appointed representative of TenetConnect Services Limited, which is authorised and regulated by the Financial Conduct Authority.

Skyridge Financial Planning LLP are members of the Association of Scottish Dental Professionals, an association of dental experts dedicated to supporting the dental profession in Scotland. To find out more about the ASDP visit www.asdp.org.uk

Market opportunities

SCOTLAND IS PROVING AN ATTRACTIVE PROPOSITION FOR BUYERS SEEKING A SUCCESSFUL BUSINESS AT A COMPETITIVE PRICE, BUT THE TIME TO ACT IS NOW AS THE MARKET IS STRENGTHENING

PAUL GRAHAM

Generally speaking, the NHS model in Scotland is the most alluring factor to buyers south of the border. There is no CQC in Scotland and, unlike in England, there are no NHS contracts as such. In other words, you are not restricted in terms of where you can practise.

If this is considered alongside the fact that NHS practices in the Scottish market are generally being bought at about 90 per cent of their overall value – compared to the English market where this is far more likely to be well in excess of this – we can see real opportunities for buying north of the border.

Now is undoubtedly the time to capitalise on this. There are many well-established, successful businesses, with loyal patient bases and low levels of competition, available for buyers to take over for considerably less than a comparable purchase in the south.

But times are changing – already we've seen examples of practices (often those with four or more surgeries) that are fetching sale prices of 100 per cent or more of turnover. This is an incredible and unprecedented turn in the Scottish market and our view is that this will become more common as the UK market continues to strengthen as a whole.

And it is not just Scotland that is enjoying this growth; we're seeing a lot of synergy in the Welsh and Northern Irish markets as well, with buyers looking further afield when acquiring successful businesses.

It is crucial for those looking to purchase a new practice to recognise that the dental market is strong across the entirety of the UK – not just in mainstream English locations like London and the South East.

Investing further afield may be a considerable commitment to make, but in our experience, many buyers are willing to do so and they are profiting as a result.

Christie+Co

MORE INFO

Based in Edinburgh, Paul Graham of the specialist medical team at Christie + Co has more than a decade of experience in the business sales market. His experience has helped see the rapid growth of the dental sales market across Scotland and the north east of England.

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

Specialist tax

ANDREW DINES

FOR ONE COUPLE SELLING THEIR PRACTICE, AND AIMING TO LIVE OFF THE PROCEEDS IN THEIR RETIREMENT, THE SOLUTION IS STRAIGHTFORWARD TAX PLANNING

John and Sarah are both aged 70 and married. They have run a successful dental practice for more than 30 years. They were approached by one of their competitors who was interested in buying their company. The sale of the business attracted entrepreneur's relief and they were happy to exit the business paying 10 per cent on the gains made from the business sale.

At the same time, John and Sarah decided that they would sell their property portfolio and enjoy their retirement, albeit there were significant gains within the property portfolio. Net of all capital gains tax allowances, there was £300,000 of capital gains which, as higher rate tax payers, would result in an £84,000 capital gains tax bill.

John and Sarah's priorities are to maintain their desired lifestyle to an assumed age of 100 and reduce their liability to income tax, capital gains tax (CGT) and inheritance tax (IHT).

AAB Wealth's proposal:

1. Complete a lifetime cash-flow analysis, underpinned by reasoned and reasonable assumptions, to ensure John and Sarah can maintain their desired lifestyle.
2. Invest the entire gain from the property portfolio of £300,000 into an Enterprise Investment Scheme (EIS) which will:
   a. Attract income tax relief of £90,000
   b. Defer John and Sarah's capital gains tax bill of £84,000 for the life of the EIS
   c. Be outwith their estate for inheritance tax purposes immediately through Reinvestment Relief.

The result will be that John and Sarah have achieved all of their goals through straightforward tax planning.

AAB Wealth will provide confidence to both clients that they are able to live their desired lifestyle in retirement, through our cash flow modelling programme using reasonable assumptions.

Through investment into an EIS, income tax has been mitigated and CGT been deferred along with removing the capital sum exposed to IHT.

MORE INFO
Andrew Dines is a chartered financial planner at AAB Wealth. To contact Andrew, email andrew.dines@aabwealth.co.uk

iwt services

iwtech.co.uk

Specialists in Dental Practice IT Solutions

- Server Based Networks
- Email & Smart Phone Synchronisation
- Waiting Area Digital Signage
- Patient Information Signage
- Remote Access & Working From Home
- Business Telephone Systems
- Audio Visual Systems
- Secure Cloud Backup

Digital imaging and x-ray equipment, including intraoral sensors, phosphor plate scanners, digital Cad Cam Scanner, 2D Panoramic and 3D CBCT units.

myray

DÜRR DENTAL

3shape TRIOS®
Distributed by
core3d centres®

iwt dentalsupplies

iwtdental.co.uk

Specialists in Dental Practice Equipment

- Dental Chairs
- Dental Cabinets
- Surgery Design
- Preventitive Maintenance
- Handpiece Repairs

Castellini, Stern Weber and Victor dental chair packages along with a full range of dental furniture.

STERN WEBER

CASTELLINI
PASSION FOR DENTISTRY SINCE 1935

VICTOR

For more information or to arrange a practice review please contact us on

t 0845 200 2219 e info@iwtech.co.uk

HOME COMFORT

LOUISE REAY AND HEATHER MUIR HAVE RETURNED TO THE TOWN THEY GREW UP IN WITH EXCITING PLANS FOR UDDINGSTON DENTAL CARE

BRUCE OXLEY

When Louise Reay and Heather Muir took over Uddingston Dental Care earlier this year, the two Glasgow graduates admitted it felt very much like a homecoming.

Both Louise and Heather hailed from the small South Lanarkshire town and, when the opportunity arose to take over Neil Simpson's three-surgery practice, it seemed like the perfect fit.

Having graduated in the same class from Glasgow Dental School in 1998, Louise did her VT year up in Aberdeen while Heather completed hers in Whitburn. Louise then worked in Govan before the two friends crossed paths again when they both worked in Hill House, Hamilton, a practice Heather co-owned with her brother Scot. Louise then moved on to a locum position in East Kilbride before spending the last six years as an associate at a practice in Stonehouse.

Heather and Scot, who also owned Love Your Smile in Prestwick, sold both practices in 2009. Scot then became a director at the Scottish Centre for Excellence in Dentistry in 2014.

After working as an associate since graduating, Louise was starting to think about making the step up to practice principal and, with Heather selling the two practices she was involved in, an opportunity arose for them to join forces back in their hometown. They had previously discussed the possibility of owning a practice together as far back as 2007 and now seemed like the perfect time for both of them.

Heather had worked with Neil Simpson in Uddingston in 2000 and, when she heard that he was retiring, she got in touch. The practice had only just moved into new premises in 2010, having previously been situated a few hundred yards down Main Street for more than 20 years. Like many practices in Scotland at the time, the practice was forced to relocate to accommodate a new LDU and Neil took over the former Uddingston Library building at 1 Main Street, which had lain empty for a number of years.

Having been friends since before university, Louise and Heather weren't deterred from going into partnership.

Louise said: "We have been friends a long time and, as we are both mothers, we have a lot of common goals and priorities. We make a good team and work really well together.

"Heather's experience of running practices has obviously been a big help because she has done it all before but I have picked up ideas from the practices I have worked in and we have complemented each other really well so far."

From finding out that the practice was becoming available to officially taking over took around nine months and Louise and Heather opened the doors to their new practice on 1 April this year.

Louise said: "We wanted to keep as much as possible the same to make the transition as smooth as possible for both staff and patients, but we had some clear ideas of how we could develop and grow the business."

One of the first steps they took was the introduction of late nights and early mornings, as well as alternate Saturdays, to provide more flexibility for patients. The changes have proved really popular.

Heather also paid tribute to the staff, who have been on board since the start and have helped the pair immeasurably.

She said: "We could not have achieved this without the flexibility and cooperation of the dental nurses, associates and hygiene therapists who have been so willing to alter their working hours."

The change in hours proved so successful, and led to such a sudden increase in patient numbers, that Heather and Louise decided to fast-track plans to introduce an extra surgery.

When formulating their business plan for the practice, Louise and Heather had highlighted the potential for adding a fourth surgery and moving the LDU to a

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE>

different location. As they were proving to be really busy, they decided to press ahead with the work now rather than waiting a year, as they had initially planned.

The LDU was situated off a corridor that led to the original three surgeries with the X-ray room at the end. Behind the reception desk, the staff quarters consisted of a staff room and office leading to a small extension that housed a kitchen with loft space above.

The plan was to combined the large staff room and kitchen and move the LDU into what was previously the kitchen. The LDU room could then be converted into a fourth surgery, meaning all the patient and staff-only areas could be kept totally separate. The loft space in the extension was then to be floored and turned into storage for records and other stock.

