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>
> **KIERAN FALLON**

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"high quality patient-focused dental care"

Editorial

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

RELIEVING THE PRESSURE ON DENTISTS

Government-led pilot aims to help dentists steer clear of the GDC

Chatting with dentists at the recent Scottish Dental Show, it was striking just how often the conversation turned to the GDC and the pressure under which many practitioners feel they are now working. Even the remotest possibility of having to face a fitness to practise hearing is enough to strike fear into the heart of the most skilled and ethical of professionals.

One highly respected dentist, renowned for his dedication and commitment to the highest possible standards of patient care, summed it up when he said: "The thought of making even the smallest mistake that might lead to a complaint to the GDC ramps up the pressure on me every time I walk into my practice. It is like having this huge weight on your shoulders. We are all human and mistakes will happen. But to live under this pressure should not be acceptable."

Of course it is essential to have a regulator. There can be no argument about that. Patients must be protected and the profession must be governed. But consistently, practitioners are arguing that far too many cases involving minor, often administrative, breaches of the strict professional guidelines are being brought before the all-powerful disciplinary committees where entire careers, professional reputations and indeed livelihoods are at stake.

The ever increasing anger and resentment directed towards the GDC by the profession is simply fuelled this month with the news that the dental regulator came bottom of a list of nine similar bodies whose standards were examined by the Professional Standards Authority (PSA).

The PSA highlights that the GDC failed to meet a total of seven of its standards of good regulation. On fitness to practise, the GDC fully met only one of the 10 standards, and failed to meet six others, representing what the PSA describes as a significant decline in its performance compared to an assessment it carried out in 2013/14.

Despite the GDC's assurances that it is working harder than ever to get its own processes right, is it really any wonder then that that BDA asks how bad it must get before someone intervenes?

Clearly, government will not intervene directly with GDC business. But the initiative taken by deputy chief dental officer Tom Ferris and his colleagues, and which is reported in this issue of *Scottish Dental*, is to be warmly welcomed. They have come up with a 10-point check list through which dentists can benchmark their own, and their practice's, performance.

The initiative taken by deputy chief dental officer Tom Ferris and his colleagues, is to be warmly welcomed

Ferris is at pains to point out that this is not about discipline. This is about education, prevention and supporting dentists to keep them out the clutches of the GDC.

The project is only at the pilot stage and is being trialled in just four health board areas. But the potential is huge.

It is a bold step and one that the profession should applaud and give its full support to… for everyone's sake.

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1

TOM FERRIS
(ON THE NEW GOVERNMENT PILOT)
Deputy CDO Tom Ferris formed the working group for the 'Quality and Improvement and Supporting Better Practice' pilot.

2

GRAHAM OGDEN
(ON ORAL CANCER DETECTION)
Professor Graham Ogden is a professor of oral surgery and honorary consultant at Dundee Dental Hospital and School.

3

STEVE BONSOR
(ON MATERIALS SELECTION)
Steve Bonsor is an online tutor on the MSc in Primary Dental Care at the EDI as well as lecturing on applied dental materials at Aberdeen Dental School.

4

ADRIAN STEWART
(ON ENDODNOTICS)
Queen's University Belfast graduate Adrian Stewart works in practice limited to endodontics in Edinburgh and Northern Ireland.

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

APPROPRIATE REMUNERATION

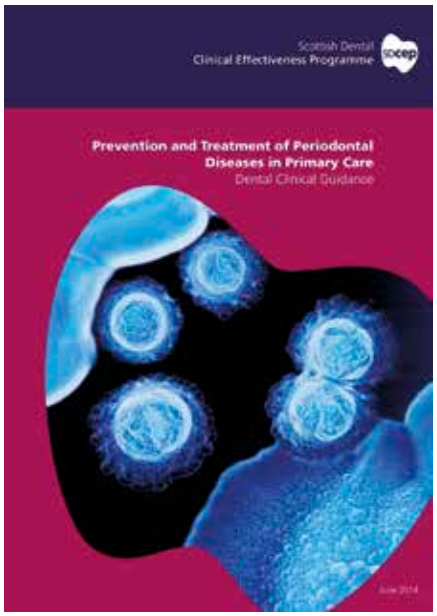
How do we follow the SDCEP guidelines, being paid according to the SDR and still manage to run a business? Something's got to give

The SDCEP guidelines for Prevention and Treatment of Periodontal Disease in Primary Care were published in June 2014. These are a set of excellent, well researched and pragmatic guidelines which we should all follow.

The Statement of Dental Remuneration (SDR) makes this impossible to achieve without either incurring further financial losses, or breaking the rules.

SDCEP states that we should "ensure that full mouth periodontal charting is performed annually in patients who scored BPE 4 in any sextant at baseline and in patients who scored 3 in more than one sextant at baseline". The SDR makes it quite clear that a 1C exam may only be claimed once every 24 calendar months. This would mean 20 minutes spent annually on pocket charting and other baseline indices without remuneration.

For our 1A exam fee of £8.60, SDCEP also expects us to provide advice on smoking cessation, alcohol, healthy eating and plaque control at the recall appointment. We still need to carry out an extra-oral and intra-oral examination of soft tissues and our dental examination for this fee. The



ABOVE: guidelines no longer achievable

advice states (6.1) that "sufficient time is required at each recall appointment to carry out long-term maintenance effectively and patients undergoing supportive periodontal therapy will require longer appointments than those receiving dental prophylaxis".

We need an SDR which is fit for modern purposes, and allows us to carry out the SDCEP guidelines properly, and with fair remuneration

I have supposed that this refers to the standard 10A, fee for which we receive £13.45. It is commonly thought that it costs £80-100 per hour to run a dental surgery – even with our (reduced) allowances it is very hard to see how it can be cost effective to do this. The guidelines also ask for a recall interval of two to six months in the first year – but we are unable to recall more frequently than every three months.

We need an SDR which is fit for modern purposes, one which allows us to carry out the SDCEP guidelines properly and with fair remuneration. Patients deserve to have periodontal treatment and maintenance carried out properly. And we deserve to be remunerated appropriately.

CORRECTION

The British Dental Association has raised some issues concerning Arthur Dent's previous article (p7, May 2015), which we wish to clarify.

In paragraph four, the author stated that the BDA didn't submit separate research on Scotland to the DDRB. The BDA insist that it did in fact submit separate research which is formulated by SDPC's remuneration committee and validated by the BDA. In addition to written evidence, the chair of SDPC, Scottish Council and national director of BDA Scotland give oral evidence for Scotland at the DDRB hearing in London.

The author also referred to redundancies in Scotland. We would like to clarify that this was a voluntary redundancy and there is no evidence that the loss of the post has affected the ability of elected members to do their work.

In relation to the statement regarding a 400 per cent increase in ticket prices, the author was referring to the prices when the event was held in Dunblane. However, both the author and *Scottish Dental* magazine acknowledge that the statement was inaccurate and misleading, and we apologise for any inconvenience caused.

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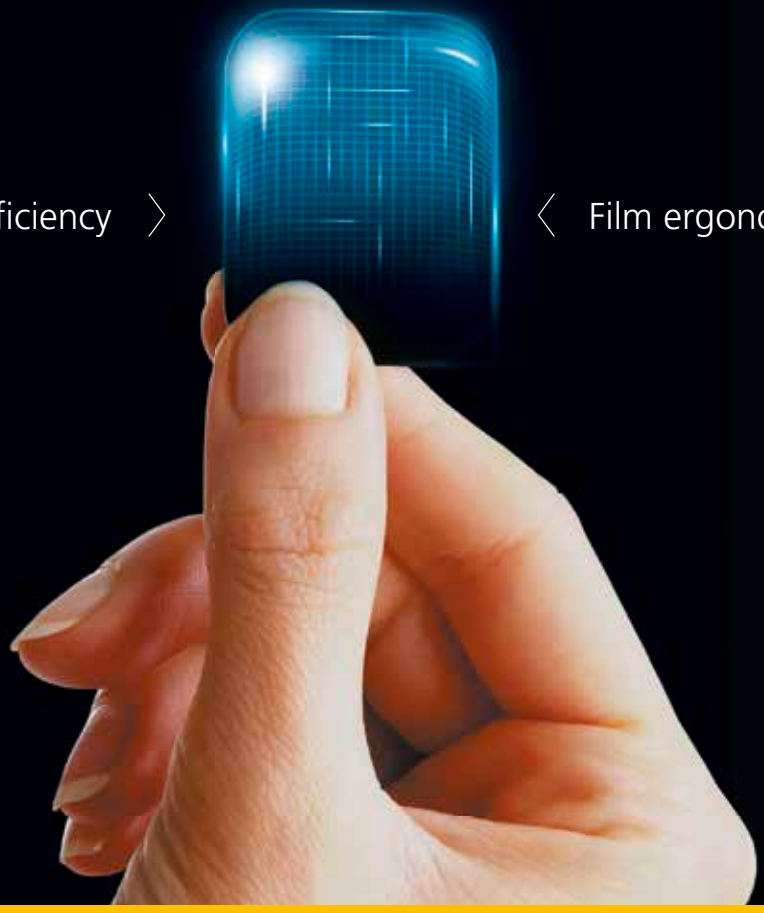

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"The show was a sell-out, registrations were well up on last year and a record number of people attended the awards"

ALAN RAMSAY

RISK MANAGEMENT

PROJECT TO CUT 'FITNESS TO PRACTISE' CASES

The government is taking action in an attempt to cut the number of Scots dentists being brought unnecessarily before GDC disciplinary committees.

The chief dental officer's office has launched a new pilot project that aims to provide practitioners with a 10-point checklist against which they can benchmark their own performance and so minimise risk.

The pilot comes at a time of soaring levels of concern among dentists in Scotland about the potential of being hauled before the Fitness to Practise committees.

It is being led by deputy CDO Tom Ferris, who told *Scottish Dental* magazine: "This is absolutely about supporting practices and allowing dentists to see their own performance and their practice's performance. It will also enable them to benchmark their performance and help them to improve.

"It is also about assisting a practice that is having problems and helping individual clinicians at a very early stage. None of this is disciplinary at all."

The pilot, which is initially being trialed by four NHS boards – Ayrshire and Arran, Dumfries and Galloway, Lothian and Forth Valley – is a combination of the Scottish Government's quality strategy and a project looking into supporting better practice that was being carried out by speciality trainee in dental public health Emma O'Keefe.

Ferris took the proposal to Chief Dental Officer (CDO) Margie Taylor, and a sub-group of the CDO's quality improvement group was formed to take the project further.

The group, chaired by May Hendry, dental practice adviser at NHS Ayrshire and Arran, identified 10 key indicators covering every aspect of clinical practice on a clinician and practice level.

NHS National Services Scotland was commissioned to build an online 'dashboard' to bring together and display all the information to support dentists in the pilot areas.

The pilot will be assessed on a regular basis and progress will be reported to the relevant boards and committees involved.

Turn to page 28 for a closer look at the pilot

ABOVE: Deputy CDO Tom Ferris is leading the charge on dentist performance

CONFERENCE AND EXHIBITION

LEADING LIGHTS ON THE PODIUM

A number of Scotland's leading dental clinicians are to be among the speakers at this year's Scottish Scientific Conference and Exhibition.

The event, sponsored by MDDUS, will take place on 4 September 2015 at Glasgow's Crowne Plaza Hotel.

It will include a special address by the Chief Dental Officer for Scotland, Margie Taylor, who will present on the current challenges facing dentistry in Scotland.

Alexander Crighton, honorary clinical senior lecturer at Glasgow Dental School, will present two sessions: the dry mouth and sensory changes in the orofacial region and managing mucosal disease in primary care.

Among the others presenting will be consultant oral and maxillofacial surgeon Nayeem Ali whi will present on managing the temporo-mandibular joint (TMJ) and facial pain.

And Jeremy Rees, consultant restorative dentist, Cardiff Dental School, will give two sessions: food, drink and dental erosion; and the composite Dahl approach.

Full programme, booking information and speaker biographies are available at: www.bda.org/scottishscientific

PRACTICE ACQUISITIONS

DENTAL GROUP TAKEOVER

A Falkirk-based dental group has secured a £1.2 million deal to take over two Edinburgh dental practices and set its sights on doubling in size by 2020.

BeDental, which already has a practice in Falkirk, as well as Moodiesburn and Possilpark in Glasgow, has bought over neighbouring practices Ocean Drive Dental Practice and Vitaliteeth Dental Spa in Leith.

The two practices bring more than 13,000 patients to the group, which is led by principal dentist and clinical director Atif Bashir. He said: "We're excited to be growing and having not one, but two practices in Edinburgh is a huge step forward for us.

"At both Ocean Dental and Vitaliteeth, we have overhauled the entire operation. Quite simply, it is about putting the needs and wellbeing of patients at the heart of everything we do."

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GDC 'WORST HEALTH REGULATOR IN UK'

Professional Standards Authority places body at the bottom of a list of nine

The BDA has expressed its alarm at a report into the performance of the GDC that puts the organisation bottom of a league of nine healthcare regulators.

The Professional Standards Authority (PSA) published its findings last month and revealed that the GDC failed to meet a total of seven of its standards of good regulation.

On Fitness to Practise, the GDC fully met only one of the 10 standards, and failed to meet six others, representing what the PSA described as a significant decline in its performance compared to an assessment it carried out in 2013/14.

BDA Chair, Mick Armstrong, said: "Yet again, GDC registrants must acknowledge that they are being regulated by the worst health regulator in the UK. It is difficult to understand how badly the GDC has to perform before someone actually intervenes."

However, the GDC mounted a staunch defence of its performance, claiming that a major change programme is delivering real improvements in the protection of dental patients.

In a statement, the GDC said that the PSA report confirmed that in the areas of guidance and standards, education and training, and registration, the GDC is performing well.

The GDC said: "The PSA has reported on data collected between September 2013 and September 2014, which confirms what was already known, namely, that in this period the GDC was faced with an increased number of complaints and a significant pressure on resources.

"The transformation programme we have put in place is already yielding results in this area and we are confident that it will continue to deliver improved performance."

GDC Chief Executive and Registrar, Evlynne Gilvarry (pictured left), said: "The GDC has set out a clear vision that puts the patient at the heart of its work. The PSA report recognises much of the excellent work being done by the GDC on a daily basis. We are not complacent, however, and are fully focused on the need to see through our current reforms and deliver improvements in the area of Fitness to Practise.

NOW TRENDING

1/5

FACT

*One in five people believe fluoride to be a marketing gimmick, despite evidence it has been proven to reduce decay by at least 40 per cent**

* Source: The British Dental Health Foundation

TOP HONOUR BRINGS A SPECIAL SMILE

A Scots children's charity has won the prestigious National Oral Health Promotion Group Patron Prize at the recent NOHPG Conference.

Action for Sick Children Scotland's Special Smiles Dental Project took the top honour. Dr Albert Yeung, consultant in dental public health at NHS Lanarkshire and a member of the ASCS Project Advisory Group in Lanarkshire, nominated the work Special Smiles had carried out in the Board area for the NOHPG prize.

The project helps children with additional support needs, using ASCS's Dental Play resources, to look after their teeth and help to reduce any worries about visiting the dentist.

ASCS chairman Professor Richard Olver said: "Since 2009 our Special Smiles project has worked in partnership with NHS boards in various parts of Scotland and we are delighted that this has been recognised in this way."

At the recent IAPD Congress in Glasgow, the Special Smiles work in Lanarkshire was a finalist in the poster competition, finishing as runner-up in the Bright Smiles-Bright Futures Award category.

RECORD HIGH FOR PATIENT REGISTRATIONS IN SCOTLAND

More Scots are now registered with a dentist than ever before, new statistics have revealed.

The figures show that 88 per cent of the Scottish population – 4.7 million people – are now registered. Children are more likely to be registered than adults, at 93 per cent compared to 87 per cent.

Of those registered, 74 per cent had seen their dentist within the last two years, with children more likely than adults to have attended an appointment.

The figures also show that dental registration levels are the same, at 90 per cent, for children living in the most and least deprived areas of Scotland.

Public health minister Maureen Watt welcomed the statistics. "This is fantastic news, and shows the real progress we have made since 2007 in improving people's access to an NHS dentist, with nearly two million more people registered under this Government," she said.

"It is encouraging to see that 93 per cent of children in Scotland are registered and that this rate remains high across all sections of society."

SCOTLAND'S CLASS OF 2015

We list the names set to pop up at dental practices around the country as the next generation of professionals pick up their Bachelor of Dental Surgery degrees

ABERDEEN BDS GRADUATES 2015

Mohammed Al-Khairulla,
Ruth Baidoo,
Suzanne Buckley,
Anna Chrystal,
Jasmin Dingri,
Matthew Doswell,
Michelle Gardner,
Thomas Green,
Trishna AM Mistry,
Bal Singh Panesar,
Alan Purves,
Paul Martin Roden,
Elizabeth Louise Sanderson,
Lynsey Katie Scott,
Veronica Ann Smith.

DUNDEE BDS GRADUATES 2015

Fatima Anwar,
Amir Abd Aziz,
Muhammad Abu Bakar,
Lohini Arul Devah
Hannah Elizabeth Agnew,
Marwa JAQA Albulushi,
Adnan Ihsan Ali,
Bashar Namat Behnam Abu Al-Soof,
Megan Elizabeth Broadley,
Rachael Sarah Burgess,
Michael John Byrne,
Darragh Thomas Byrne,
Aoife Frances Cannon,
Grace Trea Conway,
Rachel Tracy Dack,
Marianne Louise Dobson,
Eliska Jana Dvorakova,
Louise Emma Flavell,
Christopher Fowles,
Carly Nicole Fraser,
Alasdair Scott Gilmour,
Claire Catherine Gilsenan,
Aidan Hannah,
Benjamin David James Hastings,
Elaine Hogan,
Alexandra Holden,
Ammar Juzar Alibhai,
Laura Catherine Kelly,
Arran Eleanor Lang,
Michaela Laverty,
Victoria Anne Wakefield Lawson,
Joshua Liam Daniel St.Clair Low,
Heather Jane Lundbeck,
Kamal Kapil Madhok,
Rebecca Louise Manson,
Rebecca Masterson,
John Patrick McAleavey
Meabh Catherine McKeown,
Aoife Maire McKeown,
Megan Celine McMullan,
Jennifer Ann Miller,
Stewart Alexander Milligan,
Norfatihah Mohd Yatim,
Clare Paula Murphy,
David Graham Murray,
Sebastian Antonio Mylchreest,
Grainne O'Rourke,
Salam Bashar Protty,
Faye Rosemary Rice,
Marium Rizwan,
Catriona Xanthe Ross,
Jennifer Elizabeth Sands,
Nirmal Pravinchandra Shah,
Simon James Shannon,
Nurul Munirah Mohammad Sohaimi,
Patrick James Steed,
Ryan James Stewart,
Rory Lamont Stewart,
Emma Summers,
Maria Louise Taheny,
Jennifer Helen Tanzilli,
Neha Thummalapenta,
Kirstin Livingstone Walker,
Andrew James Wilson,
Stephanie Louise Wiseman.

GLASGOW BDS GRADUATES 2015

Catriona Lynn Aitken,
Andrew George Baird,
Matthew Barr,
Brian Beggan,
Francesca Capaldi,
Kevin James Colgan,
Becky Coulter,
Grant Stephen Creaney,
Mari Nadia Dabjen,
Jennifer Danks,
Alan Cameron Davies,
David Devine,
Anne Catherine Devlin,
Matthew John Dickie,
Ciara Dunleavy,
Nurul Nadia Ataillah Emran,
Jonathan Fitzpatrick,
Hayley Margaret Foulds,
Paul William Gallacher,
Ross Ian Gallacher,
Colin Gordon,
Neil David Gordon,
Jinan Safa Hashim,
Nina Louise Haveron,
Craig Hogg,
Gillian Catherine Howie,
Lauren Humphries,
Esther Elizabeth Johns,
Robert Kirke,
Shona Lambie,
Dominic Lamont,
Michael Brian John Lewis,
Harriet Rose Liddicott,
Samuel Lockhart,
Elaine Macdonald,
Katielyn MacDonald,
Lee MacKie,
Hannah MacMillan,
W Roger Marsh,
Andrea Rose Mathieson,
Jordan Matthew,
Peter Jonathan McCreadie,
Rachel-Wong McDermott,
Sheryl McFarlane,
Kate McKenna,
Lauren McPhillips,
John McQueen,
Ashleigh Janet Meikle,
Lucy Marie Morgan,
Sarah Andrea Mossey,
Zoe Mullaney,
Kathleen Margaret Murphy,
Rachel Mussen,
Sukhdev Singh Parhar,
John James Perry,
Amy Grace Porter,
Jaspal Singh Purba,
Hazel Ellen Reid,
Stewart Robertson,
Louise Robinson,
Peter Shankland,
Thomas Short,
Ryan Shum,
Craig Spence,
Jill Symington,
Hira Tariq,
Asha Thomson,
Shakil Umerji,
Callum Ross Ward,
Callum Andrew Wemyss,
David A Wilson,
Lauren Amy Elizabeth Wilson,
Natalie Wilson,
Ailsa Annie Woodley,
Xin Hui Yeo.

ABOVE: Glasgow graduates
LEFT: Aberdeen graduates
RIGHT: Dundee graduates

ABOVE: presenting the white gloves to Prof Hector is 2015 graduate Nirmal Shah

MILESTONE FOR DUNDEE'S BDS GRADUATES

For the first time since 2004, all 65 final year BDS students at Dundee Dental School have passed their examinations at the first sitting.

To mark the occasion, Dundee dental dean Professor Mark Hector was presented with a pair of white gloves during the graduation ceremony on 26 June. He said: "I should like to express my delight and extend my congratulations to all the students graduating this year. It was a marvellous achievement. I was also hugely honoured to be presented with the white gloves as they represent a special reminder of a memorable year."

The white gloves will be permanently displayed outside the dean's office alongside the final year photograph to mark the achievement.

This was made all the more special as all the oral health science students at Dundee also passed their examinations on 19 May, marking a double celebration for the school.

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"We would do well as a profession to more proactively contribute to the political and policy discourse"

DAVID CONWAY

BDA PULLS PLUG ON SCOTTISH SURVEY

Practitioners have reacted angrily to the BDA's decision to pull their support for a survey of Scottish dentists' attitudes to the GDC just hours before it was due to be sent out.

The survey was scheduled to be distributed on 6 July to all Scottish GDPs asking if they thought the GDC was still fit for purpose and whether they would support a separate Scottish regulator.

Scottish Dental magazine understands that Principal Executive Committee (PEC) chairman Mick Armstrong, personally intervened and stopped BDA staff sending out the survey, saying that the questions related to Scottish Dental Practice Committee (SDPC) policy, but that it was "not BDA policy".

He is also said to have described the exercise as potentially disruptive and divisive.

ABOVE: Mick Armstrong is believed to have stopped BDA from sending survey

A source close to the SDPC said: "All SDPC wanted to do was survey dentists to see what their thoughts were. And, in fact, the BDA was initially quite supportive of that. It was providing administrative support and was going to post out the survey.

"Then, at the 11th hour, the chair of the PEC has stepped in and said it is not BDA policy, we are not doing it."

And Kieran Fallon, former member of the SDPC and one of those involved in proposed formation of the new Scottish Association of Local Dental Committees, said: "This is another example of the BDA in London stepping in to rule over Scottish committees and it is exactly why I and some others resigned from the BDA last year. It encapsulates all that is wrong at the moment with the BDA."

Robert Donald, chair of the Scottish Dental Practice Committee, said: "SDPC is disappointed that the BDA has decided to withdraw support for the survey, but we will carry it out ourselves using Survey Monkey.

"Scottish GDPs will be contacted and invited to participate over the next few days."

The BDA was contacted, but refused to comment.

STUDENT GETS TANZANIA BRUSHING

An Aberdeen dental student is set to launch a new oral health programme to help children in Tanzania.

For the past three years, Clare Lowe has been working with the Go Make a Difference charity, building a health centre, teaching oral health and organising surveys and fact-gathering exercises.

However, the student from Westhill is now taking her charity work in the country to new levels by introducing the programme that she has developed.

She said: "When I first went out, I hadn't started my dental course yet so I was helping to do all kinds of things like helping provide clean water sources and teaching general health education to youngsters.

"But as I progressed in my dental course, I realised the skills I was learning in Aberdeen could be put to good use in Tanzania."

Clare is going to roll out the programme in the town of Musoma, where she has identified a particular need for her support.

"Locals use a frayed stick to clean their teeth as toothbrushes and toothpaste are expensive. They're just not a priority for these people.

"Little was done in terms of prevention. They were forced to wait until something went wrong with a tooth and then either pull it out, or consult a local witch doctor."

Now, however, she intends to spends time each year returning to the village to help improve the community's oral health.

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Dr David Bloom
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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

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MSc (Ed), MSurgDent(Ed)
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PRACTICES' GRANTS IN THE SPOTLIGHT

NHS Grampian is reviewing whether practices receiving grants were ineligible

An Aberdeen dentist who waged a one-man campaign over non-compliance of grant conditions by new practices in the city, has welcomed NHS Grampian's decision to take action.

Three years ago, Ross McLelland (pictured), principal dentist at Waverley Dental Health Practice in Aberdeen, spotted a drop in business. He discovered that the health board had funded several new practices in the local area with money from the Scottish Dental Access Initiative (SDAI).

However, when he started digging, he found that one practice wasn't eligible as it was a limited company and began a campaign for an investigation.

Now, the board has confirmed that five practices are being looked at and named them as Britedent, West End Dental, Portlethen Dental Care, Green Dental and Deeside Dental Care.

McLelland told *Scottish Dental* magazine: "I'm not against the SDAI grant initiative. In principal it's a good scheme if used appropriately, but there are strict terms and conditions attached, and I was astonished at how lax NHS Grampian was being.

"We now have overcapacity in Aberdeen, with one committed NHS practice closing and several other practices downsizing. The west end of Aberdeen already had seven practices, so you have to question why three new SDAI practices with a minimum capacity for 24,000 patients were funded within the same square mile. There was no business case for this.

I believe that NHS Grampian is guilty of mismanagement of public funds and I seriously doubt their commitment to tightening their scrutiny of these contracts

"I believe that NHS Grampian is guilty of mismanagement of public funds and I seriously doubt its commitment to tightening its scrutiny of these contracts.

"All these potential breaches were highlighted to NHS Grampian years ago, and little has been done. There should have been a more robust process in place from the very start – it's frankly embarrassing for NHS Grampian to be promising better compliance in future. It's even possible that this is a pattern repeated across other health boards in Scotland."

A spokesman for NHS Grampian said: "NHS Grampian is completing a comprehensive review of the monitoring processes for SDAI grants. This will be both prospective and retrospective, resulting in a more robust process that will ensure better compliance with the grant conditions.

"These investigations are ongoing and it would be inappropriate for us to comment further."

PRIVATE DENTAL PRACTICES TO BE REGULATED BY HEALTHCARE IMPROVEMENT SCOTLAND

Private dental clinics are to be regulated by Healthcare Improvement Scotland (HIS) from next April as a result of recommendations to the Scottish Government on the non-surgical cosmetic industry.

Legislation will now be commenced after the Scottish Cosmetic Interventions Expert Group published its advice on the best way to regulate the growing cosmetic industry in Scotland. The Scottish Government has announced that all private clinics where services are provided by doctors, dentists, nurses, midwives and dental care professionals will be regulated by HIS from April 2016.

Chief executive and registrar of the General Dental Council, Evlynne Gilvarry, said: "The General Dental Council is very keen to have regulation of entirely private dental practices. We work with relevant bodies in the other three administrations and are keen to have similar arrangements in Scotland.

"The General Dental Council regulates the whole dental team, so practices owned and run by dental care professionals would also be covered."

The report proposes a three-phase new regulation regime, starting with independent clinics next year.

The second phase will look at certain high-risk procedures, such as dermal fillers, which are being done in clinics provided by other health practitioners.

The final phase will seek to develop a system of regulation for other groups of practitioners.

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SAFEGUARDING THE VULNERABLE IS KEY

After more than a decade of campaigning, Glasgow Professor Richard Welbury has welcomed the GDC's decision to recognise the reporting of abuse or neglect of children and vulnerable people as a core CPD topic

Speaking at a press conference during the 25th Congress of the International Association of Paediatric Dentistry (IAPD) at the SECC in Glasgow recently, Professor Welbury said that safeguarding children and young people has become a significant element of the work of paediatric dentists.

He said: "We have actually been asking the General Dental Council since 2004 for this to happen, so we are very grateful that it has now actually happened.

"It is an increasing part of my work as a paediatric dentist – having to get in touch with children's services to talk to social workers. It is a significant part of our work now and I am very relieved that it is been recognised by the GDC."

Prof Welbury chaired the recent IAPD congress that saw more than 1,600 delegates from over 60 countries attend. IAPD president Jorge Castillo hailed the conference, which had the theme 'The Voice of the Child', as "the greatest congress by the IAPD ever".

Prof Welbury also remarked that the congress was unique in its approach. He said: "It is quite innovative in that I am not aware of any previous paediatric conference that has included a holistic view of the child before. Usually, dental conferences have been related to dental materials or dental traumatology, but never with a total holistic view, which the Voice of the Child gives us."

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FACT

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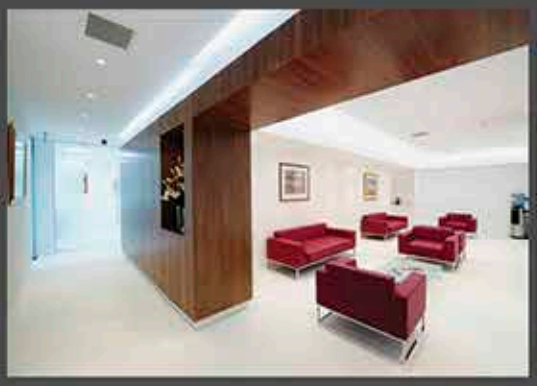
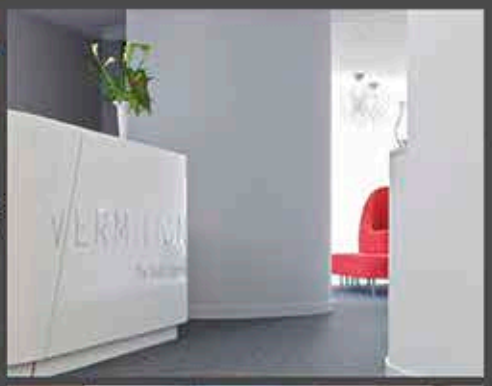
Source: Childsmile

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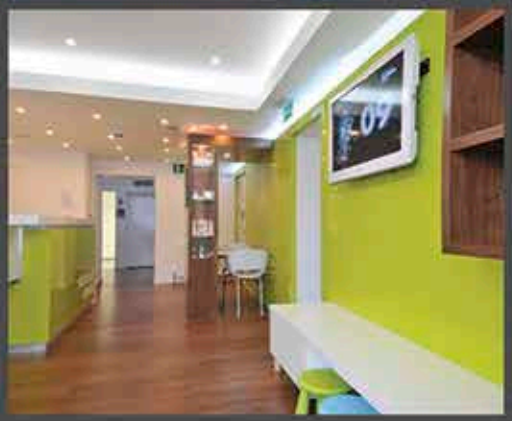

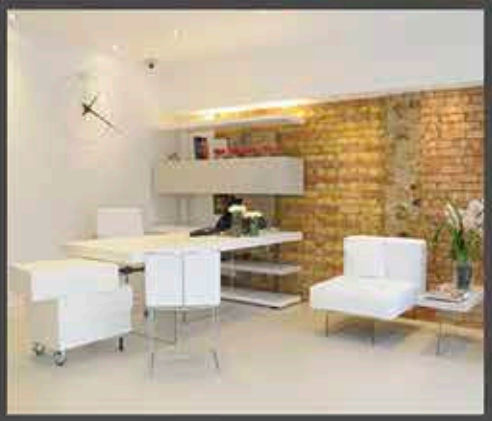

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Sir Winston Churchill painted under the alias Charles Morin.

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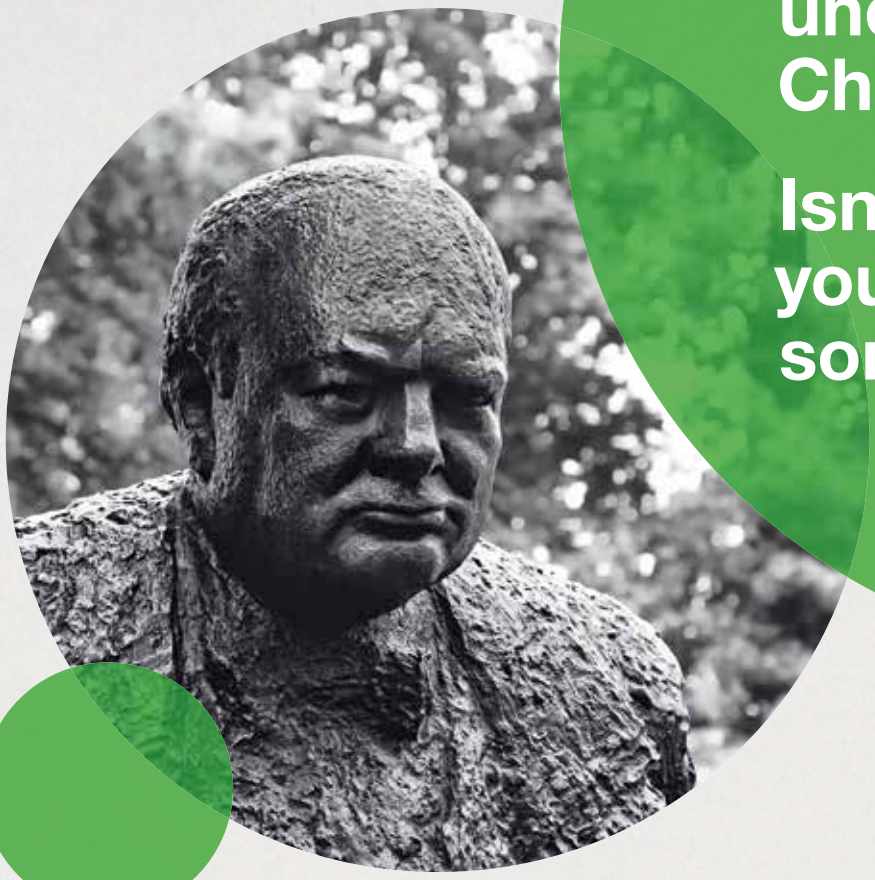

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Dispatches

WITH MARTIN WOODROW →
BDA director of member services
dispatches@sdmag.co.uk

YOU CAN PLEASE SOME OF THE PEOPLE, SOME OF THE TIME...

Improving communication and raising the profile of dentistry – two of the BDA's key priorities says Martin Woodrow

As we come towards the anniversary of the independence referendum, the tremors are still being felt across politics and broader society. Not just in Scotland, but across the whole of the UK.

The consequences were certainly felt in this year's Westminster elections, and no doubt will be at the polls in Scotland next year. We've still got debate and disagreement about the Smith Commission proposals – do they go far enough, does the Scotland Bill really reflect the Commission's intentions? It was the Welsh Labour MP Ron Davies who came up with the phrase back in 1997 that "devolution is a process and not an event", and can it ever have seemed more appropriate?

Organisations need to repeatedly challenge themselves as to whether they are fit for purpose, to reflect the constitutional order of things

But it isn't just in big politics that there is a sense that everything has changed and continues to change. Across society, companies and organisations need to repeatedly challenge themselves as to whether they are fit for purpose, to reflect the constitutional order of things. That applies to the British Dental Association as much as it does to any other organisation.

One of the key issues in any debate is bound to be how much power is devolved from the centre (usually in London) to other parts – be that nations, or indeed now regionally within England. And an interesting context to that debate is likely to be the personal perspective of the key players and their views on the wider political question.

But for organisations like the BDA, there are additional constraints that stem directly from its role as a trade union. Authority simply cannot be delegated away from a trade union's executive committee, which is understandably frustrating for those who would like to see greater or complete autonomy. That is not to say that things cannot or should not be done to reflect the devolution process. The debate about how the BDA can change is very much a live one, with chair Mick Armstrong meeting Scottish colleagues in August to discuss this very subject.