With the plans in place, Louise and Heather turned to Bruce Deane from IWT Dental to turn them into reality. Louise explained: "I've known Bruce for many years and he helped us install our new computer system. I knew he was involved with this new dental business and we discussed how he could help us.

"Bruce project managed all the work, from sourcing the chair to co-ordinating all the contractors. He's got a great reputation and has been very reliable. We have been delighted with the progress of the work."

Heather said: "The great advantage of using IWT is that we simply have one point of contact for both our dental and IT equipment, from purchasing to maintenance."

Louise explained that, despite the upheaval of moving an LDU and installing a brand-new surgery – featuring a brand-new Stern Weber s 280 TRC chair – the work has been completed without losing a single day of seeing patients.

She explained: "Bruce has managed to arrange all the work around a busy practice and it hasn't affected patients.

"We've also taken the opportunity to repaint the waiting room and install some new flooring to make it feel less clinical."

The Stern Weber s 280 TRC chair is high quality

The move from associate to practice co-owner has been fascinating, explained Louise. She said: "Heather has had some experience at this but I'm totally new to it, so it has been an eye-opener. I've had to get used to the admin and I have learned a lot.

"However, I do feel that I benefitted from my time as an associate. I wouldn't have wanted to do this any earlier in my career, as I felt I needed the experience."

However, one element that has made the transition run even more smoothly for both Louise and Heather has been the presence of practice manager Janice Penman, who has been with the practice for more than 30 years. Janice has been working in Uddingston since before Neil Simpson took over and she has proved invaluable in helping the new owners settle in and hit the ground running.

Louise said: "Janice has been excellent throughout the transition and knows the practice inside out, which has been a big help. We wanted to keep things as settled as possible after we took over and she has helped us so much and been incredibly supportive, as have all the staff."

Even though they are a predominantly NHS practice, Louise and Heather are keen to offer a range of other private treatments to give their patients plenty of choice.

To this end, Heather completed an MSc in Facial Aesthetics from the University of Central Lancashire and is fully qualified to provide a full range of non-surgical facial aesthetic treatments. The practice also offers tooth whitening and implants, and associate Lesley Struthers has just completed a Six Month Smiles course adding another string to their bow.

When asked "What's next?" Louise, who also works as a part-time CPD advisor at NHS Education for Scotland, insists that they are just interested in "getting our heads down and getting on with it".

Louise said: "Learning how to be a manager as well as a dentist has been challenging but we're really enjoying it."

And Heather said: "We can now focus on our customer service skills to create a comfortable and desirable workplace for both staff and patients alike."

Waiting room is welcoming for patients

ST ANDREWS ORTHODONTICS

Email:
info@standrews
orthodontics.co.uk

St Andrews Orthodontics Limited
Eden House
35 Largo Road
St Andrews KY16 8NJ

Telephone: 01334 474203
Dedicated Dentists Line: 01334 837900
Fax: 01334 460742
www.standrewsorthodontics.co.uk

IT'S TIME TO GET REAL

FOLLOW MY FOUR-STEP GUIDE AND GAIN INSIGHT INTO YOUR PATIENTS, FORM A BOND WITH THEM AND BECOME A BETTER DENTIST IN THE PROCESS

ADAM MORGAN

Today, many people are trying to stand out and be different. In fact, it is one of the top things people tell me they want when I meet them. The truth is, most people do not create something different and they certainly do not stand out because they fail to break away, think differently and behave differently.

In a world where you can get pretty much anything you want and have access to limitless opportunities to grow and succeed, why is it that almost 90 per cent of companies and businesses are similar to all of their competitors?

Why is it that we have come to accept a certain standard as the norm? We walk into a retailer and come out underwhelmed by their products or level of customer experience. We have all been somewhere and been met with the tired dreary face of the receptionist and lacklustre illusion of warmth they give off. And there are many more examples I could give here.

The more I travel and speak around the world, the more I have come to believe that we must put the patient experience at the very heart of everything we do. You see, if we want to be truly different and stand out in the sea of sameness that is out there right now, we must stop comparing ourselves to others in our field and start looking up at the world around us.

For me, everything rises and falls on communication – great or poor. Think of the people you most love to spend time with – why is that? How do those people make you feel when you are around them? Why is it you only feel that way when you are in their company? It is true that everyone is born with a need to be valued, wanted and liked. In fact I haven't met a single person who has ever said to me: "Adam, I just love being undervalued, disliked and unwanted!" That has never happened.

And yet, many practices communicate the wrong messages to patients. We make it hard for them to deal with us. We treat them like we are in charge and that they are just "the patient" – as if we are more important than they are. I've seen patients walk out of practices in tears because they have been communicated with poorly and then I see dentists and their teams bragging about how much they care.

Simply put, if you want to be different and create a truly world-class practice, you have got to stop the madness and get real about patient experience because there is more choice than ever and we are no longer being compared with the other practice down the street. We are being compared to all the other companies out there – and let's be honest, some do it very well and some do not.

There are four key communication principles that are absolutely essential to creating a personalised, skilfully crafted patient experience. These simple principles are literally life-changing when used religiously and passionately and I have worked with many companies around the world that make these elements the foundation of their business. They should be talked about daily, practised continually and the whole team should be involved in the delivery of these principles – remember, this is a whole team responsibility.

It's time for you and your team to get REAL:

RELATE

The first principle is that we must be able to relate to people. The dictionary definition of relate is: to find the connection between two or more things, objects or people. So, in other words, we need to find something in common with the other person. Correct? I don't think so!

It is much deeper than this. In actual fact we should be looking for emotional bonds that can be formed with patients. We must be able to feel how they feel, value what they value and remove the barriers that lie between us. Think about a close friend or family member. Do you treat your patients like you would treat them? Do you ask about their day and wholeheartedly hang on every word of their response?

You see, to truly relate to another human being, we must stop focusing on

ABOUT THE AUTHOR

Adam Morgan is an award-winning training specialist who teaches businesses and individuals how to grow and create greatness in their marketplace. His fresh approach and dynamic style make him highly popular with companies around the world.

Adam works specifically with practices throughout the UK and helps dental teams to raise the bar, be more successful and achieve their goals and vision. With more than a decade of expertise working with many of the leading hotels and resorts, retailers, financial institutions of the world, he is a talented consultant able to deliver results.

To contact Adam, call 07557 763 785, email hello@adammorgancompany.com or visit www.adammorgancompany.com

You can also find him @AdamMorganUK on Twitter and on LinkedIn, search for Adam Morgan.

what is important to us and place all of the focus onto the other person. How can you relate if you are not fully listening or do not have a genuine interest in the other person?

Do you know what they do? What they are working towards? My challenge to you when it comes to relating to others is that you must get under the skin of your patients. Ask them meaningful questions about their life and in return talk about your own life and experience. Truly relating means giving and taking – the sharing of something valuable – not just talking about the weather or trip in to your surgery!

ENGAGE

Secondly, all great companies engage with their customers. They have a partnership with them. They are on the same level. They have mutual respect and trust for one another. Do your patients say that about you and your team?

When two people are fully engaged in conversation with one another – nothing else exists. You stop thinking about all the things you have to do in the day, what is for dinner, what time the kids need to be picked up, whether you locked the front door, and are fully present in the conversation you are having in that precise moment.

That is how it feels to be fully engaged. The same is true when we look at engaging with our patients. Do your conversations fully engage them, or do we superficially skim the surface? When someone is engaged, they feel a tremendous sense of being valued. Their respect and trust for you grows and their openness to share more about themselves increases.

AUTHENTIC

Thirdly, today it is paramount that we are authentic. No one likes to be served by the fake friendly waitress or be met by the phoney cheery receptionist. You can spot the people who are disingenuous a mile off.

And yet, we can sometimes do the exact same thing with our patients. We put on the smile and away we go – but our patients can tell we are not being genuine. People value authentic people. It's a fact.

So when you are with your patients, treat them like the kings and queens of the world. Look after them and value their business. After all, they don't have to come to your practice, they choose to. And, in return, choose to give them a piece of yourself by making them laugh, taking a real interest in them and showing them you too are a real person, just like they are.

LISTEN AND LEARN

Finally, listen and learn. I put these two together because apart they do not work. I know many people who listen and do not learn – and also those that have knowledge but do not listen. You need to do both.

Listen to what your team are saying. Have you ever sat down in your team meeting and asked for as many ways the team can think of to improve the practice? Or sat in the waiting room and just talked to each person that sits down to find out what they like and don't like? Do you use surveys that tell us what we already know or do you actually have a heart-to-heart with patients about how you could be a better dentist or practice?