I come at this whole discussion from an unusual perspective. Part of my BDA director role is to look after the advice and representational services provided to members across the UK, including in Scotland. My job is London-based but I live with my family in Edinburgh. The reason is that, before joining the BDA, I was the director for the British Medical Association in Scotland. Edinburgh is a great place to live, so we stayed. That background gives me an interesting angle – I've been part of the process of UK organisations grappling with devolution from both ends of the equation and understand the frustrations.

What I would say is that the BMA faces many of the same issues, as do other similar organisations like the RCN. We all struggle to keep everyone happy. Nobody is getting things completely right, and that's probably because there is no right answer that will suit everyone. What we should do is commit to continuing the dialogue, and doing what we can to best represent our members.

We all struggle to keep everyone happy. Nobody is getting things completely right, and that's probably because there is no right answer that will suit everyone

In that respect, there have been criticisms in Scotland of the BDA and what it does for members. But again drawing on my BMA days, I have been hugely impressed by the range and quality of services that BDA members get – in comparison to their medical colleagues. For example, the scope of business advice is much wider, the depth of the input to the review body process for all the nations is striking, and the provision of high-quality continuing professional development is impressive. There is certainly no equivalent of the excellent value BDA Scottish Scientific Conference for doctors.

One of the issues I have heard, across the UK, since coming to the BDA is that the association's voice is not loud enough, that we don't get our views across like the doctors. The BMA certainly gets criticised by its members for the same thing.

But we can do better to raise the profile of dentistry, to make sure that it is a key part of the wider health debate. Improving communication, raising that profile, is one of the key strategic priorities for the BDA across the UK. Dentistry is a small and diverse profession and will have a much better chance of getting its voice heard if it stands together.

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

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Accounting issues when selling your practice: Roy Hogg and Neil Morrison of Campbell Dallas cover taxation issues on the sale of the practice including the use of entrepreneurs' relief and pre-retirement tax strategies. Campbell Dallas is one of Scotland's leading firms of accountants with a specialist healthcare division.

Financial planning for retirement: Independent financial adviser Jon Drysdale of PFM Dental considers how delegates can best forecast various income sources in retirement. The NHS Pension will be covered including flexible retirement options and mitigating the Lifetime Allowance Charge.

FOR MORE INFORMATION AND BOOKING:

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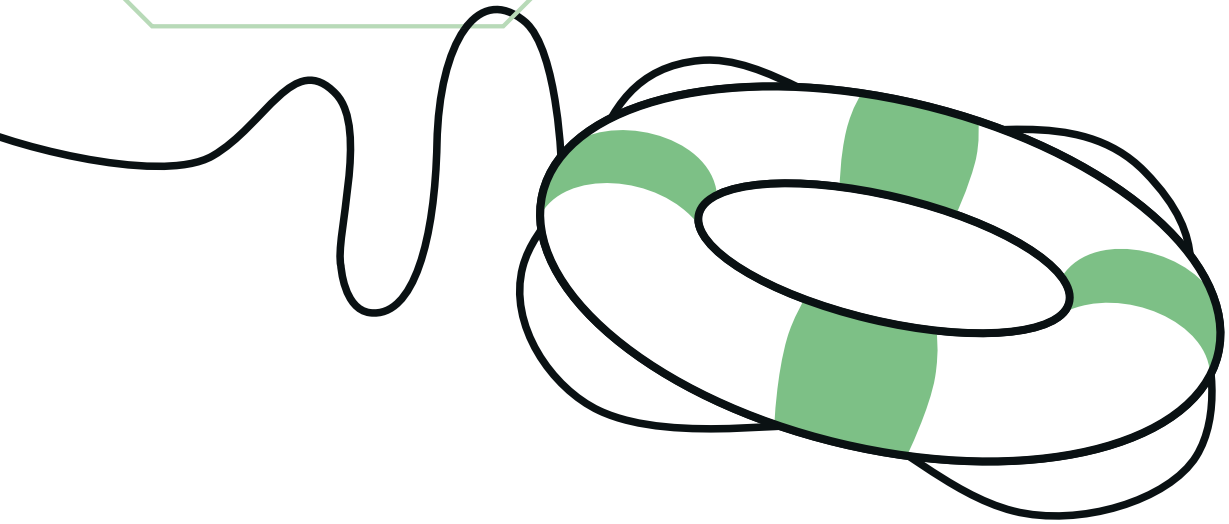

SUPPORTING QUALITY PRACTICE

AN AMBITIOUS NEW PILOT PROJECT THAT AIMS TO SUPPORT DENTISTS IN PRACTICE AND STOP THEM ENDING UP IN FRONT OF THE GDC HAS BEEN LAUNCHED

BRUCE OXLEY MARK JACKSON

The nightmare of being referred to the GDC has long struck fear into the heart of the profession. Controversial the regulator may be, but it still has the power to end a career.

Now, however, the number of cases coming before fitness to practice committees has reached such a level that the government is taking action to identify concerns as early as possible to provide support and, by doing so, reduce the number of dentists facing the powers that be.

Under the guidance of Scotland's deputy chief dental officer Tom Ferris, a new pilot has been launched called 'Quality Improvement and Supporting Better Practice.' The pilot brings together information from a range of sources to get a picture of the quality of dental care that individual clinicians and practices are providing. However, rather than singling out underperforming dentists and failing practices, the pilot is all about early intervention to avoid problems that could lead to, among other things, referrals to the GDC, said Tom.

He said: "This is absolutely about supporting practices and about allowing dentists to see their own, and their practice's, performance. It will also enable them to benchmark their performance and help them to improve.

"But it is also about assisting a practice that is having problems and assisting individual clinicians at a very early stage. None of this is disciplinary at all. All we want to do is have a consistent approach – that all boards will do all these stages, at the same time, to the same level and with the same trigger."

The pilot, which is initially being trialled by four NHS boards – Ayrshire and Arran, Dumfries and Galloway, Lothian and Forth Valley – is a combination of the Scottish Government's quality strategy and a project looking into supporting better practice that was being carried out by speciality trainee in dental public health Emma O'Keefe.

> "THIS IS ABSOLUTELY ABOUT SUPPORTING PRACTICES AND ABOUT ALLOWING DENTISTS TO SEE THEIR OWN, AND THEIR PRACTICE'S, PERFORMANCE"
>
> TOM FERRIS, DEPUTY CHIEF DENTAL OFFICER

Purely by chance, Emma, who is now a consultant in dental public health at NHS Fife, was working alongside Tom, who was tasked with implementing the quality strategy within dentistry and they discussed what they were each working on. It occurred to them that it would make perfect sense to combine their two pieces of work and form a larger and broader project.

Tom took the proposal to chief dental officer (CDO) Margie Taylor, and a sub-group of the CDO's quality improvement group was formed to take the project further. The group, chaired by May Hendry, dental practice adviser at NHS Ayrshire and Arran, identified 10 key indicators covering every aspect of clinical practice on a clinician and practice level (see over).

NHS National Services Scotland was commissioned to build an online

CONTINUED OVERLEAF>

Tom Ferris says that the pilot is not about discipline, it is about supporting dentists in practice

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'dashboard' to bring together and display all the information – which comes from a range of sources such as ISD and NES as well as the health boards themselves – in one place. Tom explained: "These indicators all exist somewhere but at the moment they are not all in one place. The end point is that we will be able to extract data automatically from the various places where it sits and that will feed into the dashboard and get updated as and when is required."

The indicators are RAG (red, amber, green) scored using the traffic light system with green meaning no issue or concerns, to amber which indicates some concern or a shortfall of some degree, to red, which highlights serious concerns, non-compliance or multiple/major breaches. Amber and red scores would initiate a response, ranging from advice and support for the practice or individual up to referral to an NHS board performance review group, or equivalent, to discuss if further action is needed.

Tom explained that during the pilot the information that is being fed into the dashboard will not be made widely available. In fact, of the members of the sub-group, only the primary care managers currently have access. He said: "We had a long debate about who should access this raw data and we decided that, for the pilot, not many people needed to look at it. So, the only people who have access to it are the primary care managers in each of the pilot health boards.

"If they see a change in performance or something going from green to amber, they would highlight that to the relevant person. So, it would primarily be the dental practice adviser, but it could be the Childsmile co-ordinator and it could be the clinical director for the PDS."

Tom admitted that he and Margie will never get access to the information in the dashboard and the preview they have seen of how it will look was developed using dummy information. He said: "When it is live, I expect you would primarily see a sea of green, because most dentists are working really well and there are very few dentists getting into trouble.

"This is really important to stress; most dentists do really well and most dentists want to do really well and we have to trust them. But there will be the odd amber, the odd red and that will show up as quite noticeable on the dashboard. Whereas, if that information is kept in a drawer or if it was kept in various places as it is at the moment, it can be difficult to spot if there is something happening there."

As the pilot progresses and the dashboard is developed, Tom explained that the aim is for the information to be made available for individual clinicians to access and see how they compare with their peers through anonymised benchmarking on a health board and national level. Eventually, he believes that some of the information should be available to the public as well, although that is expected to be much later in the process.

He said: "There will be a discussion down the line, probably when we are well into the pilot and other boards have joined, about extending the level of access. Because, in the end, there should be some level of access for the DPAs, practice owners and individual clinicians. It is important that we get that right and the logical end point is that there should be some way that we can present some of this information to the public.

"But, that is way down the line and it wouldn't be raw data. There must be a discussion about that. We would need to find a way of presenting the information so that it is understandable and makes sense to the public."

However, as this is a pilot, the indicators and thresholds that are in place at the start might be altered or removed as the project develops. Tom said: "These indicators are not set in stone, this was what we felt as a group were the right indicators. If we sit down in six months time and discover that one of the indicators is not really telling us anything, we could change it and bring something else in.

"That also goes for the thresholds between green, amber and red – this is the pilot, it's about learning and the end point will certainly look a lot different to what we started with."

Tom expects more health boards to come on board, two are currently in discussions at the moment, with the eventual aim of it being rolled out to all 14.

He said: "The pilot has been shared with the lead officers for all of the health boards, so they are all aware of it.

"Two boards have approached us asking if they could start now. But, rather than bring them in straight away, what we may do is offer the new boards the spreadsheet that almost sits underneath the dashboard so they can start to bring things together locally. So, when we decide to go live with the system in their board, the import is that much easier."

And, rather than being sceptical about the process, Tom hopes that the profession will see this as a powerful tool for developing practices and improving clinicians' clinical work.

He said: "I am quite excited about the prospect of giving dentists access to the data to allow them to see how they are getting on because I think that is really important. We are only just getting the mechanics of it sorted at the moment, but the next stage for the four pilot boards is opening up access in a secure way to the practice owners and the dentists. They will never see one another's data, they won't see their colleagues' down the road, but it will be anonymised and benchmarked so they can gauge where their data sits within the range. That is thought to be a very powerful way to drive improvement, to see how you are comparing to someone else. So that's the bit I'm really looking forward to."

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DENTIST INDICATORS
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2. Drug prescribing
3. Childsmile FVA
4. Clinical quality
5. Clinical audit
6. Patient view (PDS only)
7. Probity

QUALITY IMPROVEMENT AND SUPPORTING BETTER PRACTICE WORKING GROUP

May Hendry – Dental Practice Adviser, NHS A&A (chair)

Colin Duncan – Lay representative on Scottish Dental Practice Board

Emma O'Keefe – Consultant in Dental Public Health, NHS Fife

Valerie White – Consultant in Dental Public Health, NHS Dumfries and Galloway

Anna Slaven – Primary Care, NHS Ayrshire and Arran

David Conway – Consultant in Dental Public Health, Information Services Division

Jill Ireland – Senior Analyst, ISD

Greg Thomson – Primary Care Strategic Lead, NSS IT

Tom Ferris – Deputy Chief Dental Officer, Scottish Government

PROVIDING ONGOING ADVICE TO THE GROUP:

Tony Anderson – Director, NHS Education for Scotland

Linda Bunney – Primary Care, NHS Dumfries and Galloway

Alison McNeillage – Primary Care, NHS Lothian

Evelyn Hadden – Primary Care, NHS Forth Valley

Alan Whittet – Dental Adviser, Dental Reference Service

THAT IS THOUGHT TO BE A POWERFUL WAY TO DRIVE IMPROVEMENT, TO SEE HOW YOU ARE COMPARING TO SOMEONE ELSE

AGAINST THE ODDS

THE ONCE SEEMINGLY UNSTOPPABLE TIDE OF ALCOHOL-RELATED GANG VIOLENCE IS TURNING. THE MEDICS AGAINST VIOLENCE CHARITY HAS PLAYED A PROMINENT ROLE IN AN EDUCATION INITIATIVE TO MAKE THE STREETS SAFER

TIM POWER MIKE WILKINSON

When emergency medicine consultant Alastair Ireland came to work for his evening shift at the Glasgow Royal Infirmary he knew it was going to be a busy night. In three separated cubicles his colleagues were dealing with three individual stab victims.

He described the scene: "One had his chest already open as the medics tried to try to save his life. The other had a sword sticking out of his eye. Another young man had horrific wounds all over his body from multiple machete attacks. He died... well, they all died."

Alastair was describing what had become an all too common Saturday night in Glasgow around 10 years ago for a video produced by Medics Against Violence (MAV). The hard-hitting production is being screened to show today's schoolchildren the dangers of alcohol-related gang violence.

Two hundred and fifty MAV volunteers have been visiting schools since 2009 and so far have spoken to more than 17,000 children, mostly across the Central Belt and also in Dundee where they run their intervention programme.

Christine Goodall was one of the original founders of MAV, after being appalled at the level of senseless violence that was enveloping young people in Glasgow. As an oral surgeon training in oral and maxillofacial surgery at the time, she witnessed the bloody results of this type of "recreational violence", dealing with multiple facial fractures from blunt trauma – from baseball bats and fists – and also knife-related injuries, such as slashes and the infamous "Glasgow smile".

Ten years ago Glasgow was dubbed the "murder capital" of Europe and had violent assault statistics to rival New York. However, today it's a different story, thanks to the impact of the Police Scotland's Violence Reduction Unit, set up by Strathclyde Police in 2005, and the work of organisations like MAV and other community initiatives across the city.

AS AN ORAL SURGEON TRAINING IN ORAL AND MAXILLOFACIAL SURGERY AT THE TIME, SHE WITNESSED THE BLOODY RESULTS OF 'RECREATIONAL VIOLENCE'

Today, Glasgow's – and Scotland's – annual murder rate has more than halved, from 39 in 2004-05 to 18 in 2014, with similar reductions in attempted murder, serious assault and people carrying knives.

What is interesting about the crime statistics is the reduction in the numbers of young people involved: the majority of violent crime is now committed by people in their 20s and 30s.

Christine explained: "There really is a sea change in attitudes. The statistics speak for themselves and it's with young people where the change is happening. The messages are getting through as they are drinking less and not getting involved in violence as much as before – they are really making this happen."

Christine and her MAV colleagues average around 50 school and youth club visits a year, speaking to classes of second

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"THE STATISTICS SPEAK FOR THEMSELVES AND IT'S WITH YOUNG PEOPLE WHERE THE CHANGE IS HAPPENING"

Christine Goodall, one of the founding members of Medics Against Violence, a charity that works alongside Police Scotland's Violence Reduction Unit to keep the issue of gang violence and knife crime high among school children

FROM PREVIOUS PAGE>

to fourth years about the dangers of drinking and getting involved in violence. The team are also regular visitors to HM Young Offenders Institution Polmont during the summer.

Today, she is at the Cardinal Winning Secondary School which caters for 120 children with special or additional needs in the east end of Glasgow, where she is giving her talk as part of the school's Health Day.

The schoolchildren are transfixed by the new video, which pulls no punches. It features CCTV footage of gang violence on the street, graphic photography of hospital A&E teams trying to save stab victims, as well as thoughts of a surgeon, ambulance driver and a forensic pathologist on the repercussions of such violence. However, the most powerful message comes from two young men currently under a long sentence for murder in Polmont who regret the day they got involved in a mindless knife fight at the age of 14, which resulted in the taking of a life.

Christine has met these boys many times and said they are truly repentant: "They wanted to be involved with our video and to warn others about the dangers of getting involved in violence – I think their words are very powerful and resonate with other young people."

During the group discussions after the video some of the boys admit to drinking on the street and realising how this made them vulnerable. One admitting to being in a gang and getting into fights but turned away from violence when he realised that he could have put his family at risk if a rival gang came after him.

Christine said MAV's message has changed over the years: "We've moved away from 'don't carry a knife' to broader messages about keeping safe, not drinking

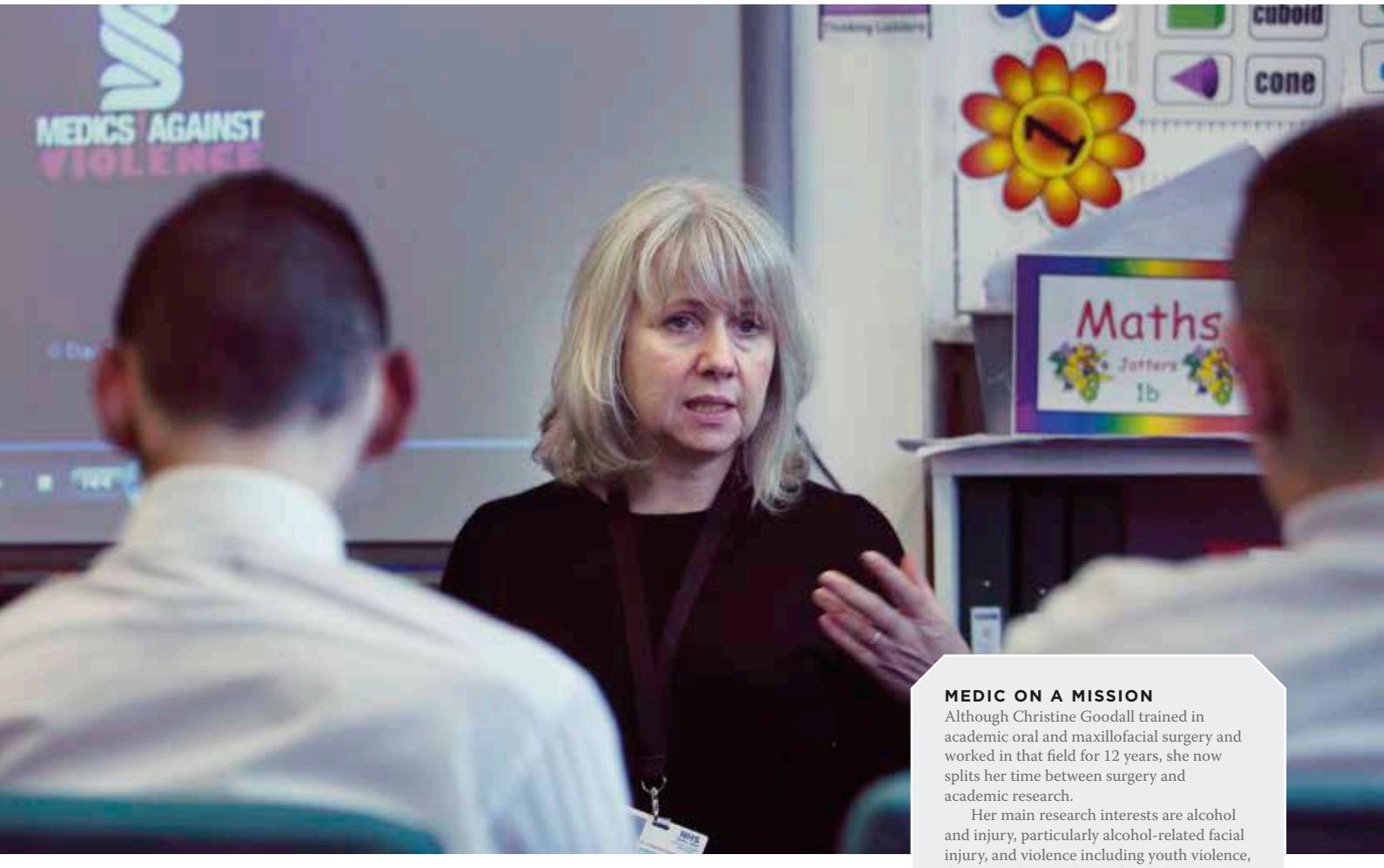
> "WE'VE MOVED AWAY FROM 'DON'T CARRY A KNIFE' TO BROADER MESSAGES ABOUT KEEPING SAFE... AND WALKING AWAY FROM TROUBLE"
>
> CHRISTINE GOODALL

VIOLENCE REDUCTION UNIT

In 2005, Strathclyde Police established the multi-disciplinary Violence Reduction Unit (VRU) to reduce all types of violent behaviour, particularly knife crime among young men in Glasgow. The VRU adopted a public health approach to violent crime, similar to projects in the US, which showed that primary intervention and collaborative prevention work are essential in reducing violence.

In 2008, the VRU established the Community Initiative to Reduce Violence (CIRV) programme which brought together many different agencies and professions into tackling the issue of youth violence. In an effort to meet the issue head on, the VRU invited gang members to attend a meeting where they were told what to expect going forward: a zero tolerance police response if violence did not stop, whether they were involved or not. But also on offer was help with education, training and job finding from various agencies and charities if they turned their back on violence. After the first year, the programme had led to a 49 per cent reduction in violent offending and a 59 per cent decrease in knife carrying by those engaged with the initiative. The CIRV finished in 2011 and the VRU is now engaged in other projects such as Mentors in Violence Prevention now operating in 50 schools across Scotland.

Christine Goodall and her MAV colleagues visit schools and youth clubs to speak on the dangers of drinking and getting involved in violence. The schoolchildren are transfixed by a MAV-produced video which pulls no punches



on the street, being aware of what's going on around you and walking away from trouble.

"But we now emphasise to young people that things have changed for the better in Scotland regarding gangs and violence, and that they are and need to be part of maintaining that change.

"This is an important message as we want to normalise that change for them – to make them realise that if they are not changing like others then they are actually unusual. This is powerful because kids have a great desire to be like their peer group."

After each session the children are given feedback forms to assess what they picked up from the video and group discussions.

She added: "Feedback shows that we've been effective in raising awareness and, to an extent, in changing attitudes to violence.

"Some kids say they have learned they should not get involved in violence and that they should walk away, but many – and this is a common theme – also say they have changed the way they think about the victims of violence. A lot of them have the perception that victims of violence are 'losers', but now they realise that some people are victims for no fault of their own – sometimes it's just down to bad luck.

"They are saying they now have much more sympathy for victims and this is helping to reinforce their attitudes to violence in general."

> "THEY NOW HAVE MUCH MORE SYMPATHY FOR VICTIMS AND THIS IS HELPING TO REINFORCE THEIR ATTITUDES TO VIOLENCE IN GENERAL"
>
> CHRISTINE GOODALL

Christine is able to give MAV sessions to three classes at the school before she has to rush off at lunchtime to get back to her day job, which she splits between oral surgery for the NHS and academic research based at the Glasgow Dental Hospital and School and the University of Glasgow.

"I'm very grateful to Professor Jeremy Bagg, head of the dental school, who is very supportive of this initiative as it is part of the university's mission to engage with the community. It's ironic as I would not have been able to do these talks ten years ago – I would have been too busy to get out of hospital because of the prevalence of these kind of assaults."

MEDIC ON A MISSION

Although Christine Goodall trained in academic oral and maxillofacial surgery and worked in that field for 12 years, she now splits her time between surgery and academic research.

Her main research interests are alcohol and injury, particularly alcohol-related facial injury, and violence including youth violence, domestic abuse and sexual assault.

She is member of the Community Oral Health Research Group but she works with a wide range of different professionals on research projects including fellow surgeons, public health specialists, psychologists, psychiatrists, nurses, statisticians, criminologists and the police.

She has also has an interest in the role of the dental team in screening for alcohol misuse and domestic violence.

She explained: "I do a lot of training around teaching professionals, such as dentists, vets, doctors, fire service and even hairdressers, to raise the issue of domestic abuse so they can signpost people towards help.

"If someone came into a surgery with a black eye, a lot of dentists would not bring it up because they are very unsure about what to do about it. It's not that they are ignoring it, it's that they worry about opening that big can of worms.

"I give them tools to have that conversation with the person which limits their involvement but helps them signpost people to organisations that are more expert at dealing with this situation."

The service has been going since 2010 and since then about 700 dentists have undergone the training.

"I've developed the service along with the Violence Reduction Unit and provide the training. I'm now looking at making it sustainable with more trainers on board," added Christine.

If you are interested in domestic violence training, contact Christine at Christine.Goodall@glasgow.ac.uk

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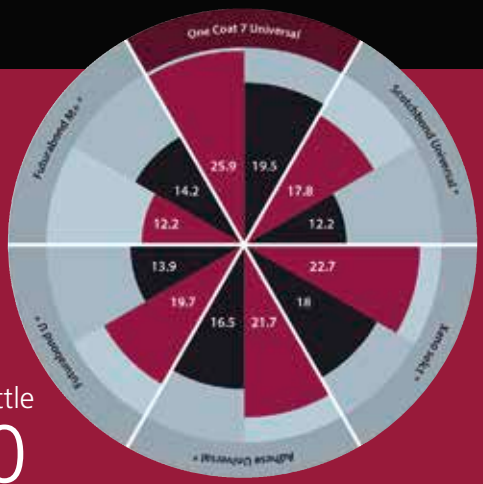

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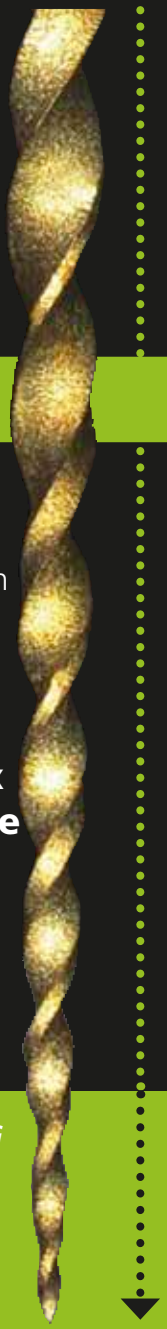

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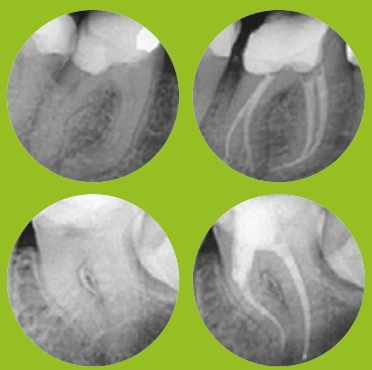

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SCOTTISH DENTAL SHOWCASE

THE 2015 SCOTTISH DENTAL SHOW DREW RECORD NUMBERS AND EXCITEMENT IS ALREADY BUILDING FOR THE 2016 EVENT

BRUCE OXLEY MIKE WILKINSON

The Scottish Dental Show was a sell-out success this year, attracting record numbers and offering even more – proving that it is the must-attend event for the Scottish Dental community.

Taking place over Friday 29 May and Saturday 30 May, the event saw nearly 1,800 people walk through the doors of Braehead Arena, a 30 per cent increase on last year.

The trade show was also fully booked with more than 140 exhibitors, and the response has been so great that the 2016 exhibition hall is already nearly half full as companies rush to return to the event at Braehead on 13 and 14 May next year.

The lecture programme again featured a world-class line-up of more than 40 speaker sessions and workshops, offering up to eight hours of verifiable CPD. Among the speakers were some of the leading figures of the dental profession, such as Professor Edward Lynch of the University of Warwick and Prof John Gibson from the University of Glasgow, as well as show regulars Professor Paul Tipton and Ashley Latter.

Attendances at the lectures broke records too, with 250 delegates attending Professor Gibson's first talk on oral cancer; nearly 190 turning out for Lee McArthur's infection control talk, and just under 170 listening to Rachel Bell from the MDDUS's talk, entitled 'I'm a GDC registrant, get me out of here!'

Initial feedback from delegates has been extremely positive, with more than 90 per cent rating the show as 'Excellent' or 'Good'. The speaker selection got a big thumbs up as well, with 89 per cent saying the choice of lecturers was either 'Excellent' or 'Good'.

When asked if they would be attending the Scottish Dental Show in future, 68 per cent said 'Definitely' with 28 per cent saying they would 'Possibly' be back.

Alan Ramsay, managing director of Connect Publications, which organises the Scottish Dental Show and publishes *Scottish Dental* magazine, said: "It's been another cracker this year – the show was a sell-out, registrations were well up on last year and a record number of people attended the show and the awards. The amazing success of this year's show demonstrates that this really is the must-attend event for the dentistry sector in Scotland."

VIDEO

The official Scottish Dental Show video is now online, so head to our YouTube channel to see what all the fuss is about.

The video aims to give a snapshot of what has become the biggest annual dental exhibition and conference in Scotland.

Visit bit.ly/SDS15video to see if you made the cut.

IF YOU ATTENDED THE SCOTTISH DENTAL SHOW AND HAVEN'T RECEIVED YOUR CERTIFICATE YET, EMAIL INFO@SDSHOW.CO.UK AND WE'LL SEND IT OUT. ALSO, IF YOU HAVEN'T FILLED IN THE FEEDBACK QUESTIONNAIRE, VISIT BIT.LY/SDS15FEEDBACK

DELEGATE TESTIMONIALS

"BRILLIANT WAY TO GAIN CPD, WELL ORGANISED AND WELL PRESENTED – FAB!"

"FELT THE SHOW WAS WELL ORGANISED AND THE LECTURES AND STALLS WHERE VERY HELPFUL"

"I REALLY ENJOYED IT. THE SPEAKERS MADE IT A REALLY INTERESTING DAY"

"THE LECTURES I ATTENDED BROUGHT ME UP TO DATE AND WERE VERY INFORMATIVE"

"FIRST TIME ATTENDING AND WAS VERY IMPRESSED. WELL DONE AND THANK YOU!"

SCOTTISH DENTAL SHOW 2015


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SCOTTISH DENTAL SHOW 2015

Left: Diamond sponsors Leca Dental Laboratory

Top right: Professor John Gibson's talk on the Saturday was packed to the rafters

Right: Keynote speaker, Professor Edward Lynch


SHOW
2015


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SCOTTISH DENTAL SHOW 2015

Top right: Philip Friel's implant workshop proved hugely popular again

Left: Sandy Littlejohn from Platinum sponsors DTS talking with delegates

Bottom left: Delegates were encouraged to use the hashtag #SDShow15 when tweeting about the show

SCOTTISH DENTAL AWARDS 2015

WINNING SMILES

THE 2015 SCOTTISH DENTAL AWARDS WERE A TRUE CELEBRATION OF THE INDUSTRY IN SCOTLAND

BRUCE OXLEY MIKE WILKINSON

Dr Elizabeth Saunders received the Scottish Dental Lifetime Achievement Award to a rapturous reception at the Thistle Hotel in Glasgow. The 2015 Scottish Dental Awards saw just under 400 guests rise to their feet to acclaim the winner of the night's most prestigious prize. Dr Saunders' career spanned nearly 40 years and she dedicated a large part of that to the practice, teaching and research in the field of endodontics.

A past president of both the British Endodontic Society and the Royal Odonto-Chirurgical Society of Scotland, she also served on the editorial board of the *International Endodontic Journal* during her illustrious career.

In her acceptance speech, she remarked with pride that women are no longer in the minority compared to when she started out on her dental career. And she had this piece of advice for the women in the room: "I would encourage you to step out of your comfort zone, to aim higher than you think you are capable of, higher than you think you can achieve. If you don't try, you will never know what is possible."

In summing up Elizabeth, who in retirement plans to spend more time with her five grandchildren and her country garden in Perthshire, said: "I know I have been very lucky and, indeed, privileged, to have the career I had in what could well have been the best of times. I do hope I made a meaningful and lasting contribution to the teaching and practice of endodontics in Scotland."

Deveron Dental Centre in Huntly was the other big winner on the night as practice principal Morven Gordon-Duff picked up Employer of the Year and dental nurse and practice manager Kirsty Rodger was named DCP Star.

G1 Dental in Glasgow was named Practice of the Year; Samuel Barry Lemon of Bluewater Dental in Lochwinnoch picked up the Dentist of the Year gong, and Donna Morrison of The Dental Directory was named Scottish Dental Representative of the Year.

The Young Dentist Award was handed to Jonathan Dougherty of Kilmarnock Dental Care; the Crown Dental Group in Aberdeen won the Dental Team Award and the Digital Strategy Award was picked up by Dental Studios Scotland.

Scottish Dental Awards judge Margaret Ross accepted the Unsung Hero Award on behalf of Dr Jon Victor, who was unable to attend, and the Laboratory of the Year award was presented to Leca Dental Laboratory from Glasgow.

The Business Manager/Administrator of the Year went to Liz Alexander of Southwest Smile Centre in Stranraer and Newton Stewart; the Community Award was presented to Linsey Paton of the Tryst Dental Practice in Stenhousemuir, while the Style Award was picked up by Glasgow Southside Orthodontics.

TO SEE THE OFFICIAL VIDEO OF THE 2015 SCOTTISH DENTAL AWARDS, VISIT BIT.LY/SDA15VIDEO
IF YOU WANT TO FIND OUT MORE ABOUT THE 2016 AWARDS, VISIT WWW.SDAWARDS.CO.UK OR FOLLOW @SCOTTISHDENTAL ON TWITTER.

Dr Elizabeth Saunders received the 2015 Scottish Dental Lifetime Achievement Award


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THE SCOTTISH DENTAL AWARDS 2015
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SCOTTISH DENTAL AWARDS 2015

Top row from left: Laboratory of the Year winners Leca Dental; Employer of the Year Morven Gordon-Duff; Young Dentist Jonathan Dougherty; DCP Star Kirsty Rodger and (top right) the Style Award winners Glasgow Southside Orthodontics

Middle row from left: Digital Strategy winners Dental Studios Scotland; Business Manager/ Administrator of the Year Liz Alexander; Community Award winner Linsey Paton; and (middle right) 2015 Scottish Dental Lifetime Achievement Award winner Elizabeth Saunders

Bottom row from left: Practice of the Year G1 Dental; Dentist of the Year Samuel Barry Lemon; The Dental Directory's Donna Morrison, winner of the Scottish Dental Representative Award; and (right) the Dental Team Award winners, Crown Dental Group

23RD WORLD CONGRESS ON PSYCHOSOMATIC MEDICINE GLASGOW 2015

19TH - 22ND AUGUST 2015, SECC, GLASGOW, SCOTLAND

THE PSYCHOSOMATIC FACTOR IN CLINICAL PRACTICE

This is a small selection of the full programme which can be found on **www.icpm2015.com**

THURSDAY 20TH AUGUST

Quit: say goodbye to smoking. McCarthy P

Using technology to enhance CBT for depression & anxiety. Wright J

Mindfulness workshop. Noguera V & O'Dowd B

Clinical uses of hypnotherapy. Spiegel D.

States of consciousness: a new mind/body model of integrative recovery. Dobbin A & Ross S

Plenary: Tranceformation: Hypnosis in brain & body. Spiegel D.

FRIDAY 21ST AUGUST

Eden energy medicine workshop. Willocks C & Berry S

How much of what at face value appear to be situational base placebo responses from manual intervention administered to patients with musculoskeletal pain is explainable? Szmelskyj AO

Pain & addiction. Strelzer J et al

Pain management & rehabilitation strategies. Overholser J et al

Holistic considerations in healthcare from the dental perspective. Wright SJ

SATURDAY 22ND AUGUST

The mind-teeth connection. Campbell N

How do dentally anxious patients account for the onset of their dental anxiety? Burgess D

Hypnosis & simple techniques in rapport, communication & language. Gow M & Kit K

The Spectrum of Fear. Campbell N.

Psychic tension modification techniques. Anisimova N.

Temporomandibular disorder pain treated with behavioural therapy. Cosci F

Practical shiatsu techniques for healthcare workers. Trend L.

Relax: Say goodbye to anxiety & panic. McCarthy P.

POSTERS

Dental care for patients with white coat syndrome. Orekhova I

Hypnosis & trainer appliance therapy replaces patient's DIY denture made from ladies acrylic nails. Dunlop D.