Once you have listened, what changes are you willing to make? This is the hard part, because when you have truly listened, you can always learn something. Then you should get your team around you, rally the troops and change.

So to wrap up – it's time to RELATE, ENGAGE, be AUTHENTIC, LISTEN and LEARN. By doing so, I promise that your communication and patient experience will increase and you will have happier and more open patients – and team members!

Be different, don't follow what the rest are doing, but break away and put excellent communication and experience at the heart of what you do. The results will speak for themselves.

NEW LIFE TEETH
the **dental implant** people

Providing you with cutting edge dental care technology to give your patients a new smile and a new lease of life

- Patient referral service
- Your patients remain your patients
- Fast, efficient treatment
- Using the latest Zirkonzahn cad cam technology and milling centre
- Same day repairs and additions
- Based in Edinburgh and Glasgow

"I actually had consultations with 3 different practices but, ultimately, I wanted to ensure I dealt with the consultant who was going to complete the treatment. I felt most confident with Stuart; the personal touch was very important to me and the cost was also a consideration.

My teeth are back to where they should be now. I don't feel embarrassed anymore and I have my confidence back. After my hygiene consultation and final check-up in Edinburgh I transferred back to my own dentist for ongoing care."

Martin Peach

Dr Stuart Lutton
Dental Implant Surgeon
BDS MJDF MSc Implant Dentistry

"I met with Rob Leggett, who provided clear and concise information but ensured I was given time to consider whether to move forward with the treatment. He covered all aspects of the procedure from beginning to end, and I was given a date to suit me.

The procedure was pain-free and exactly as explained to me. I'm pleased with the procedure and my new teeth. I feel more confident with eating and smiling now."

Elizabeth Pirie

Robert Leggett
Clinical Dental Technician
RDT Dip CDT RCS Ed

New Life Teeth • Edinburgh & Glasgow
0800 917 9992 • www.newlifeteeth.co.uk • info@newlifeteeth.co.uk

ScottishDentureClinic

Scottish Denture Clinic, 2 Gillespie Place, Edinburgh EH10 4HS
T: 0131 228 6650 • www.scottishdentureclinic.co.uk • info@scottishdentureclinic.co.uk

BEING A CDT

IN THIS SECOND ARTICLE, CLINICAL DENTAL TECHNICIAN ROBERT LEGGETT DESCRIBES THE TREATMENT OPTIONS AND NEW TECHNOLOGIES THAT ARE AVAILABLE AT THE SCOTTISH DENTURE CLINIC, AND DISCUSSES THE FULL-ARCH DENTAL IMPLANT OFFERING AT NEW LIFE TEETH

ROBERT LEGGETT

Scottish Denture Clinic refers patients for partial denture treatment plans, consultations for suitability for implants and any abnormalities detected during the initial consultation. As Clinical Dental Technicians (CDT), we see mostly edentulous and partially dentate patients. These patients also often have the greatest need for implants.

As part of our initial consultation we discuss all options from conventional dentures to implant-retained over dentures and fixed teeth (All-on-4, Same Day Teeth). We use demonstration models, pictures and videos to show every aspect of each treatment option. We also give the patients literature to take home with them, as well as written estimates.

All-on-4 has attracted a great amount of interest from our patients. In August 2014 we therefore decided to set up a new brand dedicated to promoting same-day fixed teeth – New Life Teeth. The business is a collaboration between Scottish Denture Clinic, Dr Stuart Lutton (former owner of Ivy Dental) and Dr Avron Smith (owner of Avsan Holdings).

One of the most exciting things about New Life Teeth is that the team involves dentists, clinical technicians, dental technicians, dental nurses and administration staff all working closely to deliver a most challenging service, both clinically and technically.

Our philosophy is simple: we believe in changing people's lives for the better. By providing affordable full implant surgery and excellent aftercare, we deliver new teeth – and a new life – for our patients. Our service is underpinned by three key elements: cutting-edge technology, professional expertise and unrivalled care. As a modern dental practice using the latest emerging dental technologies, we also believe in putting technology to effective use in all aspects of our patient care.

We invested in a Zirkonzahn digital workflow system, allowing us to utilise CAD/CAM technology and mill the bridge in house. Our zirconia bridge from Prettau comprises a number of layers, is bio-compatible and non-porous, and therefore has a translucency that effectively makes the teeth look alive. These teeth also last a lot longer than traditional materials and they won't fracture. Due to these characteristics, especially when they are used in conjunction with a special colouring technique, the use of veneer ceramics can be entirely eliminated. In this way, aesthetically pleasing full zirconia restorations such as the Prettau Bridge can be realised.

Producing this type of appliance has been huge for the Scottish Denture Clinic in terms of time and training. As a business we have invested heavily in our staff training, sending our staff around the world on courses to learn the skills and technologies needed to provide our patients with the very best of what is available in today's market. We believe that the future lies with this type of technology.

Rob Leggett (left) with Stuart Lutton

One of our greatest advantages, and one of the reasons patients opt for treatment with us, is our strong team relationship, especially the relationship between our technical and clinical staff. I am sure that being a Clinical Dental Technician has helped us bridge that gap.

BREATH OF FRESH AIR

LATEST RANGE OF CLASS-LEADING COMPRESSORS HAVE BEEN SPECIALLY DESIGNED TO MEET THE NEEDS OF MODERN DENTAL SURGERIES

The dental compressor is most likely not your main concern when running a busy dental practice but ultra-clean air, free of all contamination, is an essential part of modern dentistry and healthcare. Compressor engineer Scot Industrial Air have linked with UK compressor manufacturer Bambi to provide a specialist service for dentistry to meet the demands of busy contemporary surgeries.

VT range – oil-free air compressors
Bambi's revolutionary VT range of oil-free compressors is available with an innovative air dryer unit. With quality the key word, they are class leading and packed with the latest features including soft start valve, internally coated receiver, after cooler and coalescing filter and sequential start.

VTS range – silent oil-free air compressors
The Bambi VT range of compressors has exceptionally low noise levels compared to other oil-free compressors, but recognising the need for totally silent oil-free compressed air, Bambi has developed the brand new VTS range.

Not just an acoustic hood but a dedicated silent range, engineered from the ground up with noise levels as low as 54dB(A).

MD range – silent air compressors
Ultra high performance with ultra low noise – the Bambi MD range is designed for applications demanding the highest quality air supply with the benefit of very low noise levels. At the heart of the range is an oil lubricated pump unit developed to deliver 50 per cent more air compared to other silent compressors and the only silent compressor fitted with piston rings eliminating oil carryover to the air supply.

With sound levels from just 40dB(A) and almost no vibration when running, they can be located in the work area without causing any noise intrusion.

Scot Industrial Air supply, install and service Bambi compressors all over Scotland from branches in Aberdeen, Dundee, Glasgow and Muir of Ord.

REFERRALS FOR IMPLANT AND RECONSTRUCTIVE DENTISTRY

Stephen accepts referrals from single implant placement to the more complex cases involving full arch reconstruction, sinus lifts and bone grafting. Imaging services also include CT scans and DPT radiography

Stephen Jacobs

Patients can be referred to the practice in the following way:

email **info@dentalfx.co.uk**,
refer via the website **www.dentalfx.co.uk**
or call us on **0141 931 5533**

Lee Savarrio

New Service: Consultant periodontist Lee Savarrio is now accepting periodontal and implant referrals at Dental fx.

Email **perio@dentalfx.co.uk**

www.dentalfx.co.uk
call us now on: 0141 931 5533

dental fx
implants and cosmetic dentistry

Understanding the unique needs of the Dental profession.

- Buying or selling a practice
- Buying, selling or leasing premises
- Practice incorporation
- Partnership agreements
- Associate agreements
- Employment contracts
- Regulatory/disciplinary issues
- Performance management
- Retirement planning
- Succession and trust planning

Thorntons

For specialist legal advice contact one of the partners in our Dental Law Team:

Michael Royden
mroyden@thorntons-law.co.uk

Ewan Miller
emiller@thorntons-law.co.uk

thorntonsdental
Tel 01382 229111
www.thorntons-law.co.uk

NASDAL
Members of the National Association of Specialist Dental Accountants & Lawyers

ASPD
Members of the Association of Specialist Providers to Dentists

WORKING ALONGSIDE THE PROFESSION

THE DENTAL TEAM AT THORNTONS SOLICITORS ARE PERFECTLY PLACED TO PROVIDE SUPPORT AT ANY TIME, NOT JUST IN YOUR HOUR OF NEED

Lawyers are seen as a necessary evil by many. Only go to see one when you really need to, and that tends to be when something has gone wrong. That's similar to some people's view of going to the dentist – an occasion to be feared.

Put lawyers and dentists together, not a great combination? Not according to the Dental Team at Thorntons Solicitors, they see it as a perfect match.