Effectiveness of amitriptyline in atypical odontalgia. Miura A.

Depression, anxiety, stress scales: a validation study. Campos J

Psychometric properties of the multidimensional pain inventory & its application in different orofacial pain conditions. Campos J

Predictors of dental anxiety. Navarrete A

Psychometric evaluation of psychopathological disorders in patients with atypical facial pain. Fofanova Y

A validation study of the pain self-efficacy questionnaire in dental care patients. Bonafe F

Comparison of cerebral blood flow in oral somatic delusion in patients with and without a history of depression. Watanabe M

Transcultural adaptation of the dental environment stress questionnaire-DES. Garcia P

Patient profile of management of paediatric dental/needle phobia- a retrospective audit. Simpson C.

SUNDAY 23RD AUGUST POST CONGRESS WORKSHOP

'Focusing on enhancing well-being' with Dr Michael Yapko (see www.icpm2015.com/post-congress-workshop-p49 for more details)

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RAISING OUR SUSPICIONS: COULD THIS BE AN ORAL CANCER?

ORAL CANCER

With the number of cases on the increase, dentists have a key role to play in the early detection of the disease and in raising patients' awareness of the risks of cancer

GRAHAM OGDEN

The early detection of oral cancer has now become a recommended topic by the General Dental Council (GDC) for Continuing Professional Development (CPD).

The importance of raising our suspicions for any lesion was brought home to me as I was writing this paper. The brother of a medical friend had just been diagnosed with mouth cancer at the age of 54. No obvious risk factors were present and yet, despite going to his GP with a persistent ulcer, it was more than two months until he was referred.

My doctor friend called me for advice regarding her brother on the day I received feedback on a lecture I'd given to some medical students doing their cancer prevention module. Despite presaging my lecture with the reasons why medics needed to be as genned up on this as the dentists, one student still felt it was more important for dentists than themselves (presumably a reflection on the numerous other topics competing for their attention within the medical curriculum).

The GDC based their recommendation in part due to an increasing number of patients who are claiming (rightly or wrongly) that their dentist failed to diagnose their mouth cancer and, as such, are suing them for negligence. Other reasons include an increasing number of cancer cases (hence increased likelihood of seeing a patient with oral cancer,) and the life-threatening nature of this disease (the later it is diagnosed, the worse the outcome for the patient).

It used to be an anecdote that a dentist might only see two cases of oral cancer in their entire career. But was or is that actually true? There may be a need to recalculate this because, although there are many more dentists now than, say 30 years ago, the incidence of oral cancer has risen sharply (threefold) over that time period without a marked increase in size of population. We recently recalculated this and arrived at a conservative estimate of one case every 10 years, with two potentially malignant lesions seen every month.[1]

What can we do to help minimise such an event?
Reasons why a patient may pursue a case of negligence against a dentist in respect of oral cancer are:

- Failure to identify a lesion in the mouth
- A failure to consider the lesion might be a cancer and thus miss the opportunity to make an early diagnosis
- Failure to refer to a specialist
- Claims for damages following the consequences of a failure to detect the cancer at an early stage
- A perception by the patient that the dentist had not taken their concerns seriously.

Key questions to consider when assessing the malignant potential of an oral lesion:

1. What risk factors are present?
Tobacco
While the number of cigarettes consumed within the UK has dropped profoundly over the last 25 years or so (from a staggering 102 billion in 1990), the reduction in the number of smokers has not been as dramatic. Approximately 20 per cent of the population in Scotland still smoke. Although novel approaches to certain groups have had some success (e.g. "Give it up for baby" – a smoking cessation intervention for pregnant women in Scotland, organised by Paul Ballard and NHS Tayside) – there is still a long way to go.

Clinicians should be actively involved in raising awareness of the potential detrimental effects of smoking on oral health and giving smoking cessation advice. A key question to ask the patient with a clinically suspicious lesion is "Do you smoke?"

At least 75 per cent of oral cancers are associated with tobacco use.

With the increase in cost, many people are turning to hand-rolled cigarettes because they are cheaper but they

may lack an effective filter. Key additional questions include recording type of tobacco use, number of years they have smoked and daily quantity consumed.

Don't forget ecigarettes, although in theory devoid of the usual carcinogens found in tobacco, are still unregulated and hence their exact content is not always known. More than three million ecigarettes were sold in the UK in 2012. However, many patients find Allen Carr's book *Easy Way to Stop Smoking* an effective alternative to other techniques such as nicotine replacement therapy.

Alcohol

As with tobacco, it is worth asking about their use of alcohol, as this is an important risk factor for oral cancer, particularly when combined with tobacco use. The Government, and indeed all the Royal Colleges, support the guidance as regard low-risk drinking. For men this is currently considered as no more than four units in a day or 21 units in a week (for women it is no more than three units in a day and 14 units in a week) with at least two days free of alcohol.

Obtaining a reliable alcohol history isn't always easy, partly because many patients don't know the alcohol unit content of what they drink, but also because we are often economical with the truth. Studies have shown that in the UK there is a 40 per cent underestimation of what people claim they drink, when compared with actual alcohol sales.

We have gathered data regarding drinking habits and understanding of alcohol guidelines over several years during our annual Mouth Cancer Awareness Week campaigns at the University of Dundee. There is a tendency for students to underestimate the number of units of alcohol in a pint of beer. When this is combined with the frequency that they admit to binge drinking (defined as at least six units in any one session for women, and at least eight units for men), then many students would appear to be drinking at a level that would trigger a brief alcohol intervention.

The development of an appropriate intervention for dental practice is currently being explored[2].

Human Papilloma Virus (HPV)

The subtypes (associated with both cervical cancer and oral cancer) are HPV 16 and HPV 18. It is more often associated with oropharyngeal cancer than oral cancer. The virus interferes with the tumour suppressor gene, P53 that protects us against cancer .The HPV virus disables the protective effect of the P53 gene allowing those mutations which retain the cell's ability to replicate, to further develop on its journey to potentially becoming a cancer. Infection with HPV can be transitory , with HPV 16 and HPV 18 acquired through oro-genital contact. Perhaps not the easiest question to ask of a patient visiting their dentist! Jaime Winstone's BBC3 programme "Is oral sex safe?" is well worth viewing.

Don't forget that a patient doesn't have to have an obvious risk factor.

2. What is its colour? ('Red is a mean mean colour')

While I'm sure Steve Harley didn't have oral cancer in mind when he wrote that song, it seems peculiarly apposite. Red is a far more significant colour when it comes to early manifestation of oral cancer, yet leukoplakia is often considered the most frequent precancerous lesion. By focusing on the white element, the issue of any surrounding

Studies have shown that there is a 40 per cent underestimation of what people claim they drink, when compared with actual alcohol sales

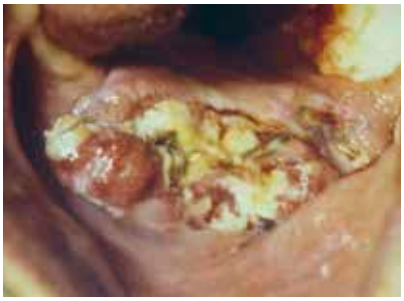

FIGURE 1
Typical textbook appearance of an advanced oral cancer Reproduced from Dental Update (ISSN 0305-5000), by permission of George Warman Publications (UK) Ltd

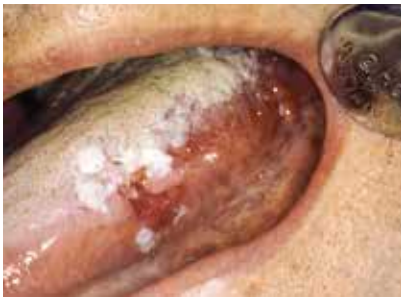

FIGURE 2
Note atrophic red area of early cancer surrounded by satellites of white keratoses

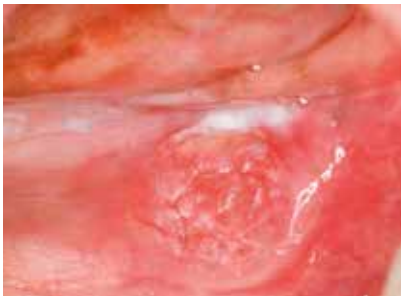

FIGURE 3
Early oral cancer affecting buccal sulcus. Note the areas of diffuse keratosis and atrophy surrounding the 'whorl' of slightly raised, reddened mucosa

erythema may be lost. Although much is made of the white patch its malignant transformation rate is probably less than five per cent whereas that of the erythroplakia is at least 80 per cent (far more significant).

Having said that, the most significant leukoplakia's are those that are large and non-homogenous. Far more important and more frequently associated with asymptomatic early oral cancer are the so-called speckled leukoplakia's (erythroleukoplakia).

3. What does the early oral cancer look like?

The early asymptomatic cancer presents in a far more subtle way than many of the textbooks might suggest. The identification of an oral cancer that has raised, rolled hard

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edges surrounding an area of ulceration that is oozing blood is an advanced lesion that hopefully no one would miss. Unfortunately, by the time is has that appearance, such an advanced lesion has had plenty of opportunity to either invade surrounding tissues (such as bone) or metastasise to local, regional or distant lymph nodes.

Our attention as clinicians should be to focus on raising our index of suspicion. High-risk sites in the UK are the so-called non-keratinising sites such as ventral tongue and floor of mouth. However, the routine screening and recording in the notes of the entire oral mucosa should be mandatory, not only to help to detect an early lesion, but also to help protect yourself from any claims of negligence that you failed to detect the cancer at an early stage. Such a task that takes minimal time, requires no fancy expensive equipment, but yet could make such a difference to the patient's prognosis (if a cancer is there), is ignored at our peril. (The use of dyes or techniques based upon fluorescence or cytology are still being evaluated or have not proved to have the sensitivity or specificity to become adopted as routine tests).

Conclusion

The early detection of an oral cancer can quite literally save that patient's life. In helping to raise your index of suspicion when assessing the malignant potential of an oral lesion we should consider:

- What risk factors are present? (NB tobacco and alcohol, HPV?)
- What is its colour? (NB importance of red)
- How long has it been present? (Review the patient to ensure it has improved/resolved within two weeks or arrange urgent referral when cancer is suspected)
- Is it painful? (Pain is often a relatively late manifestation hence a non-painful ulcer should arouse suspicion)

Remember, the early lesion is often asymptomatic (no pain, no ulceration, no bleeding). Remember too that a patient is never too young to get oral cancer. One in 10 cases now arise in those below the age of 45 years (see the Ben Walton Trust www.benwaltontrust.org).

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To increase the dental team's awareness in the detection of oral cancer
- To review our understanding of the main risk factors for oral cancer
- To be familiar with what oral cancer looks like, particularly the early lesion.

LEARNING OUTCOMES

After reading this article, the reader should:

- Understand the reasons why oral cancer has become a recommended topic for CPD by the GDC
- Be aware of the need to assess for exposure to the two main risk factors for oral cancer
- Have an increased awareness of what an early oral cancer can look like ie raise our suspicions.

EXAMPLE QUESTION

Which of the following statements is wrong:

a) Twice as many men are affected by oral cancer than women

b) You cannot get oral cancer if you are under the age of 30

c) Red is a strong warning sign for early cancer

d) Oral cancer can present in those who do not drink or do not smoke

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BY WORD OF MOUTH

For those who wish to get involved in raising awareness of oral cancer, for example during Mouth Cancer Awareness Week in November each year, then see the link to "You too can raise awareness of mouth cancer" at http://bit.ly/BWTpdf

The Ben Walton Trust has done much to raise both professional as well as public recognition of the disease. There is also another Scottish-based charity – https://letstalkaboutmouthcancer.wordpress.com – which aims to achieve greater recognition of the disease within the general population.

While we should all maintain our suspicions regarding any lesion within the oral cavity, we can do nothing about the patient that presents to their GP in preference to their GDP. Or can we?

I would suggest that we, as dentists, need to explain to our patients every time they attend that we are screening their mouth for any suspicious changes that they may not even be aware of; that we are trained to examine the whole mouth, not just the teeth and gums.

Establishing links with local GPs should benefit both clinicians and patients. The days when colleagues felt referral for a second opinion implied they were not capable have surely gone. But, to do that, we first have to see the lesion, i.e. examine the whole mouth and then consider that it might be an early cancer. It is for this reason that it is entirely right that oral cancer has become a recommended topic for CPD by the GDC and serves as a reminder that every time a patient attends, there must be a careful clinical examination of the entire oral mucosa.

Where cancer is suspected, the patient should be urgently referred to be seen within two weeks. Furthermore, with an increase in oropharyngeal lesions that may spread to cervical lymph nodes, it is more important than ever that dentists should carefully check for swellings in the neck. This may be particularly important in irregular attenders, as that may be the one chance for early detection, which could quite literally save that person's life.

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AN OPEN AND SHUT CASE

CASE FILES

One of the many cases that have been handled by Dental Protection, in order to demonstrate an important learning point

HELEN KANEY

The registration of DCPs has created many benefits, not the least being the formal recognition for the different members of the dental team. Dental Protection has advocated the benefits of team working for many years and is a large enough organisation to ensure that the interests of every member of the dental team can be independently represented by a different dento-legal adviser (there are now 70) should there be a dispute about clinical matters.

Fortunately, disputes between colleagues are infrequent but if they should ever arise it is important that independent advice is available for everyone concerned. But let's think positively and consider the advantages of teams when they communicate well and work in harmony.

Consider the case of a patient who recently had a large filling placed in a molar tooth. He rang the practice three hours after returning home to say that the tooth was starting to hurt him. The receptionist reassured him over the phone and advised him to take analgesics. She also logged the telephone conversation in the patient's notes on the computer.

The following morning the patient telephoned again, saying that the pain was getting worse. An appointment was offered later that morning, but when the patient was examined, there was no indication of anything more than the normal post-operative sensitivity from a large filling. A periapical radiograph that was taken at the time revealed nothing abnormal.

A day later, the patient was waiting in the practice car park as the staff opened up. He had been unable to sleep all night because of the intensity of the pain. He was most angry when the receptionist told him that the dentist was away for the day on a postgraduate course. He demanded that some attempt should be made to reach the dentist and recall him to the practice, or alternatively arrangements should be made for him to be seen by another local dentist. The receptionist suggested that, if all else failed, she might be able to arrange for his local doctor to see him, but in the meanwhile she undertook to try to contact the dentist on his course.

As it happened, the dentist telephoned during the lunch break, and offered to see the patient that evening on his way home. He opened up the surgery specially to accommodate the patient. As he had already anticipated, it was necessary to remove the pulp of the tooth and start endodontic treatment. The patient's pain disappeared immediately.

The patient refused to pay for the endodontic treatment on the grounds that he thought he should be compensated for the earlier three days of pain

Some weeks later, the patient refused to pay for the endodontic treatment on the grounds that he thought he should be compensated for the earlier three days of pain, made worse by the dentist's unavailability and the lack of emergency arrangements. The situation escalated even further when the patient's complaint became the subject of a formal hearing before the GDC.

The committee completely exonerated the dentist. He had provided emergency treatment very promptly and appropriately on two occasions, and on the third occasion he had made himself available in a situation where many other dentists might not have done. The dentist elected not to pursue the patient for the unpaid endodontic fee, offering this as a goodwill gesture.

Both the dentist and the team had learned a valuable lesson from the experience, about the importance of establishing effective emergency arrangements at times when the dentist is away from the surgery, and of good record keeping by himself and his staff. Without the documented episodes of this patient's phone calls and appointments that were offered in response, it would have made the defence of the complaint so much more difficult.

A NEW APPROACH TO DEFINING CANCER RISKS

ORAL CANCER

To quote one of New York's most famous adopted sons, Bob Dylan, and one of his most socially challenging lyrics – *the times they are a changin'*

DAVID CONWAY

Change, socioeconomics and indeed New York are relevant to this update on oral cancer risk. How we define oral cancer is changing. This is important not only for how the disease is managed and its prognosis but also in terms of the changing risk profile and factors associated with oral cancer, which in turn is essential for prevention. Oral cancer is increasingly falling into two distinct diseases: oral cavity cancer (OCC) – "mouth cancer" and oropharyngeal cancer (OPP) – "throat cancer". Although the tumours do not always recognise such clear-cut boundaries and more often overlap the anatomical sites (particularly in the retromolar trigone – behind the wisdom teeth).

While oral cavity cancer rates are either stable or only marginally increasing, oropharyngeal cancer is the most rapidly increasing cancer in Scotland – with a threefold increase in incidence among men in the last decade, and a 2.5-fold increase among women. Oropharyngeal cancer increases are now greater than malignant melanoma, adeonocarcinoma of the oesophagus and cervical cancer [1]. In 2013 there were 494 cases of oral cavity cancer and 343 cases of oropharyngeal cancer diagnosed in Scotland [2]. This changing trend of flat-lining oral cavity cancer and increasing in oropharyngeal cancer is a global phenomenon and has been related to changing population risk factors – described as "controlling a tobacco epidemic while a human papillomavirus epidemic emerges" [3].

Risk

When we talk about risk we are talking about probability – the chance that an event/the disease/oral cancer diagnosis will occur. Patients and the public may view risk as completely random chance – the flip of a coin, 50/50, one in two, 50 per cent chance, it will either happen to me or it won't.

However, risk estimates for cancer can be determined by undertaking studies on large groups of people, which identify the probability that an individual or group will develop the disease over a period of time. These studies also identify risk factors – characteristics or behaviours that are associated with increased risk. We generally define risk in two ways: absolute risk and relative risk.

Absolute risk

This is the numeric chance or probability of developing oral cancer during a specified period of time. The Scottish Cancer Registry computes this over a whole lifetime. The absolute risk of developing oral cavity cancer in Scotland in a lifetime is estimated at 1.7 per cent, or to put it another way – about 1 in 59 persons will develop oral cavity cancer at some time in their lives. For comparison, about one in 12 persons in Scotland will develop lung cancer in their whole lives, while about one in 2.5 persons will develop any type of cancer. These lifetime risks have a lot to do with other factors such as gender and age. A man's lifetime risk of developing oral cavity cancer in Scotland is higher – 2.4 per cent, or about one in 42 men – but his risk of developing oral cavity cancer (at a younger age) by the age of 64 is 0.7 per cent, or about one in 135 men [2].

Relative risk

This is a comparison or ratio rather than an absolute value. It provides an estimate of the relationship between a risk factor and outcome by comparing the number of cases in a group of people with a particular trait or behaviour

A man's lifetime risk of developing oral cavity cancer in Scotland is higher – about one in 42 men – but his risk of developing oral cavity cancer (at a younger age) by the age of 64 is about one in 135

with the number of cases in a (otherwise similar) group of people who don't have that trait or behaviour. The risk of oral cavity cancer for people who smoke has been estimated at around 5.8 times higher than for those who don't smoke – the relative risk is 5.8. Relative risk is also presented as a percentage. In the same example the risk of oral cavity cancer is 580 per cent higher than in those who don't smoke[4]. This percentage over 100 per cent and lack of an upper limit in relative risk estimates is counter-intuitive. Most people would think 100 per cent is the highest possible risk. But 100 per cent equates to a doubling of risk associated with a risk factor, while 200 per cent to a tripling of risk estimate.

Population attributable risk

This is another way of expressing relative risk at the population level. It is the difference in the rate of disease between a population exposed to a risk factor and a population not exposed to the risk factor. It is more commonly used in public health policy decisions, where the burden of the disease reduction can be calculated by "hypothetically" removing the risk factor in question.

INHANCE

The most comprehensive and up-to-date data on oral cancer risk can be found from research by the INHANCE (International Head And Neck Cancer Epidemiology) Consortium (www.inhance.utah.edu). It was established in 2004 as a collaboration of researchers from around the world-leading large epidemiology studies of head and neck cancer to improve the understanding of the causes, risks and mechanisms of head and neck cancer.

The consortium includes data on 25,500 patients with head and neck cancer (including oral cavity cancer, oropharyngeal cancer, and larynx cancers), and 37,100 controls who did not have these cancers, from 35 studies from across the world. Overview papers have been published which detail INHANCE methods [5] and research findings [6].

It was a privilege to be invited to participate in the 12th Annual INHANCE consortium meeting in May this year. We convened at the Icahn School of Medicine at Mount Sinai New York City, on the weekend the new Freedom Tower was opened. During our meeting, we reflected on over 10 years of INHANCE research, while at the same time looking forward to taking on the ongoing challenges of the increasing and changing burden of head and neck cancer.

Oral Cancer Risk

It is well recognised that smoking tobacco and heavy alcohol consumption are the main risk factors for oral cancer. INHANCE provides us with an opportunity to understand this risk better, including providing precise estimates of risk, understanding the joint tobacco-alcohol effects and the dose-response, as well as investigating the risk associated with smokeless tobacco and the benefits of quitting both smoking and alcohol.

INHANCE provides sufficient numbers of people who never smoked or drank alcohol – thereby avoiding the problems of confounding – to identify true and precise risk estimates. Among "never" alcohol drinkers, cigarette smoking was associated with a two-fold increased risk of oral cavity and oropharnx cancers [7]. And heavy alcohol drinking (three or more drinks per day vs never drinkers) among those who never used tobacco was also linked to increased risk but only among heavy alcohol consumers. However, it should be noted that those who reported never smoking and never drinking alcohol may differ in other ways from the wider population. The complexity of the relationship with smoking and alcohol was also unpicked in the estimates of the population attributable risk (PAR) for tobacco and alcohol of 64 per cent, made up of 0 per cent for alcohol alone, 24 per cent for tobacco alone, and 40 per cent for tobacco and alcohol combined [8] – but remember this risk description is mainly relevant at the population rather than individual risk level.

In terms of the dose-response relationship, risk for oral cancer increases with increased frequency and duration of both smoking and alcohol. However, fewer cigarettes per day over a longer period of time was worse (gave a greater risk for oral cancer) than more cigarettes per day over a shorter period of time. This contrasts with alcohol consumption which found that higher intake over a shorter period of time was worse (gave a higher risk for oral cancer) than a lower intake for a longer time [9]. Moreover, there are no safe low-intake levels associated with negligible risk – so, the old sayings: "everything in moderation including moderation itself" or "a wee bit of what you fancy does you good" unfortunately do not hold up here.

Smokeless tobacco in the form of snuff (powdered tobacco) and tobacco chewing are not safe harm reduction alternatives some might want you to believe, with both associated with slight increased risk for oral cavity cancer. But good news does exist in the form of the benefits of quitting – with benefits appearing immediately (one to four years) after stopping smoking, and equating with those who never smoked after 20 years of quitting. The risk effects associated with heavy alcohol consumption last a bit longer with benefits of quitting taking 20 years to emerge [10].

The promise of the breakthrough in identifying genetic variants as strong markers of increased oral cancer risk has yet to fully materialise. Considerable research effort has found slight increased risks for oral cancer associated with the presence of genetic variants involved with alcohol metabolism, DNA repair pathways, and genes involved in the metabolism of nicotine [6]. Similarly, there is limited evidence of dietary risk factors for oral cancer beyond confirming the protective effects associated with diets high in fresh fruit and vegetables (with approximately five or more fresh fruit and vegetable portions per day conferring a 50 per cent lower risk than those consuming low levels [11].

The INHANCE work which our team in Glasgow have led on is in relation to socioeconomic inequalities and determinants of oral cancer risk [12]. You can see from the

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reference list with 75 co-authors the extent of the international collaborative effort involved. In our analysis we identified increased risks for oral cancer associated with low education and income relative to those in higher socioeconomic positions which were not explained by smoking or alcohol consumption, i.e. there were socioeconomic effects operating in two ways both in influencing risk behaviours (the causes of the causes) and also more direct or explained effects from low socioeconomic circumstances to oral cancer risk. Moreover these socioeconomic effects are of a similar magnitude (twofold increase) to risks associated with smoking and alcohol, and are strongest in countries where income inequalities are widest.

Finally, no discussion about oral cancer, and certainly not oropharyngeal cancer, can be complete without talking about sex and oral HPV (human papillomavirus) infection. Oral HPV is mainly associated with oropharyngeal cancer risk, with up to 80 per cent of cases having HPV identified. There are over 200 HPV types, but as for cervical cancer, HPV16 and 18 subtypes are the main high-risk oncogenic types. Increased risk for oropharyngeal cancer has been estimated as high as 15 times greater in those with oral HPV16 infection in the ground breaking *New England Journal of Medicine* paper [13]. However, the natural history of oral HPV infection is not well understood (in terms of prevalence, persistence, and determinants). The only large epidemiological study of oral HPV prevalence has been undertaken in US [14]. They found a prevalence of 7 per cent, with slightly greater peaks (around 10 per cent) among 25-30 and 50-55-year-olds, and among men. Risk factors identified included smoking and alcohol, number of sexual partners/oral sex partners, but also open mouth kissing. We are currently completing a feasibility study to undertake a similar study in dental practices in Scotland – HOPSCOTCH (HPV Oral Prevalence in Scotland) study (http://www.sohrc.org/projects/hopscotch/). We are grateful for the outstanding support that we have received from dental practices and teams across Scotland in stepping up to this important research area, and we look forward to disseminating our feasibility study findings and taking forward a full population study in dental practices in due course.

INHANCE studies also point to a slight increased risk for oral cancer associated with six or more lifetime sexual partners, four or more lifetime oral sex partners, and early age (≤18) of sexual debut [15]. However, it is worth noting again that this research and our understanding is at a far earlier stage, perhaps several decades behind our knowledge of the role of HPV in cervical cancer.

Communicating risks for oral cancer is not straightforward. I had a go at trying to explain the oral cancer risks associated with alcohol drinking on the BBC Radio 4 statistics programme More or Less [http://www.bbc.co.uk/programmes/b03qfzgx]. I am not convinced I helped communicate this complex risk issue particularly well. This reflection is not helped by my students who let me know I sounded drunk on the interview!

Communicating risk

This is a key challenge for clinicians and public health practitioners. Effective risk communication can stimulate health behaviour/belief change and reduce risk levels [16]. One of the major barriers to communicating risk effectively is the difficulty both patients and clinicians have in understanding statistics and numbers, e.g. even among highly educated adults in a US survey only 21 per cent correctly identified that one in 1,000 was the same as 0.1 per cent [17].

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

To provide clinicians with:
- an update on risk factors associated with oral cancer
- An overview of the concept of risk communication
- An outline of the prevention approaches for oral cancer and their role in prevention

LEARNING OUTCOMES

Following reading and assimilating this article, clinicians will:
- Be aware of the recent trends and risk factors associated with oral cancer and of the importance of separating oral cavity and oropharyngeal cancers
- Be able to discuss with patients the risks associated with oral cavity and oropharyngeal cancers.

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Communicating risk more generally, in relation to treatment options and associated risks, has similar and perhaps even greater complexity for clinicians and patients, and is beyond the scope of this article.

INHANCE researchers are currently developing and validating a risk-prediction model that could be used to identify those at highest risk of oral cavity and oropharyngeal cancer which could potentially guide opportunistic screening, and risk factor counselling interventions. Such personalised risk information can be presented to individuals based on their characteristics and behaviours and can improve decision making in relation to screening [18]. Such risk tools already exist for presenting breast cancer risk [http://www.cancer.gov/bcrisktool/] and are widely available for cardiovascular risk [http://www.qrisk.org/]. The major risk factors identified (above) and going forward in this model for oral cancer risk profiling are smoking, alcohol, and socioeconomic status, alongside age and gender determinants.

Prevention strategies

To paraphrase Johannes Clemmesen (the founder of the Danish Cancer Registry), the purpose of all cancer epidemiology studies is to prevent it.

Understanding risk is the key first step in the pathway to prevention. Prevention approaches therefore depend on whether the cancer is HPV-driven or non-HPV driven.

The primary prevention for HPV-driven oral cancer is likely to be via the HPV vaccination. There is one proof of principle study which demonstrates that the HPV vaccine (designed for cervical cancer prevention) prevents oral HPV infection. However, more evidence is needed to fully inform policy in relation to extending the vaccination to males. Although the case could be (and has been in other countries) argued on equity grounds, where men who have sex with men or men who have sex with women outside of the vaccinated population will not benefit from the hypothetical and assumed "herd immunity" to the population now that girls have been widely vaccinated (~90 per cent of 12 year olds from 2008 in Scotland). In addition to HPV vaccination, in theory HPV-driven oral cancer could be prevented via behavioural modification/safer sexual practices (i.e. condom

use or dental (rubber) dam use for oral sex – for more information see http://www.nhs.uk/chq/Pages/970.aspx).

Secondary prevention – whereby we interrupt disease progression via early detection (i.e. "screening") and early treatment – does have potential to prevent oral cancer. It will remain necessary for oropharyngeal cancer for decades to come (even with the prevention prospects of the HPV vaccine) as there will be a substantial unvaccinated cohort who will suffer the future oropharyngeal cancers. Unfortunately, there is no validated "screening" method for oropharyngeal cancer (although HPV16 E6 antibody serology blood test could be promising). Problems and research evidence gaps remain in relation to oropharyngeal cancer screening include: there is no identifiable precancerous lesion (like the Pap smear detected cervical intraepithelial neoplasm (CIN)), uncertainty about effectiveness of early intervention and treatment, and demonstrable reductions in cancer mortality.

The same difficulties for direct visual inspection of the oropharynx do not exist for comprehensive visual inspection of the oral cavity, and there is some limited evidence of effectiveness and cost-effectiveness of opportunistic screening [19,20]. Research questions remain (and we have three PhD students working on some of them) including: what constitutes best practice for oral examination/screening? Can risk assessment and profiling assist in focusing on groups or on recall interval? Given low volume of disease is early detection a realistic proposition? Are there inequalities in access and uptake of the opportunity to screening? And what are the barriers and facilitators to delivering screening?

Non-HPV driven (oral cavity cancer) prevention in or via dental practice is important. Again we have research in our group ongoing in this area. The principles of prevention for oral cancer should reflect the evidence from our understanding of risk. These principles include: i) age is not an issue in terms of risk factors – work led by Tatiana Macfarlane, Aberdeen Dental School has shown that even among young adults with oral cancer the same risk factors smoking and alcohol dominate [21]; ii) risk can reduce when behaviours stop; iii) oral health assessment is an important first step in any prevention intervention (we must ask the questions); iv) signposting and/or referring for more intensive preventive intervention services; and v) the role of tailoring advice and support to individual patients needs – recognising the dominant role of socioeconomic circumstances.

Public health and policy response needs to focus on the upstream structural causes of the causes; on what has been defined as the "common risk factor" approach [22](Sheiham and Watt 2000) – risk factors for oral cancer overlap with periodontal disease, with other cancers, with cardiovascular disease and so on…; and on multiple risk factors – our research has shown that risk factors do not exist in isolation – they cluster: people who smoke also drink heavily and have poor diets, this clustering is even more socioeconomically determined [23]. Policy developments also need to extend to the increasing preventive focus and wider healthcare role of dental practitioners and teams.

And as the times they are a changin' – we would do well as a profession to more proactively contribute to the political and policy discourse; to advocate for societal change for tackling health inequalities; to prioritise research and development to tackle the burden of oral cancer – a burden on health services and society, but an even greater burden of suffering on communities, families, and patients.

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MATERIAL SELECTION

DENTAL MATERIALS

The final part of Steve Bonsor's series of articles examines the factors affecting dental material selection which, he says, is far from Hobson's choice

STEVE BONSOR

The first two articles in this series examined how dental materials should be handled prior to and during clinical placement to optimise clinical success. While this is obviously very important, failure to select an appropriate material for the situation will not yield the best clinical outcome. This article addresses the factors which the clinician should be mindful of during this decision making process.

Material selection determined by conservation of tooth tissue

Management of the disease

In modern dentistry there has been a huge change in emphasis with respect to how direct restorative materials are selected. A little over a hundred years ago, in the time of the so-called father of dentistry GV Black, the dentist had a choice of only two materials – namely dental amalgam or gold.

Cavities, therefore, had to be prepared to accommodate the properties of the material. This resulted in sound tooth tissue being needlessly sacrificed so rendering the tooth more prone to fracture and a higher incidence of pulpal death.

The modern philosophy is completely opposite to what it was at the turn of the 20th century. Conservation of tooth tissue is now the most important factor and this has been made possible due to the large increase in the number of materials which are now available. The disease should be manage, i.e. the caries removed, the cavity examined and THEN the appropriate material selected (Fig 1).

At this point, some further preparation may be required to optimise the cavity to conform to the properties of the chosen restorative material. Examples would be the removal of unsupported enamel which may fracture due to its friability or sharp internal line angles which would lead to stress concentrations and a plane for failure (Fig 2).

Influence of dental materials' properties

It is important that the dentist has a working knowledge of the properties of the various materials which may be used for a given situation as these may have an influence on the selection of the chosen material.

For example, a cavity whose depth is less that 2mm is not indicated for dental amalgam. In this case, it is preferable for an alternative material to be selected such as gold alloy or resin composite so that tooth tissue may be conserved (Fig 3).

Material selection determined by clinical situation

Anatomy of the prepared cavity

There are certain prerequisites that may determine the best material for a given situation. For example, resin composite should only be used in cavities which have a complete circumferential enamel margin (Fig 4). This is because the bond gained between enamel and resin composite is the strongest and most durable.

For this reason, the American Dental Association recommends that another material should be selected if a complete enamel margin does not exist [1].

Achievement of an optimal environment for placement

As discussed in the second article, most dental materials are inherently hydrophobic and require a dry environment when they are placed. The inability of the clinician to achieve excellent moisture control when manipulating and using these materials intra-orally will result in inferior results.

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Any direct restorative materials containing resin are most susceptible. If the clinician is unable to achieve and maintain adequate moisture control then an alternative, more forgiving material should be considered.

This is also the case for inherently hydrophobic impression materials such as the silicones (Fig 5). In subgingival areas, adequate moisture control may be very difficult to achieve resulting in the margins of the preparation for a cast restoration not being captured accurately, so compromising the rest of the process.

Classically, this is manifested as a rolled edge in the impression (Fig 6). If the clinician cannot achieve excellent moisture control then they may be well advised to choose an alternative product such as a polyether which is more hydrophilic in nature (Fig 7).

Some materials react with moisture. For example, if a zinc containing dental amalgam alloy is contaminated with water, hydrogen gas is evolved which becomes incorporated into the material resulting in its expansion [2]. This may have detrimental effects such as extrusion of the material out of the cavity or fracture of the surrounding tooth tissue.

Selecting the appropriate material for mechanical reasons

On occasion, the clinician may be faced with a dilemma of removing more tooth tissue or choosing a material whose mechanical properties are superior. The choice between dental amalgam, gold alloy or resin composite in shallow cavities was discussed earlier. This is also the case for indirect restorations.

If insufficient interocclusal clearance is present, then the clinician may reduce the amount of occlusal reduction done to maintain preparation height and therefore retention for the cast. The use of a non-precious metal alloy in preference to a precious metal alloy will be more successful (Fig 8). Such alloys are stronger, harder and have a reduced ductility than precious metal alloys and may be used in sections of 0.5mm [2]. Some of the new zirconium based ceramics may now be used in such thin section as they have sufficiently good mechanical properties to be used in this situation.

Biological considerations

Many dental materials are bioactive (the ability to actively promote activity with the tissues) and need be to biocompatible i.e. the ability to support life and having no toxic or injurious effects on the tissues [2]. Inappropriate selection of materials which are cytotoxic will result in detrimental biological effects.