The Thorntons Dental Team was established a number of years ago, and is now firmly recognised as one of the leading firms of advisers to dentists in Scotland. From its base of nine locations on the East Coast, the team provides specialist advice to dentists the length and breadth of the country, and prides itself on continually providing a level of service which is second to none.

The team draws on a number of legal disciplines to provide the full range of legal services required by dentists.

Michael Royden, who heads up the team, said: "Going back a number of years, we had dental clients who were advised by various lawyers in the firm, but there was no direct focus on them. We came to realise that, while dentists have similar legal needs to other clients, such as wills, house purchase and sale, etc, when it came to their practice, they had a need for specialist advice based upon a strong knowledge of how a practice works.

"We therefore created a specialist team who have the knowledge required to provide the detailed service. There was a lot of learning along the way, with the team getting their heads around the intricacies of the NHS, the terminology of the profession, and so on, but that knowledge has allowed us to create a strong base for the team."

That effort has paid off. Alongside the ever growing number of dental clients, many of whom are introduced by word of mouth recommendation from existing clients and other dental professional advisers, the team is regularly asked

to speak at dental events such as the Scottish Dental Show and the Blackhills Symposium. They also write regularly for dental publications.

"Just like our dental clients, our reputation is paramount for us," continued Michael. "We were therefore delighted to be accepted as members of the Association of Specialist Providers to Dentists and the National Association of Specialist Dental Accountants and Lawyers. Both applications involved a rigorous process to evidence our dental experience, and we are very proud to be ASPD and NASDAL members.

"Even more so than that, we are incredibly proud of the recommendations from existing clients, many of whom have provided testimonials. That shows us that we are doing the right things. As an example, one client described the team as 'unfailingly professional, approachable and reliable. We cannot recommend them highly enough.' We are delighted when clients feel so strongly about the service which we provide."

The team continues to grow from strength to strength. One of the more recent additions to the team is Kim McNaughton, senior solicitor. Kim joined Thorntons two years ago, and became involved in some of the dental advice at a time when the team were being instructed by an increasing number of dentists. She enjoyed that work, and is now an established member of the team.

Kim's high standard of client service is often greatly received by clients, with one recent client commenting favourably on her "outstanding efforts in the face of some tricky obstacles and delays". When asked what she enjoys most about her role, Kim said: "I enjoy the variety. The work we do involves so much more than simply buying and selling dental practices. While that is obviously an important element of it, I am also constantly being asked to advise on issues such as associate contracts (or in some cases the absence of them), NHS grants and various other regulatory and compliance issues. This allows us to offer added value to clients, as we are aware of recent developments and common issues to watch out for."

The team wants to continue to expand its delivery, and is determined to maintain its close links with the profession.

Michael said: "We don't just want our dental clients to see us as their lawyers to turn to in hours of need. We aim to create a relationship where they view us as people they can turn to for support and guidance at any time. If we can achieve that, we have achieved our aim."

Thorntons is a trading name of Thorntons Law LLP.

GOING THE EXTRA MILE AT SCED

REFERRAL CENTRE NOT ONLY ACCEPTS PATIENTS FOR ALL ASPECTS OF DENTISTRY, IT OFFERS A GREAT RANGE OF COURSES AND SEMINARS AS WELL

Scottish Centre for Excellence in Dentistry (SCED) is a renowned referral centre that always goes that extra mile for referring dentists. We are happy to accept referrals for all aspects of dentistry, including implants, oral and facial surgery, periodontics, orthodontics, prosthodontics, restorative dentistry, hypnotherapy, sedation and CT scanning. We can offer advice only, carry out part of the treatment or all of the treatment; the choice is yours. We call it "Shared Care at SCED".

For many years, we have offered courses and seminars, many of which are complimentary to referring dentists, together with lunch and learns at practices. In more recent years, we have introduced courses in prestigious and interesting locations to make the educational process enjoyable and relaxing. Scot Muir is also clinical supervisor to the blended learning 'Ultimate Implant Year Course' via smiletube.tv held at the centre.

We are now offering the Esthetic Alliance Program to all referring dentists in partnership with Nobel Biocare. This program involves treatment planning and restoring the single posterior and anterior dental implant and the treatment planning and restoring multiple dental implants in the edentulous arch and mandible.

Scottish Centre for Excellence in Dentistry are delighted to present Tidu Mankoo, who is one of the world's leading authorities on restorative dentistry. He will be presenting a one day seminar on 'Contemporary rehabilitation of the compromised dentition' (PGEA approved) on 30 October at Loch Lomond Golf Club.

Places are limited, so please apply soon. Full fee £395.

SEMINAR DATES FOR THE DIARY

Update in Orthodontics	23 September	6.30-8pm
Treatment Planning	8 October	6.30-8pm
Implant Seminars – Extraction Techniques	22 October	6.30-8pm
Endodontics Seminar	12 November	6.30-8pm

MORE INFORMATION
For details of all the SCED courses and to book your place(s), call 0141 427 4530 or email secretary@scottishdentistry.com

Edinburgh Dental Specialists

EDINBURGH
DENTAL SPECIALISTS
SINCE 1994

What ever problem your patient may have we're here to help

Our team of clinicians

Dr K A Lochhead BDS, MFGDP RCS(ENG),
Clinical Director and Specialist in Prosthodontics, GDC No. 62945

Dr C Tait BDS Hons, MSc, MFDS RCS(Ed), MRD RCS(Eng),
Specialist in Endodontics, GDC No. 62862

Dr P Coli DDS, PhD,
Specialist in Periodontics and Prosthodontics, GDC No. 104397

Dr F Veldhuizen BDS, MFDS RCS(Ed), M Clin Dent, MRD RCS(Ed),
Specialist in Prosthodontics, GDC No. 72100

Dr P Hodge BDS, PhD, FDS RCS(Ed)
Specialist in Periodontics, GDC No. 56503

Dr N Heath DCR, BDS, MSc, MFDS RCS(Ed), DDRRCR,
Specialist in Oral and Maxillofacial Radiology, GDC No. 70569

Mr M Paley BDS, MB ChB, FFDRCSI, FRCS, FRCSEd(OMFS),
Consultant Oral & Maxillofacial Surgeon, GDC No. 64778, GMC No. 4398217

Mrs G Ainsworth BDS (Sheff '96) FCS RCPS Glas, MSc (Ed), MSurgDent(Ed)
Specialist Oral Surgeon, GDC No. 71932

Dr Donald Thomson BDS (Edin), FDS RCSEd, FDS RCPSG, DDR RCR
Specialist in Oral and Maxillofacial Radiology, GDC No. 70079

Dr N Heath DCR, BDS, MSc, MFDS RCS(Ed), DDRRCR,
Specialist in Oral and Maxillofacial Radiology, GDC No. 70569

Dr R Philpott, BDS MFDS MClinDent MRD (RCSEd)
Specialist in Eddodontics, GDC NO. 82646

Visiting Professor
Professor L Sennerby DDS, PhD
Professor in Dental Implantology, GDC No. 72826

If you would like to discuss **referring a patient to the Practice** please contact our friendly reception team on **0131 225 2666** visit us online at **www.edinburghdentist.com**

Edinburgh Dental Specialists,
178 Rose Street Edinburgh EH2 4BA.
www.tele-dentist.com
www.allonfourscotland.com

Nobel Biocare™

ALL SMILES AT EMMA'S RETURN

ALL 1 SMILE ASSOCIATE ORTHODONTIST EMMA HENLEY HAS RETURNED FROM MATERNITY LEAVE AND IS NOW SEEING NEW PATIENTS AT THE JORDANHILL PRACTICE

Emma Henley graduated from Dundee in 2002 and completed her VT year in Blairgowrie, before working as a community dental officer in Aberdeen.

This was followed by a Senior House Officer (SHO) in paediatrics at Dundee Dental Hospital and an oral and maxillofacial surgery, restorative, oral medicine and paediatric SHO in Liverpool and Manchester from 2003 to 2007. During this time she gained her MFDS from the Royal College of Surgeons of Edinburgh (RCSEd) and did her three-year orthodontic specialist training in Cardiff where she received a distinction for her MScD in 2010. Emma also gained her MOrth from RCSEd in the same year. She is on the GDC's specialist list.

Born and raised in Edinburgh, Emma says she enjoys the daily challenges and rewards that orthodontics provides. She returned from maternity leave in March and is now seeing new patients at All 1 Smile in Jordanhill.

Emma Henley

CLINICAL TIP

It is important to consider the timing of extraction of the first permanent molars if their prognosis is poor. The extraction of the first permanent molars should be considered between the ages of eight to 10 years of age for spontaneous space closure of the second permanent molars. However, it is important to seek an orthodontic opinion if in any doubt prior to extraction of the first permanent molars.