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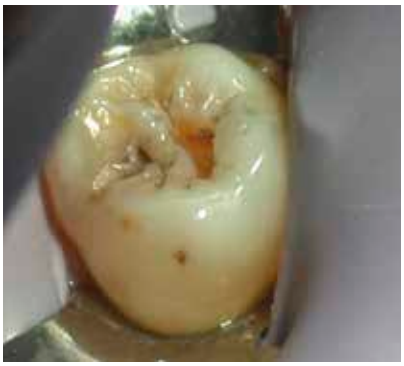

FIGURE 1
Once the caries has been managed then the most appropriate material to restore the cavity should be chosen

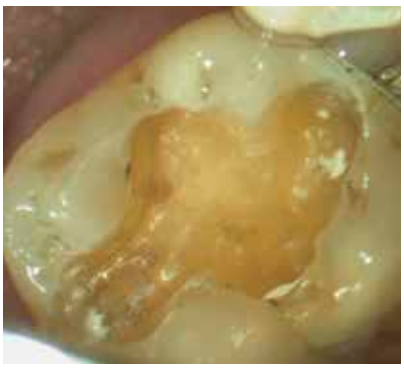

FIGURE 2
All unsupported enamel should be removed and a rounded internal cavity form achieved prior to placement of dental amalgam or resin based composite

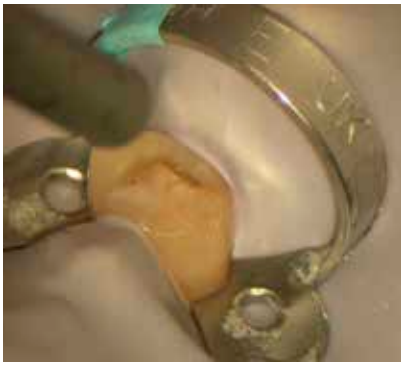

FIGURE 3
This shallow and unretentive cavity is not suitable for restoration with dental amalgam without further preparation involving the removal of sound tooth tissue. The cavity was restored with resin composite in this example

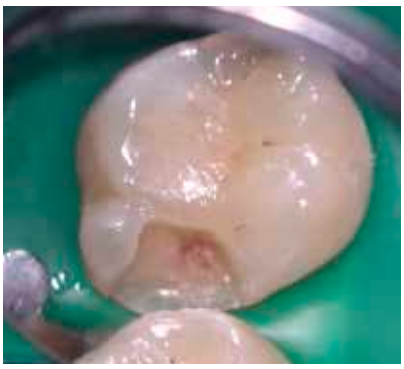

FIGURE 4
A cavity with a circumferential enamel margin which may be restored with resin-based composite

FIGURE 5
Silicone is frequently used to seal shower units illustrating its inherent hydrophobic nature

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For example, resin modified glass ionomer cement and zinc oxide eugenol cement are contraindicated to be placed directly on pulpal tissue.

The taking and recording of a thorough and comprehensive medical history is an essential prerequisite prior to embarking on any treatment. Hypersensitivity reactions may occur where individuals can become sensitised to certain components in materials. The commonest allergens are methyl methacrylate and hydroxyethyl methacrylate (HEMA).

This latter chemical is cytotoxic and is a powerful dermatological sensitiser [2,3]. Patients and dental staff may become sensitised to this substance if it comes into contact with naked skin. Furthermore as surgical gloves are porous and this molecule small, it may permeate the material of the glove so accessing the skin [3,4] (Fig 9).

It is used widely in dentistry in such materials as resin composites, resin modified glass ionomers, compomers and bonding agents to name but a few. Dental staff should therefore be careful when handling these products to avoid hypersensitive reactions. This may be achieved by practising good resin hygiene and by using a no touch technique.

Intermaterial chemical incompatibility

Some materials may interact with each other chemically. There are a number of common examples:

- Zinc oxide eugenol and resin composite. The eugenol acts as a plasticiser (additives that increase the plasticity or fluidity of a material) with the resin resulting in incomplete setting of the composite which will result in inferior mechanical properties and so compromising clinical success (2).
- Self-etch bonding agents may not be used with dual or chemical cured resin composite as they are chemically incompatible. The acidic monomers required for the etching process react with the amine initiator that is needed for the chemical curing mechanism in self- or dual-curing systems (2).
- The catalyst used in silicone impression materials is poisoned by sulphur residues of which are found on latex gloves (2). If the putty presentation of these materials is to be mixed by hand then non latex gloves should be used (Fig 10).
- The astringent Racestyptine (Septodont) and polyether impression materials react chemically resulting in gas being evolved causing porosity in the cast die (2).

The clinician should be mindful of these and other examples and avoid potential chemical reactions when making material selection choices.

Practice management issues

Valid consent

It is important that the advantages and disadvantages of each material are discussed with the patient. This is so that they are involved in the decision and they can make an informed choice as to the care they wish to receive. Sometimes the patient may request the use of a specific type of material at the outset, such as resin composite.

If, at the end of the cavity preparation phase, the clinician feels that the preferred material is not the most appropriate material in the situation then this must be communicated to the patient and the situation discussed. This will involve why this is the case and what the consequences would be if it were to be used.

It is important that the advantages and disadvantages of each material are discussed with the patient. This is so that they are involved in the decision and they can make an informed choice as to the care they wish to receive

Furthermore, alternatives should be explained together with their advantages and disadvantages. If there is a deviation from the original agreed treatment plan then an updated one should be issued with it being signed by the patient to confirm their acceptance. At the end of this process, the clinician is safe from a medico-legal perspective with valid consent having been obtained.

Appointment length estimation

Different techniques may result in more time being required to complete the procedure. For example, it has been reported that a posterior resin composite restoration takes three times as long to do as the commensurate amalgam restoration. It is more difficult for the dentist to allocate the correct time to the procedure if there is some uncertainty as to what the final procedure will be.

As mentioned above, a change of material may have increased cost implications as more time may be required to place the restoration.

Surgery set up procedure

The new approach of choosing the dental material to fit the clinical situation is clearly unhelpful for the dental nurse who would prefer to assemble all of the equipment and materials required for the procedure at the beginning of the appointment to facilitate its efficient execution.

They may be well advised to wait until the final decision has been made as to the material selection before getting the chosen materials out of cupboards and drawers.

Conclusions

Each and every dental material has advantages and disadvantages. It is the responsibility of the clinician to carefully consider these together with the intended clinical objectives. Only then can they come to a balanced decision as to the best material to use in the situation which must be underpinned with a thorough knowledge and understanding of all of the materials which are available and their properties. There are so many options that dental material selection is far from Hobson's choice!

ABOUT THE AUTHOR

Steve Bonsor graduated from the University of Edinburgh in 1992 and in 2008 gained an MSc in Postgraduate Dental Studies from the University of Bristol. From 1997 until 2006, Steve was a part-time clinical teacher at Dundee Dental Hospital and School and honorary clinical teacher at the University of Dundee in the sections of operative dentistry, fixed prosthodontics, endodontology and integrated oral care. He currently holds appointments at the University of Edinburgh, as an online tutor on the MSc in Primary Dental Care programme, and at the University of Aberdeen as honorary clinical senior lecturer leading the applied dental materials teaching at Aberdeen Dental School. As well as lecturing throughout the UK, Steve is actively involved in research, having published original research articles in peer-reviewed journals. His main research areas are photo-activated disinfection and the clinical performance of dental materials.

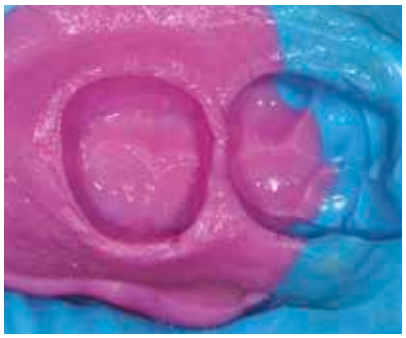

FIGURE 6
A rolled edge of a silicone impression indicating moisture contamination during impression taking

FIGURE 7
An example of a polyether impression material which is more hydrophilic than the silicones

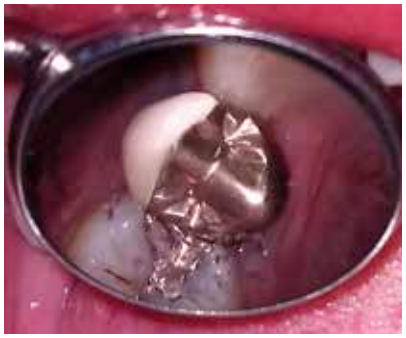

FIGURE 8
Using metal on the occlusal surface of a metal-ceramic crown requires less tooth preparation so increasing preparation height and retention. Non-precious metal alloys function in thinner section than precious metal alloys

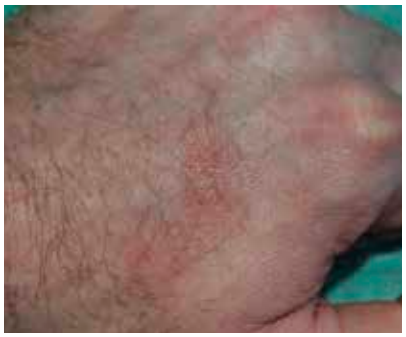

FIGURE 9
An area of erythema on the dorsal surface of this dentist's hand caused by HEMA. This occurred by the wiping of instruments contaminated with resin composite on the surgical glove during material placement

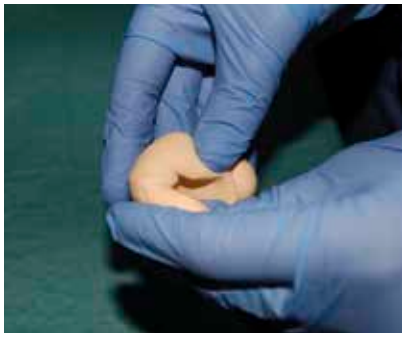

FIGURE 10
An additional silicone putty impression material being mixed by hands wearing non-latex gloves

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VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To examine the factors which require to be considered when selecting a dental material for a given situation.
- To appreciate the primary objective of conserving tooth tissue and to select an appropriate material which fits the clinical situation.
- To offer practical advice on how the clinician may negotiate the maze of material selection.

LEARNING OUTCOMES

- Be aware of the factors which need to be considered when dental materials are being selected for clinical use.
- Be able to illustrate such factors with practice examples
- Understand how correct material selection can have a major influence on clinical outcome.

EXAMPLE QUESTION:

1. A direct restorative material should be selected:
a. At the outset of the appointment so that the dental nurse can have all equipment and material to hand
b. After the cavity has been finalised just prior to restoration
c. After the cavity has been examined after caries removal/gross preparation if required
d. On the insistence of the patient.

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CANAL CLEANING

ENDODONTICS

A review of the role of irrigation in contemporary root canal treatment

ADRIAN STEWART

Apical periodontitis has been established to be a microbial-induced disease[1-3]. The aim of root canal treatment is the prevention or treatment of apical periodontitis by the elimination of micro-organisms from the root canal system and the prevention of subsequent recontamination[4]. To this end, our primary treatment modality is chemo-mechanical debridement of the root canal[5].

Mechanical cleaning of the root canal system with hand or rotary instruments has been shown to engage only a proportion of the root canal wall – 35 to 53 per cent of the canal wall surface may remain untouched following preparation[6]. Fins, lateral anatomy and communicating canals render the goal of mechanical removal of all infected tissue impossible; therefore, after gross debridement of the vital and non-vital tissue from the canal, the main goal of mechanical preparation is to enable chemical disinfection of the root canal[7].

The functions of endodontic irrigation include:

- Disinfection
- Degradation of pulp tissue
- Disruption of the biofilm
- Removal of the smear layer
- Lubrication of endodontic instruments
- Flushing of debris from the canal.

In practice, no single irrigant achieves all of these aims and a combination regime is recommended. Saline and local anaesthetic have each been employed, but these provide only a flushing and lubricating function. Irrigation with such chemically inert media has been shown to be incapable of adequately reducing the viable microorganisms in infected root canal systems[5].

Irrigants in contemporary use can be classified as antimicrobial or decalcifying[4] (see table, right).

Mechanical instrumentation has been shown to result in the burnishing of organic material and dentine debris against the canal wall and into depressions and lateral anatomy[8]. The role of decalcifying agents such as EDTA incudes chelation of the mineral content of this "smear layer" and the opening of access to the lateral anatomy[9].

Sodium hypochlorite

Sodium hypochlorite (NaOCl) is recommended as the main endodontic irrigant due its ability to dissolve organic tissue and its broad anti-microbial spectrum[9]. Its action on organic tissue enables it to disrupt and kill biofilms adherent to the root canal walls.

Concentrations in use in endodontics range from 0.5 to 5.25 per cent.

Chlorhexidine

Chlorhexidine is a bisguanide, generally used in the form of chlorhexidine digluconate. As a root canal irrigant, it is generally presented in 2 per cent concentration. While several in-vitro studies have shown anti-microbial efficacy to be similar to sodium hypochlorite, some in-vivo studies have demonstrated chlorhexidine to be inferior, with more culture reversals from negative to positive between visits. This is likely to be due to its inability to dissolve pulpal remnants[10].

The major advantages chlorhexidine has over sodium hypochlorite are lower toxicity, less objectionable smell and taste and substantivity, meaning it persists on the walls of the canals. Like sodium hypochlorite, chlorhexidine lacks the ability to dissolve the smear layer[4].

Chlorhexidine should not be used in conjunction with sodium hypochlorite due to the formation of a precipitate

or flocculate. This flocculate contains para-chloroaniline (PCA), which is known to be carcinogenic, although the level of exposure in such cases is likely to be low. The presence of the flocculate may lead to blockage of narrow anatomy and subsequently hinder adequate penetration of hypochlorite.

Alternative concepts for antimicrobial irrigation include electrochemically-activated water (eg. Sterilox), laser photo activated disinfection and ozone gas filtration of the root canal system. Studies comparing the antimicrobial efficacy these approaches to irrigation, with a 3 per cent sodium hypochlorite solution found all to be inferior to varying degrees[11-13].

ANTIMICROBIAL IRRIGANTS
Sodium hypochlorite
Chlorhexidine
Electro-chemically activated water
Iodine-potassium-iodide
Hydrogen peroxide
DECALCIFYING IRRIGANTS
Ethylenediaminetetraacetic acid (EDTA)
Citric acid

Decalcifying agents

Although sodium hypochlorite has the ability to dissolve organic tissue, it cannot dissolve the inorganic component of dentine. Decalcifying agents such as EDTA and citric acid are recommended for dissolution of dentinal debris and removal of the smear layer from canal walls. In addition, inorganic obstructions to negotiation of the root canal during preparation may be overcome with the aid of chelation agents[9].

It is not recommended that EDTA be used as an alternating rinse with sodium hypochlorite due to the deactivation of sodium hypochlorite by EDTA[14]. It is recommended that EDTA be used as a penultimate rinse. The canal is dried of sodium hypochlorite and the EDTA is introduced and left in the canal for one minute. This is then rinsed out and the canal dried again before the final rinse with sodium hypochlorite. In this way, the smear layer is removed, opening the dentinal tubules and any lateral canals to penetration with hypochlorite.

There is clinical folklore that mixing sodium hypochlorite in the canal with EDTA and creating an acid-base reaction, the so-called "Champagne Effect", aids with coronal transportation of debris. No evidence exists to support this claim[9].

Factors that influence the effectiveness of irrigation:

- Concentration of the irrigant
- Temperature of the irrigant
- Level of corono-apical penetration of the irrigant
- Volume of irrigant exchange.

Concentration

The antimicrobial and tissue dissolution capacity of sodium hypochlorite are both a function of its concentration, but so is its toxicity. Spangberg found that a 0.5 per cent solution of sodium hypochlorite was sufficient to kill most micro-organisms, with the exception of Staphylococcus aureus, and retained the ability to dissolve necrotic tissue, though not vital tissue. One per cent solution killed Staphylococcus aureus[15] and 5.25 per cent sodium hypochlorite has been found to reduce the elastic modulus and flexural strength of human dentine, while 0.5 per cent solution does not[16].

The risk of apical extrusion of sodium hypochlorite also militates against the use of unnecessarily high concentrations, although a concentration of 0.01 per cent has been demonstrated to be lethal to fibroblasts and a case of skin injury with exposure to 2.5 per cent following rubber dam leakage is recorded[17].

Rapid dissolution of vital and necrotic tissue remnants within the pulp canal is an essential facet of the use of sodium hypochlorite irrigant. No other irrigant has been shown to dissolve pulpal remnants in the same manner. It is, therefore, necessary to balance the needs for a higher concentration of hypochlorite with the caveat that higher concentrations are more likely to result in tissue damage if accidentally extruded through the apex or exposed to the mucosa. A concentration of 2.5 per cent is commonly used. An alternative to increased concentration has been experimented with ex-vivo as described below.

Temperature

Heating the hypochlorite solution has been shown to increase both its bactericidal and tissue dissolving effects. The capacity of a 1 per cent solution of sodium hypochlorite at 45°C to dissolve human pulp tissue was found to be equal to that of a solution of 5.25 per cent at 20°C[18]. No clinical studies have been carried out to determine the applicability of this technique in-vivo, however; the benefit of using heated, weaker solutions of hypochlorite is that a temperature equilibrium is quickly reached within the root and extrusion or mucosal exposure is less likely to cause serious injury.

Corono-apical penetration

Root canal irrigants are conventionally delivered using a side-vented needle, fitting loosely in the canal. Side venting and loose fit are important to reduce the risk of apical extrusion of irrigant and to increase the flushing effect on debris. Vapour lock (a body of gas trapped in the apical portion of the root canal) means that penetration of the irrigant under such passive irrigation circumstances has been shown to be no more than 1mm beyond the tip of the needle[19]. In order to increase the efficacy of the irrigation, it is vital to:

1. Maximise the extent to which the needle can penetrate
2. Activate the irrigant in order to increase the penetration of the root canal.

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The needle penetration is a function of both the size of the needle and the size of the apical preparation of the canal. Apical preparations in the order of ISO size 25-30 and the use of currently available 27-30 gauge needles will enable penetration to approximately 1mm from Working Length (Figure 1). This has been found by at least one study to be the most dominant factor in irrigant penetration[20].

The preparation taper has also been found to affect irrigant exchange, with apical preparations of greater taper producing greater flow of irrigant than narrow tapers[21].

Irrigant activation may be enabled either by manual or machine-assisted means. Manual techniques include agitation with the delivery needle, use of endodontic brushes or by manual dynamic irrigation. In this technique, a well-fitting gutta percha cone is placed into the irrigated canal and moved rapidly in and out with a 2-3mm stroke. This action is thought to create a hydrodynamic effect increasing the penetration and exchange of the reagent[20]. A drawback of manual pumping is that it is laborious (Figure 2).

Machine-assisted agitation systems have come about to facilitate better penetration. Rotary brushes, such as Canalbrush, can be used in a handpiece but, again, only where the brush can penetrate.

Quantec-E provides continuous irrigation during rotary instrumentation. This concept should provide for greater irrigant exchange than needle irrigation alone and this has been shown to be true in the coronal third of canals; however, this has not resulted in cleaner canal walls in the middle and apical thirds of canals studied[22].