In Class II division 1 or Class II division 2 cases it is helpful to try to maintain the upper first permanent molars until the upper second permanent molars erupt. This will allow the extraction space to be used during ortho treatment to correct the overjet, reduce the overbite or both.

KEEPING CUSTOMER SERVICE AT THE CORE

HIGHLY-REGARDED PAIR HAVE TEAMED UP IN NEW BUSINESS THAT OFFERS DENTAL CHAIRS AND CABINETS IN ADDITION TO OUTSTANDING IT

After nearly a decade at Carestream Dental, Bruce Deane will be a familiar face to many in the Scottish dental community having been involved with the sale and support of hundreds of practice management solutions and digital X-ray systems.

During his time at Carestream (formerly Kodak Dental Systems) he worked on several projects alongside Ian Wilson of IW Technology Services. Now the duo have joined forces to start a new dental business, IWT Dental.

Bruce explained: "After much discussion, we decided opening a new dental business to provide dental chairs and cabinets would be the best way to complement the IT business, thus enabling us to offer our customers full turnkey surgery installations, including all IT and dental room requirements.

"This process also involved the rebranding of IW Technology Services to align with the new dental business and our vision going forward."

The last few months have been extremely busy for the guys as they set up and started to grow the new business alongside the already established IT operation.

"We have been somewhat amazed by the response from our customers and colleagues," said Bruce.

"Many of the practices who use our IT services are happy to chat with us regarding the supply of dental chairs and dental furniture, and we have also been slightly overwhelmed by the response from our friends and colleagues in the dental trade.

"We have received nothing but positive comments from all, and have formed excellent new partnerships with a number of dental businesses to further develop our supply network."

When asked what makes IWT Dental stand out, Bruce was quick to highlight that their commitment to providing an exceptional level of customer service at a reasonable price was central to everything they do.

Bruce Deane

He said: "Ian has developed the support reputation of IWT Services over the years to be, in my opinion, second to none. And, during my time with Carestream, and now with IWT, my desire to provide customers with the best possible support has always been my main focus.

"Allied with this commitment to outstanding customer service, we also have expert knowledge in our field. Ian has been working in the IT sector for many years and brings a wealth of experience on IT networks and installations.

"We put great effort in to the planning of every installation to ensure the process is as smooth as possible, which in turn assists us in proving long-term support and creating strong partnerships with our customers."

Ian Wilson

And what does Bruce bring to the IWT table? "I believe I bring a wealth of experience in business strategy, marketing, and corporate process," explained Bruce.

"In addition, as I have always worked closely with my customers on installations, I also have many years' experience in project management.

"We have already installed a number of dental chairs and furniture units, and in the short term we hope to further develop our new relationships with suppliers and continue to grow both brands within the dental community."

Bruce explained that they are currently working on several new projects which will soon see them involved in the provision of several new products and services.

He continued: "In the long term we wish to further grow our team, strengthen our brand and work with many more dental practices. Ian and I share the same desire to create a company which is regarded as the best provider of customer service in our sector.

"In addition, we wish to develop our team of expert staff and create an environment where we can be serious about work, but enjoy ourselves at the same time."

Despite this new role providing plenty of long hours and the acquisition of new skills, Bruce is thoroughly enjoying the challenge. He said: "My working life today is very different to what I have been used to in previous roles.

"Today I am responsible for all aspects of running the dental business, which of course includes many tasks I have not previously been required to take on.

"While challenging, I am thoroughly enjoying my new working life and I am extremely excited about the future."

ESCHMANN DIRECT

Protection › Support › Expertise

Little Sister...helping you comply with Joint Practice inspections

Welcome to EschmannDirect's **Little Sister**, providing the advice and validated decontamination products to help you comply with your Joint Practice inspection.

For advice and details of our latest decontamination offers, call EschmannDirect

01903 875 787

For the best advice, the best products and the best protection, **go direct.**

There are four bright surgeries

Custom-built and modern practice

PHOENIX FROM THE ASHES

DR ANDREW LEITCH REVEALS HOW AN UNFORTUNATE FIRE ULTIMATELY LED TO THE CREATION OF HIS PERFECT PRACTICE, RIVERBANK DENTAL

ANDREW LEITCH

The project came about after an unfortunate fire in our previous practice in Knightswood. As luck would have it, I received a phone call a mere two days after the incident from Medical Centres Scotland, a company that builds medical, dental and pharmaceutical practices to be leased back to professionals. They were helping a GP practice move to a new purpose-built premises and had heard I wanted to build a new dental practice.

As a result, they offered me half of the building space with the other half being allocated to the GP practice. What started out as a tragedy resulted in an amazing opportunity for my practice, as we now have a custom-built surgery, just one mile down the road from our original location.

Because we were moving area and didn't want to be known as Knightswood Dental Practice, we rebranded to what is now known as Riverbank Dental. Although we are still the same company and have the same client base, rebranding gave us the opportunity to update our image.

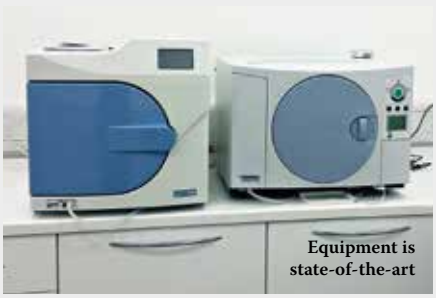
Part of the rebranding process involved working with various firms, whose roles in the design and construction were key.

For me, working closely with the architects – Keppie – was integral, because I had a clear vision of what I wanted. They included me in their meetings so they could draw up a design that was practical and creative. The plot was so large that this gave us complete freedom, in terms of room size and the number of surgeries.

I also worked with Medical Centres Scotland, Keppie and Luddon Construction in regards to materials and construction. It was great working alongside them, as it gave me the chance to influence the design, from choice of brick to interior finishes.

Because washer disinfectors have specific requirements that dictate where the water needs to come in and where the drainage needs to go, it was crucial that these systems be placed exactly as the plan detailed. To eradicate any potential problems, we utilised the services of Eschmann, the UK's leading decontamination equipment manufacturer. The team made sure that inspections were completed as the project developed, so any errors could be rectified quickly.

The experts at Eschmann helped us design the entire decontamination unit and provided us with suitable autoclaves, a washer disinfector, a handpiece maintenance unit and an RO water system. My advice for anyone pursuing a new-build project would be to utilise the advice and services of companies such as Eschmann as early as possible. Ultimately, the design for our decontamination room has been invaluable, and an engineer visited the site frequently to ensure everything was in place before the equipment was installed.



Equipment is state-of-the-art

The surgery that we now have, and take delight in working in, is all down to the dedication and precision of the companies that we worked with, and I couldn't be happier and more proud of the final result.

From inception, the project took 26 months to complete, and the final product is a custom-built practice with four surgeries. All in all it has only taken eight months to be entirely operable, and we are delighted to be able to offer such a quality surgery to all of our patients, old and new.

Although regrettable, the fire has taken me and my team on an amazing journey. Because the practice has doubled in size, we have been able to increase our patient base and increase staffing levels. It is our ideal practice and we have been involved throughout at every stage of the process.

If I were to undertake another project I would change nothing; I would use the same companies and what's more, I know I would receive a supreme service.

FOR MORE INFORMATION

Please visit www.eschmann.co.uk, or call 01903 753322

ABOUT THE AUTHOR

Dr Andrew Leitch qualified from the Dental School at the University of Glasgow in 1996 and went on to spend 10 years working in mixed NHS and private practices in Scotland. In 2006 he set up his own practice, Knightswood Dental Practice.

The completed project that is Riverbank Dental – previously known as Knightswood Dental Practice – opened its doors on 22 December 2014.

RISK-FREE TRIAL IS A PRACTICE WINNER

INCREDIBLE OFFER LETS YOU TEST BEST HIGH-SPEED INSTRUMENTS

A fundamental principle for NSK is product development, and an important aspect of that process is listening to practitioner feedback to ensure products meet the needs of the professionals who use them.

When it comes to high-speed instruments, NSK currently offer the most powerful instruments on the market, including the NSK Ti-Max Z900L, the World's most powerful turbine* and NSK Ti-Max Z95L, high-speed (1:5 increasing) contra-angle. Angela Glasgow, NSK's territory manager for Scotland and Ireland, said: "We work hard to ensure the products we deliver to the market are exceptional quality, whilst maintaining value for money."

TRY BEFORE YOU BUY

One of NSK's most successful initiatives has been its no-obligation free 10-day 'try before you buy' scheme. A selection of NSK's most popular products are available to dentists and hygienists to try out in their own clinical environment before making the decision to invest. Angela adds: "Our 10-day FREE trial is very popular and is an excellent way for customers to experience the quality and performance of our products."

NSK

CREATE IT.

INFECTION CONTROL

The key to prolonging the life of handpieces is correct and regular maintenance and cleaning and, to keep up with strict compliance and quality control, it is essential for all dental practices to use proven and reliable care and maintenance systems. NSK recently launched a range of autoclaves, including the NSK iClave, with an increased chamber volume 20 per cent higher than comparable units and fast cycles of under 20 minutes, saving time and money.

Angela said: "Fast instrument cleaning is vital in a busy practice, so quick cycles, large chamber volume and low power consumption are key."

To take advantage of NSK's 10-day, no-obligation 'try before you buy' and equipment rental scheme, contact Angela Glasgow, NSK's Territory Manager for Scotland and Ireland on 07525 911 006.

MORE INFORMATION
www.nsk-uk.com
Twitter: @NSK_UK
Facebook: NSK UK Ltd

* Power output measured by NSK internal research department

Concerned about future NHS contract changes?

With Denplan the options are in your hands

See us at the BDIA
Stand M25

We can't predict the future, but with Denplan you can plan your future.

Changes are on the horizon. Do you feel confident about the upcoming Friends and Family Test and the likely 'tiering' of treatment? Are these changes making you think twice about your NHS contract?

We offer a range of options for practices, so you can be free to practise the skills you're proud of, without additional restrictions.

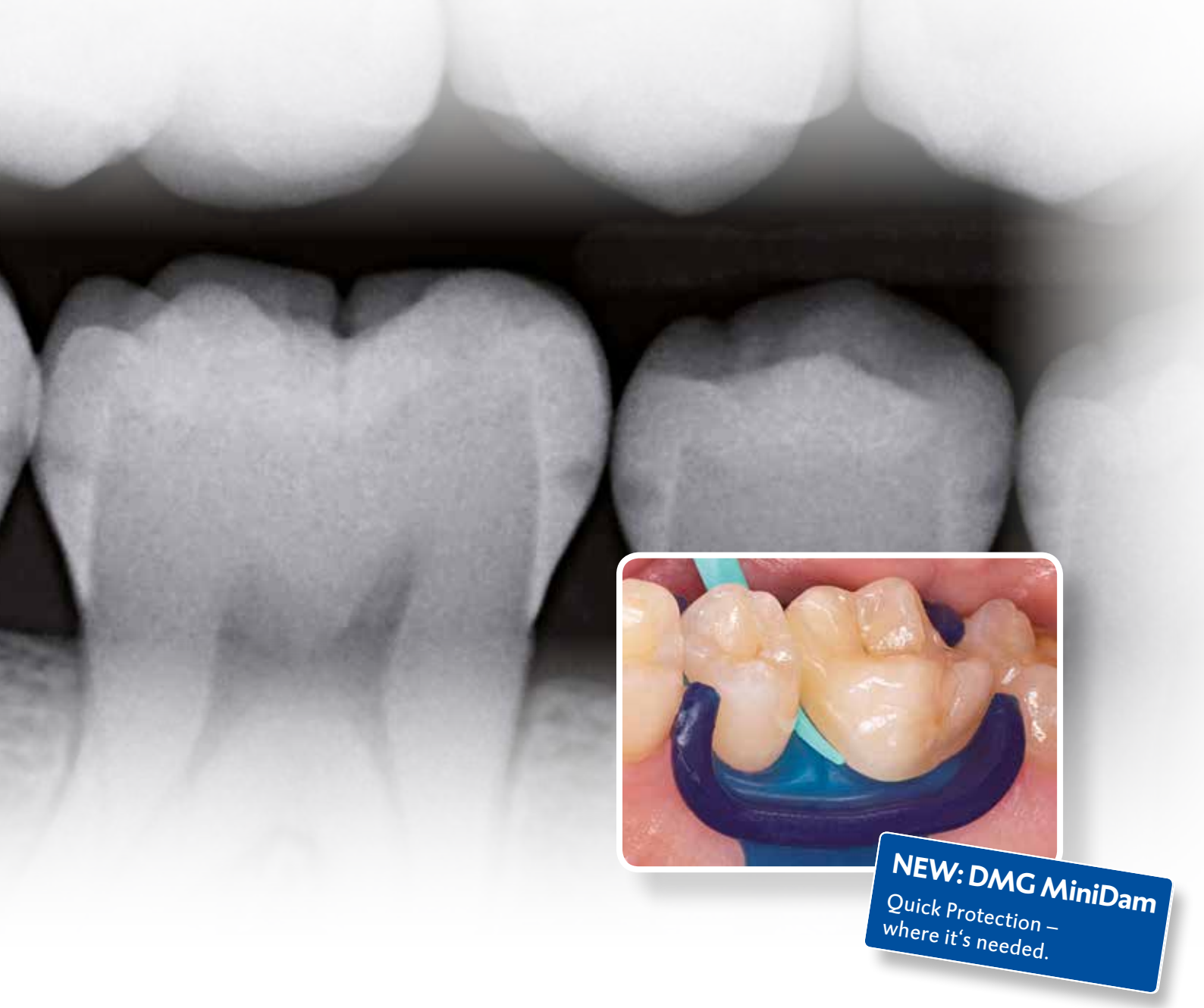
Denplan's 'Principal-only' transition option allows you to take small steps towards switching. You can keep your NHS patients at your practice and develop a private patient base at the same time.
You'll also receive a dedicated consultant to support your journey towards a more promising future.

For more information about our 'Principal-only' transition option, call us on 0800 169 9962 or visit denplan.co.uk/choices

That's the world of Denplan for you.

Denplan
At the heart of dental care

CAM1557 09-15



NEW: DMG MiniDam
Quick Protection –
where it's needed.

The answer to proximal caries:
I can Icon!

Arrest incipient caries early on without drills or unnecessary loss of healthy hard tissue. Icon's caries infiltration makes it possible. Scientifically* proven and practice-tested.

To find out more about the infiltration method, different options and support services, go to **www.dmg-dental.com/icon-proximal**

DMG
Dental Milestones Guaranteed

*Paris S, Bitter K, Meyer-Lückel H (2013); Five-Year Follow-Up of a Randomized Clinical Trial on Efficacy of Proximal Caries Infiltration; ORCA Kongress Abstract

VOCO PRESENTS A WORLD FIRST

ADMIRA FUSION – THE FIRST PURELY CERAMIC-BASED UNIVERSAL RESTORATIVE MATERIAL

VOCO presents several proven and innovative products at the BDIA Dental Showcase 2015 (22-24 October, NEC, Birmingham), including Admira Fusion, the world's first purely ceramic-based universal restorative material.

Silicon oxide forms the chemical base for this new nanohybrid ORMOCER restorative material, not only for the fillers, but also for the resin matrix. This offers several remarkable advantages – Admira Fusion, in comparison with all restorative composites of market relevance, shows by far the lowest level of polymerisation shrinkage and extremely low shrinkage stress.

The ORMOCERs used in the manufacture of Admira Fusion make it highly biocompatible, as there is no

content of classic monomers. Admira Fusion has an 84 per cent (by weight) content of inorganic fillers and covers a broad spectrum of indications. Admira Fusion's particularly high colour stability gives it an additional edge. This very homogeneous material offers outstanding

handling and is compatible with all conventional bonding materials.

Admira Fusion and Admira Fusion x-tra are available in syringes and also caps for direct application. The Admira Fusion set, optionally containing syringes or caps, is still available at an introductory price giving you 30 per cent discount. And for purchases of four syringes, or four packs of 15 caps, via a VOCO dental consultant VOCO will supply one extra pack free of charge.

MORE INFORMATION

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

Visit VOCO at the BDIA Dental Showcase 2015: stand M135

Come see us at BDIA Showcase NEC Stand E135

Reduce your stress when managing anxious patients.

Add a new income stream.

Attract more patients and help grow your practice.

CPDv Lectures @ Showcase on Stand E135

RA Medical Services Ltd
Inhalation Sedation Specialists

ISO 9001 REGISTERED FIRM

dstg

R A Medical Limited Holmes House, Skipton Road, Keighley BD20 6SD
Tel: 01535 652 444 Fax: 01535 653 333
www.ramedical.com - info@ramedical.com

BDIA MEMBER

LATEST TECHNOLOGICAL INNOVATION AND UNBEATABLE PROMOTIONS

W&H looks forward to welcoming you on Stand G115 at BDIA Dental Showcase for the latest news and special offers on handpieces, surgical and decontamination products. W&H is pleased to launch the all new Lisa vacuum B Sterilizer, which is even more intuitive and easier to use thanks to a new user interface and user-orientated menu. Lisa is faster than ever and will increase the life of your handpieces thanks to its enhanced 'ECO dry' system.

Also available is the Synea Vision range of turbines with LED optics, the Assistina handpiece

cleaning and lubrication range, and the Implantmed surgical system and the Piezomed ultrasonic bone cutting system.

For more information, call 01727 874 990, follow @WH_UKLtd or visit www.wh.com

AWARD-WINNING HANDPIECES

W&H is proud to announce that the Synea Vision turbine range has won the Clinical Innovations Commended Award presented by Healthcare Learning. These are UK product awards judged by a panel of clinicians and run by an independent organisation.

Synea Vision Turbines are the ultimate in high-end handpiece technology for excellent preparation results. The range offers unique innovations such as the new five-ring LED optics offering 100 per cent shadow-free illumination, ensuring that the rotary instrument does not cast a shadow on the treatment site.

Synea Vision Turbines are ergonomically designed for quiet, comfortable working and new scratch-resistant surface coating.

For further information, or a demonstration of the full W&H Range, call 01727 874 990 or email office.uk@wh.com

WHAT HUE ARE YOU?

From the most popular pastel Light Blue (Standard CG19) to the second best-seller Black (Ultraleather Raven Wing), Belmont offers a diverse colour range of luxury fabrics to ensure you get just the right shade to complement your practice's personality.

Good looks can sometimes belie the comfort of a dental chair, which is why Belmont's upholstery is available to order in 'Ultrasoft'. As the name suggests, the look and feel of this fabric exudes luxury and comfort.

Aesthetics obviously need to be matched with functionality,

and Belmont will not disappoint. Challenging the traditional way dentists treat their patients, the Belmont 'Below-the-Patient' treatment centres are constructed in a way that the console delivery arms are mounted below and behind the chair, creating a responsive and non-obstructive dental treatment centre.

LEADING THE WAY

As one of Scotland's leading dental practice management software companies and with almost 30 years' experience, Systems for Dentists are leading the way and proving an ever-popular choice thanks to a dynamic and solution driven approach to providing market expertise and software solutions that really deliver.

With benefits that demonstrate a critical positive difference in operational practice, customer and staff experience, a flexible range of pricing options to suit most needs and complimentary downloads of their system demo just a click away the company and their software service and product range are proving a real hit in Scotland.

For the latest version of V6 Systems for Dentists Practice Management Software, simply call 0845 643 28 28 or download a full demonstration at www.sfd.co/demo

FROM SEVEN TO 77

EQUIA Forte is the latest innovation in GC's glass ionomer and resin technologies, two innovative systems working in synergy to build a stronger, superior bulk fill material for Class I & II restorations.

EQUIA Forte Fil is the fast-setting, aesthetic restorative with an innovative hybrid glass technology offering greater fracture toughness, wear resistance and fluoride release.

EQUIA Forte is extremely tolerant and bonds equally well to all surfaces independent of the age of the teeth.

EQUIA Forte Coat is a thin

film-thickness lustre coating that enables clinicians to save on polishing time and improve the translucency and aesthetics.

For further information, please contact GC UK Ltd on 01908 218999, e-mail info@gcukltd.co.uk or visit www.gceurope.com

GC UK SPONSORS TECHNICIAN'S BID FOR GOLD

GC UK is delighted to be part of the team supporting Jamie Jessup's bid to win a badminton gold for GB at this year's World Transplant Games in Argentina.

Despite being born with kidney dysplasia and needing a kidney transplant following renal failure when he was nine, Jamie has won bronze and silver at previous World Transplant Games. Now he is aiming for gold in the men's badminton singles and doubles competitions.

Jamie, a ceramist at Kerwick & Rogers Dental Laboratory in Surrey, works full time at the lab, followed by badminton training

and gym work at night. He also performs magic shows and magic performances at trade shows, corporate events and weddings.

For further information, contact GC UK Ltd on 01908 218999, e-mail info@gcukltd.co.uk or visit www.gceurope.com

THE CROWN STANDARD OF IMPLANTS

The Full Contour Zirconia (FCZ) Implant Crown from Nobel Biocare presents complete reliability and second-to-none strength and restorative flexibility.

Manufactured from translucent, high-strength zirconia, the FCZ Implant Crown reduces the risk of complications associated with chipping. It is also part of a completely cement-free system. The strength of the zirconia means that the FCZ Implant Crown can be placed anywhere, but is particularly useful for the posterior molar region.

There are eight shades to choose from and the colour is uniform throughout the structure.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com To register for the Nobel Biocare Online Store go to store.nobelbiocare.co.uk

CHANGING BEHAVIOUR

Oral-B's SmartSeries power toothbrush, in combination with the Oral-B app, helps keep your patients on track. This ingenious app allows dental professionals to programme patients' brushing routines on to their mobile to ensure they follow advice between appointments.

The app data shows that Oral-B electric toothbrush users are now brushing on average of two minutes 24 seconds. This is compared with less than 60 seconds using a manual toothbrush.

Additionally, more than half of the recorded brushing sessions included flossing, rinsing, and tongue cleaning.

Through a combination of these statistics and consumer feedback, Oral-B can deduce that with real-time feedback, users are encouraged to brush longer, with less force and more in line with their dental professionals' recommendations.

NEW ICESPY NOTION LITE

Insurance companies are increasingly refusing to pay out on claims due to refrigeration failure where policyholders do not have a contingency plan. Reports of five-figure uninsured losses are not uncommon.

The new Notion Lite system is the ideal temperature-monitoring solution for applications where temperature-controlled storage may be minimal, but warning of refrigeration failure remains critical to prevent costly repercussions.

This compact system is designed and manufactured in the UK specifically for smaller monitoring requirements where ease of use is key and human error is eliminated. The wireless system provides time-saving peace-of-mind compliance with 24/7 alarms and immediate one-click access to real-time temperature data and audit-ready reports.

imc GROUP LIMITED

MAKING YOUR WORKING LIFE EASIER

Dürr Dental will have its largest-ever stand at this year's BDIA Dental Showcase and will be able to accommodate even more of its equipment.

Dürr products are designed to make your working life easier. This is evident in the latest networking systems that can be used with your compressor and suction system. By linking them to the network, practices can see the performance of each piece of equipment at a glance. Linking the compressor, for example, to the digital network yields numerous benefits: current status, faults or messages, such as for filter changes, are immediately displayed and can be seen with a glance on the monitor.

DÜRR DENTAL

Visitors will be able to see how VistaIntra works in partnership with its image plate scanner, VistaScan.

It is pre-programmed with the right X-ray dose when using Durr Dental image plates and sensors. This ensures it's ready for use and always delivers clear, perfectly exposed images.

ADVICE FROM THE EXPERTS

The expert team at Christie + Co has one simple aim: to use its extensive market experience to get the best results for your business.

At the BDIA Dental Showcase (22-24 October, NEC, Birmingham), Christie + Co will be on stand H130, ready to show you the range of advice and information the specialist dental team can offer.

A wide range of services are offered by the team, including buying and selling a practice, finance and insurance. Chartered surveyors will also be on the stand to advise on property related matters or formal bank valuations should you require one.

Christie+Co BUSINESS INTELLIGENCE

Regulated by RICS, the team of experts will be sure to tailor their expertise to your individual circumstances and make sure you get precisely the result you need. By combining local knowledge with national insight, their understanding of the dental market is second to none.

To discuss how Christie + Co might help you achieve your plans, please call today on 0207 227 070.

THE WAIT IS OVER

Carestream Dental will be demonstrating the very latest digital imaging products and practice management software on stand G15 at the BDIA Dental Showcase this year.

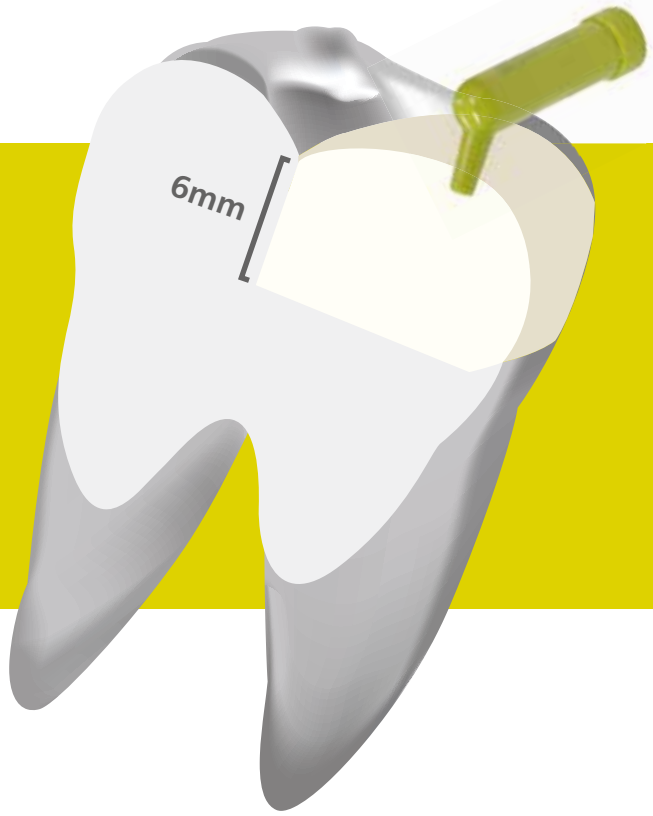
The CS 8100 3D is a fine example of the innovation on offer, bringing the power of 3D imaging within the reach of every general dental practice. Delivering images of outstanding clarity with a simple and smooth image capture process, the CS 8100 3D will significantly enhance your diagnostic and treatment planning processes.

Also on display will be the latest CS R4+ practice management software, featuring the exciting real-time data benefits of Springboard.

Carestream DENTAL

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk For the latest news and updates, follow us on Twitter @CarestreamDentl

aura bulk fill



the simplicity of bulk fill

Characteristics

- Up to 6mm depth of cure
- Ultra High Density Pre-Polymerised Filler
  - Better aesthetics
  - Reduced shrinkage
- Low polymerisation shrinkage stress
- High compressive strength

Indications

- Posterior restorations
- Core build ups
- Splinting
- Sandwich technique

THE DENTAL ADVISOR
2015 PREFERRED PRODUCTS
+ + + + ½

SDI

Your Smile. Our Vision.

www.sdi.com.au
www.polawhite.com.au

SDI Dental Limited
Email uk@sdi.com.au or contact Kelly on 00800 022 55 734 for details of your nearest SDI representative

aura
ultra universal restorative material

NEW DISTRIBUTOR FOR NEWCODENT

Newcodent is pleased to announce the appointment of its new distributor for Scotland, to sell and demonstrate the Newcodent portable dental unit.

Smile at Home Limited's sales director Tom Pringle can be contacted on 07771 776 0771 & 07771 776 372.

Also known as Dr Bunhead, Tom has made a career out of bringing science to life.

Find out more by visiting www.bunhead.com

For more information on Newcodent and its portable dental unit, visit www.newcodent.com or call 01844 213 399

SITTING PRETTY

As the sole supplier of the Anthos range of dental chairs in the country, Dolby Medical has secured the exclusive rights to offer the latest additions to the Anthos range, the L6 and L9 dental chairs, to Scottish dentists.

The L6 is positioned as the brand's most compact and user-friendly model while the L9 rewrites the rules of ergonomics with a revolutionary seat that flexes at the patient's knee joint.

The L6 model is easily personalised and with a full range of hygiene systems, instruments, multimedia devices and integrated X-ray units. The L9 floor-fixed treatment centre features the latest evolution of the full touch-control panel and can fit the complete range of hygiene devices.

For more information, contact Derek Gordon, Dolby Medical,on 01786 460 603.

MINISTERIAL VISIT FOR PLANMECA

Dental equipment manufacturer Planmeca welcomed Chancellor George Osborne to its Helsinki headquarters recently as part of a high-ranking ministerial visit.

The event, which also saw Finland's Minister of Finance Alexander Stubb attend, included a tour of the company's X-ray production facilities and its high-tech assembly process.

Mr Osborne and Mr Stubb were welcomed to the Finnish factory by Planmeca founder and President Mr Heikki Kyöstilä, as well as other top company representatives, including

Planmeca's Vice President of Sales, Mr Jouko Nykänen, and Managing Director of Planmeca UK, Mr Karl O'Higgins.

For more information about Planmeca and its range of digital solutions, please call 0500 500 586 or visit www.planmeca.com

EASY HOME WHITENING

Most patients are more concerned with the aesthetics of their teeth than their health.

Oral-B is passionate about both and is excited to introduce its 3D White Whitestrips, which will be exclusively distributed in Europe by Henry Schein.

These are a safe, easy home-whitening treatment, with results that last for up to 12 months.

A dental professional first applies the strips, with consumers performing subsequent whitening applications at home.

They use the same enamel-safe whitening ingredient that dentists use, reaching below the enamel surface to remove stains. The results are visible within 14 days.

Your patients can have the whiter teeth they desire, while dental professionals have the reassurance that with Oral-B's products and its professional guidance, teeth are kept white but also healthy, so everyone is happy!

DENTISTRY'S BEST-KEPT SECRET?

Robinson Healthcare's Instrapac range is the leading UK single-use instrument brand.

Instrapac has been adopted across multiple clinical specialties including podiatry, which has experienced identical instrument decontamination issues to those faced by the dental profession.

Moving into dentistry was a natural progression for the company, which has developed a range of premium single-use instruments to provide dental practitioners with a viable alternative to reusable hand instruments.

Managing Director Leigh Thomasson said: "Before entering the dental sector, we reviewed the market very carefully and immediately identified that many single-use hand instruments available at the time were not fit for purpose and not cost effective.

"Poor-quality single-use instruments simply did not justify replacing tried and tested reusable dental hand instruments, despite the many 'hidden' operational costs and technical challenges associated with reusable instrumentation."

The company has addressed all these obstacles and has launched its Instrapac Dental range, which provides premium quality, cost-effective instruments for

most dental clinical applications. Robinson Healthcare's new partnership with Healthcare Environmental Group (HEG) also addresses concerns about the potential environmental impact of single-use instruments.

Robinson Healthcare is so confident about delivering quality it has issued an invitation to practitioners to assess the InstrapacDental range for themselves to reassess their preconceptions and to take a more detailed look at the significant cost-savings that could be achieved by adopting high-quality single-use hand instruments as an essential component of a forward-thinking practice management strategy.

Robinson Healthcare will be at the BDIA Showcase on stand C205. For more information, please call 01909 735 000, or visit www.robinsonhealthcare.com

Tetric EvoCeram® Bulk Fill

High-performance posterior composite

The most efficient posterior composite!

NOW AS A FLOW!

Tetric EvoCeram® Bulk Fill
sculptable

Tetric EvoFlow® Bulk Fill
flowable

See for yourself:
www.ivoclarvivadent.com/bulkfill-uk

www.ivoclarvivadent.uk
Ivoclar Vivadent Limited
Ground Floor Compass Building | Feldspar Close | Warrens Business Park | Enderby | Leicester LE19 4SE | United Kingdom
Tel. +44 116 284 7880 | Fax +44 116 284 7881

ivoclar vivadent®
passion vision innovation

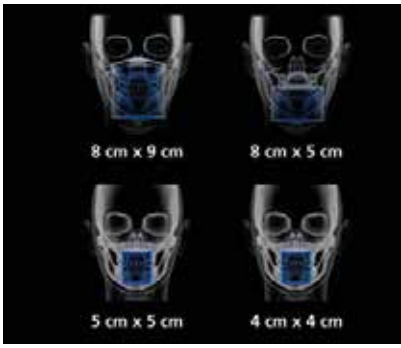
CT Scan Referral Centre

CT Scan £79*

www.ctscanreferral.co.uk

CS 8100 3D System

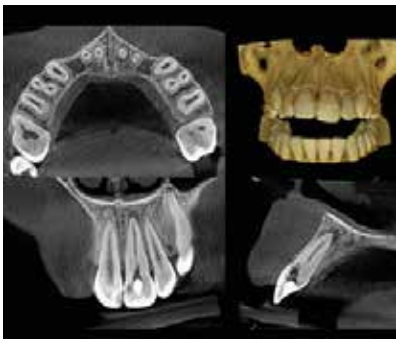
- **Dual jaw mode (8 cm x 9 cm)** - capture both dental arches in a single scan for cases that involve a larger area
- **Single jaw mode (8 cm x 5 cm)** - ideal for cases that require a full view of either mandible or maxilla, including implant planning with surgical guide creation and oral surgeries
- **Universal field of view (5 cm x 5 cm)** - the ideal compromise of image size and dose, this mode ensures you receive the details you need, with no unnecessary information; ideal for most local dental applications
- **EndoHD mode (5 cm x 5 cm; 75 µm res)** - high-resolution mode delivers maximum precision for exams that require greater visibility of the patient's root and/or canal morphologies; best-suited for endodontic applications
- **Pediatric program (4 cm x 4 cm)** - limit patient exposure by confining radiation to a small area; a great option for younger patients, implant planning, and follow-up exams



Refer Online 24/7 at www.ctscanreferral.co.uk 1

We will contact the patient to book an appointment 2

Patient will be given CT Scan on a USB stick 3



Glasgow Referral Centre
1149-1153 Pollokshaws Road
Glasgow, G41 3YH

* Strictly online referral only
Valid until Dec 2015, T&C's apply