Sonic agitation devices, such as the Endoactivator from Dentsply, work at lower frequencies than ultrasonic devices and demonstrate higher amplitudes of displacement. Endoactivator utilises a smooth-sided polymer tip that has been demonstrated to be resistant to fracture and passive towards the dentinal walls of the canal (Figure 3).

Passive ultrasonic irrigation (PUI) has been demonstrated to be highly effective in increasing both the penetration and cleaning efficiency of irrigant solutions. Although PUI can be used with intermittent irrigation, it has been demonstrated to be most effective when applied to the completed canal preparation[9]. The prepared canal is flooded with irrigant such as sodium hypochlorite. A file is then introduced to the maximum length at which it does not bind with the canal walls and activated with an ultrasonic unit. With the file tip free, a node of vibration is established, generating a wave of energy that streams irrigant coronally. Endosonore files are highly effective for this technique (Figure 4).

While passive irrigation with sodium hypochlorite does not remove the smear layer, when a 3 per cent solution of sodium hypochlorite is used with PUI, several studies have found complete removal of the smear layer[23-24]. These findings were not reproduced when the irrigant was replaced with saline.

The precise mode of action of PUI is unclear, but acoustic streaming is thought to be the primary factor in debris removal. Cavitation has also been postulated as an effect. Cavitation occurs with the generation and collapse of microbubbles within the irrigant solution as the pressure drops momentarily below the liquid's vapour point. This has been shown to generate high temperatures in the micro-environment and may explain the synergistic effect of PUI and sodium hypochlorite[25].

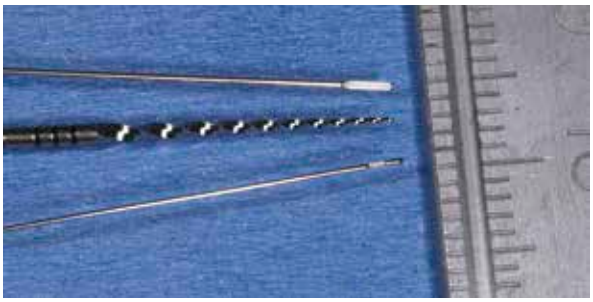

FIGURE 1
Top: A 27G cutaway irrigation needle. Bottom: A 30G side-ported needle. Middle: A Protaper F2 rotary file for comparison

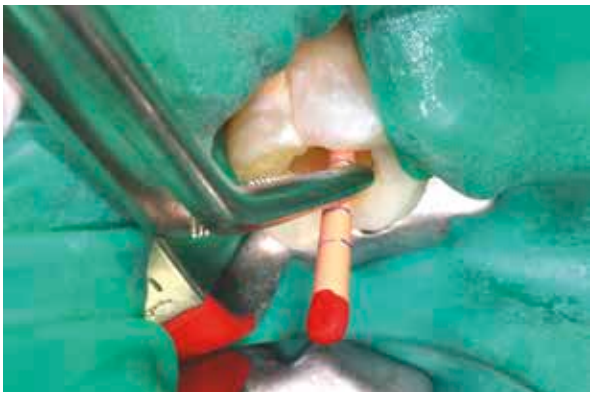

FIGURE 2
A well-fitting GP cone can be used in a rapid pumping motion for manual dynamic irrigation

Pressure alternating devices

Devices have been introduced that create alternating negative pressure and positive irrigation within the canal. Examples include EndoVac and RinsEndo. A study of one of these systems (RinsEndo) found that it outperformed passive irrigation in the removal of a layer of stained collagen from the canal walls but was inferior to manual dynamic irrigation[26].

Summary

Despite attempts to create alternative solutions and methods, the evidence supports a regime that involves:

- A solution of sodium hypochlorite with a concentration in the range 1 per cent to 3 per cent
- The use of a decalcifying agent to remove the smear layer
- Ultrasonic activation of the irrigant
- Adequate apical preparation and taper of the canal to permit placement of the irrigant within 1mm of the apex and enable sufficient irrigant flow.

Figure 5 shows two completed cases demonstrating accessory anatomy that is not accessible to files, but which has been cleaned by irrigant penetration.

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Irrigant activation may be enabled either by manual or machine-assisted means

FIGURE 3
The Endo Activator from Dentsply

FIGURE 4
An endosonic file in its adaptor

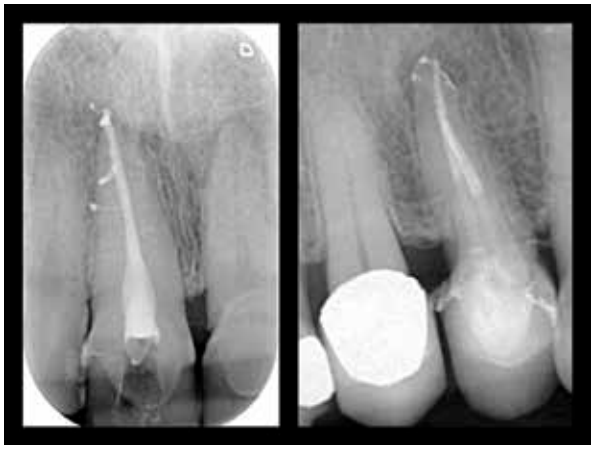

FIGURE 5
Two teeth with accessory anatomy that has been cleaned by the reagent regime, not filing

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To gain an understanding of the crucial role of irrigants in endodontic therapy
- To review the mode of action of popular endodontic irrigants
- To understand the various means to improve irrigation.

LEARNING OUTCOMES

- The dentist should be better able to choose the irrigant regime for their practice
- The dentist should be able to choose means to improve the activity of the irrigants they employ
- By understanding the use of irrigation, outcomes for dentist and patient should be improved.

EXAMPLE QUESTION

1. What is the primary cause of periapical disease?
a. Dead pulp tissue
b. Bacteria
c. Trauma
d. Cyst

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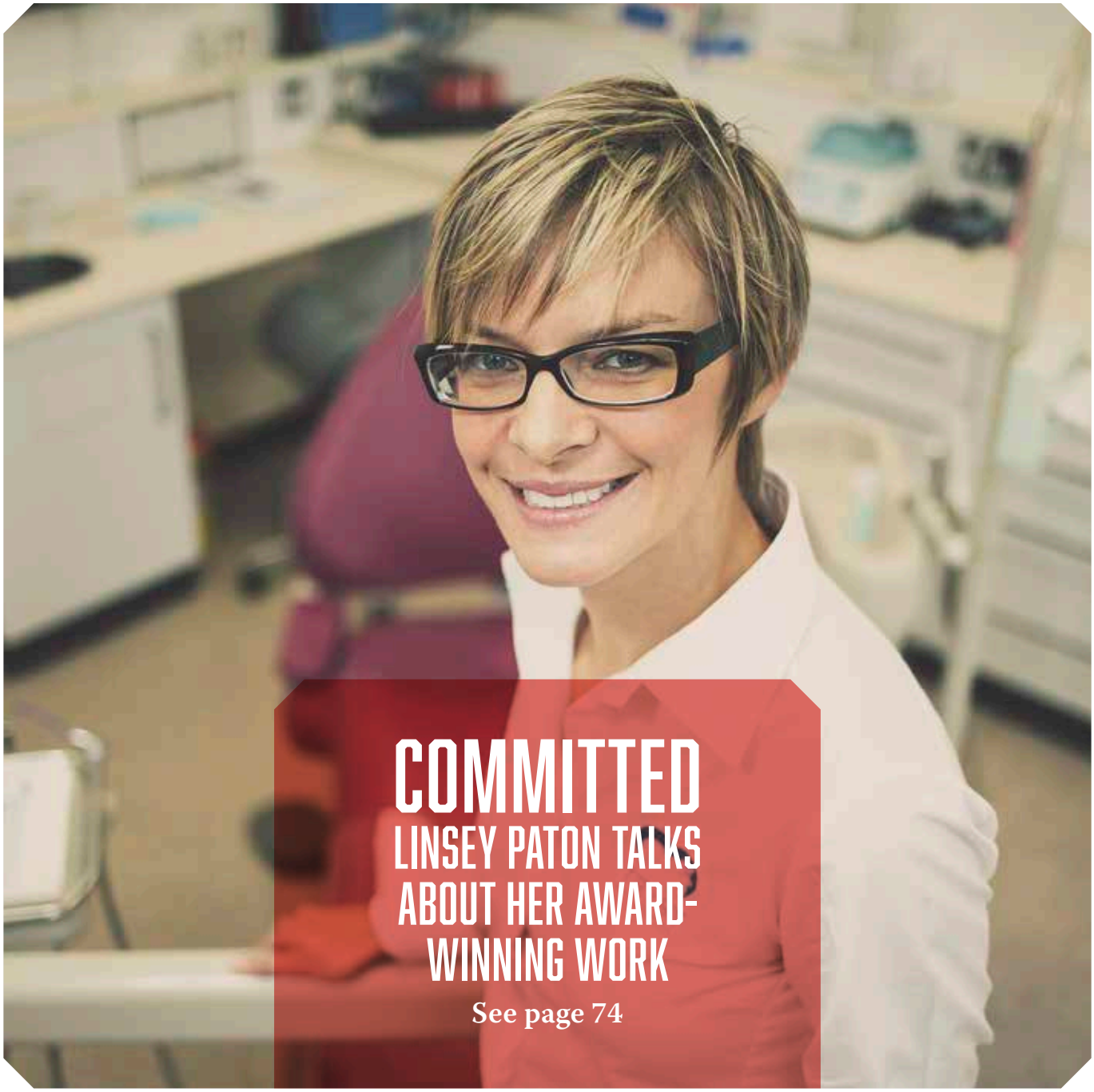

COMMITTED

LINSEY PATON TALKS ABOUT HER AWARD-WINNING WORK

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PRACTICE MAKES PERFECT COMMUNITY PARTNER

AT TRYST DENTAL PRACTICE, IT'S NOT JUST PATIENTS WHO BENEFIT FROM THEIR FOCUS ON HEALTH

STEWART McROBERT MARK JACKSON

Community means a lot to Linsey Paton, the business manager at Tryst Dental Practice in Stenhousemuir. From the time she and her brother, encouraged by a PE teacher mum, took part in team sports at an early age, Linsey has relished working with others. Picking up the Community Award at the 2015 Scottish Dental Awards was confirmation of the achievements that have already been made under her guidance at Tryst. However, as Linsey said: "We've only just started."

The practice's successful community activity includes burgeoning links with Stenhousemuir Football Club and Larbert High School. Among other things, these have led to support for a walking football project and pupils delivering oral health presentations to their peers.

Linsey's attachment to community participation was strengthened during a traumatic period in her teenage years. Her mother, who had become a special needs teacher, contracted ovarian cancer and passed away. Linsey was just 13 at the time.

"One of the last things she did was to remind me to think of other people in everything I did," said Linsey, "and that has always stuck with me." Then, at 17, she had to endure severe ulcerative colitis, which culminated in major surgery at 18. What saved her, Linsey said, was the NHS.

After recovery, she went on to study Sport in the Community with Business at Strathclyde University. Then her career took an unexpected twist. "I'd had a part-time job in a data protection company," Linsey explained. "I was subsequently offered a supervisor's role, which turned into a good career opportunity when the business was taken over by the US business, Iron Mountain."

A few years later, she had become Head of UK Scanning Services for another data protection firm when the chance to join Tryst came along. "I knew Lesley Donaldson, then an associate of Tryst Dental. Lesley had the opportunity to take over the practice in January 2014. However, she wanted to remain focused on developing the clinical aspects and improving patient care, so she asked if I would come and help with the business aspects. With clearly defined roles, I had scope to do something a bit different and thought we could give it a try. I subsequently joined full time in July 2014."

> "ALTHOUGH WE'VE ACHIEVED QUITE A LOT IN A SHORT SPACE OF TIME, I BELIEVE WE'RE ONLY AT THE BEGINNING OF WHAT WE WANT TO DO"

In many ways, she said, her role is similar to that of a typical practice manager. The current focus is on developing new skills within the team, both to take the practice forward and allow Linsey to give more time to strategy development.

COMMITMENT ETHOS

The 'something different' that Linsey mentions

Linsey Paton and the team at Tryst Dental Practice

is part of the practice's ethos; its commitment to community involvement. "We're in a very community-focused area, and even though we have a large catchment, patients often know each other. I am extremely keen for us to play our part in that," she said. As Linsey established the practice's community links, she discovered willing partners in Stenhousemuir FC and Larbert High.

A straightforward offer of help to the football club led to Tryst's sponsorship of a walking football project for men aged over 50. The practice provided initial funding, which was then doubled by sportsmatch, the Government scheme that encourages business investment in grassroots sport.

Linsey added: "I met some of the guys who took part in the football and they were very enthusiastic. It got me thinking that this is a great way to reach people and take forward the idea of partnership working in the dental sector. The more we're able to send out messages around general health and wellbeing, the more doors will start opening."

The contact with Stenhousemuir and their head of community Jamie Kirk allowed Linsey to find out about, and meet with, Billy Brotton, head of sport at Larbert High, who also looks after the Tryst Community Sports Hub. Soon, a new partnership had been established. "We're helping to promote events and carrying out work in the school. Among other things, I'm planning to work with a pupil from each year group to help them put together a presentation on oral health that they will deliver to fellow students.

"Similarly, we are developing a dental work experience programme that's properly controlled and regulated, and most importantly, allows students to demonstrate a valid record of achievement."

NURSE TRAINING

Meanwhile at the practice, in addition to the professional development work Linsey is carrying out with colleagues, she is learning to be a dental nurse. "My NHS training begins in August and there are good reasons for making this move. From a business point of view, I can help out if we're ever short-staffed. Perhaps more importantly, if I understand the ins and outs of the job, it makes it easier for me to relate to the nurses, and for them to have trust in me."

Not content with the role of pupil, Linsey

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ABOVE: Linsey Paton, business manager at Tryst Dental Practice, the deserving winner of the Community Award for her work with, among others, Stenhousemuir Football Club

FROM PREVIOUS PAGE>

is acting as tutor too, working with the NHS Education department as a trainer for the practice managers' vocational training scheme. She had originally considered undertaking the course, but the Education team persuaded Linsey that her business background would make her an effective trainer. So far, it has involved mentoring a practice manager from Edinburgh and she says that the seven hours she devotes every week have proved to be a rewarding experience.

SURPRISE NOMINATION

This myriad activity helped Linsey stand out when it came to the Scottish Dental Awards. However, her nomination came as something of a surprise. "I was quite shocked," she said. "Just to be shortlisted was fantastic, and on the night I was simply thinking about how good it was to be there.

"Similarly, although we've achieved quite a lot in a short space of time, I believe we're only at the beginning of what we want to do. In some ways, the award has come early, but it was wonderful to win, and a real vindication of the work done by all of the team here."

That success should provide a fillip as Linsey and her colleagues look to the future. "We are starting to look at new opportunities," she said. "Our hope is that we'll be able to put together roadshows with Stenhousemuir FC, the sports hub and, if all goes according to plan, the British Heart Foundation.

"The community aspect is something I really enjoy. Every business has its stresses and its routine, but if you pursue something you genuinely believe in, and that brings happiness to you and to others, you can be content that you've made a difference."

NORTHERN STAR

IN JUST A FEW SHORT YEARS, DENTAL NURSE KIRSTY RODGER'S ENTHUSIASM AND PASSION HAVE SEEN HER TRANSFORM FROM PATIENT TO PRACTICE MANAGER

STEWART McROBERT BRIAN KILOH

Some people are lucky enough to know what they want do in life from an early age – Kirsty Rodger is one. At 15, she became aware that she wanted to work in dentistry. At 21, she's already crammed a great deal into a short career, and she's just received the DCP Star trophy at the Scottish Dental Awards.

"When I was younger, my dentist in Banff referred me to an orthodontist in Aberdeen to have braces fitted," recalled Kirsty. "I remember walking into the surgery and realising that this was the kind of thing I wanted to do. I discussed possibilities with my dentist and he recommended dental nursing, saying I was more than welcome to gain work experience at the practice."

A few days during the Easter holidays confirmed her thoughts; she loved the atmosphere and teamwork and duly left school – still aged 15 – to seek a job by sending her CV to practices in and around her home near Huntly.

"I was invited to an interview in Inverurie, got the job pretty much on the spot, and have never looked back. I absolutely loved it and was there for three years," said Kirsty.

Kirsty's calming nature has helped both adult and younger patients

QUALIFICATION

Completing her training, Kirsty qualified as a dental nurse at the Aberdeen Dental Education Centre in January 2012. From the start, she has been committed to undertaking additional courses to extend her role.

In April 2012, she qualified as a Childsmile nurse at the University of Highlands and Islands, Inverness. And in November 2013, Kirsty passed the NEBDN Certificate in Oral Health Education at the Aberdeen Dental Education Centre.

By that time, she had moved to her current employer, Deveron Dental Centre in Huntly, which she joined in September 2012. "When the opportunity to work here came, I couldn't turn it down.

"Previously, I was travelling about 30 miles every day. Deveron is seven miles away from home, plus I'd heard really good things about the practice, and the owner, Morven Gordon-Duff, puts a high priority on continuing professional development, which is very important to me."

The practice has a 6,500-strong patient list, five dentists and three therapists, and its positive reputation appears well justified – as well as Kirsty's achievement, Morven was named Employer of the Year at the Scottish Dental Awards.

"Initially, I concentrated on nursing and carrying out Childsmile and general oral health education," said Kirsty. "However, recently I've been asked to act as practice manager and that's how I spend most of my time. To some extent, I miss being in the surgery, but enjoy helping out behind the scenes."

Kirsty Rodger's boss has praised her passion and dedication to her role

PASSIONATE

According to Morven, Kirsty is one of the most dedicated dental nurses she has worked with. "She is extremely passionate about her job, brilliant at putting nervous people at ease and is wonderful with our child patients.

"Although she is young, she has the maturity and skills to be a key member for training our new dental nurses and vocational trainee dentists. Kirsty is full of great ideas and enthusiasm for the practice and I never have to ask her twice to do a job."

The practice puts a high priority on charity work, and Kirsty has been instrumental in helping raise funds. Staff gathered £3,000 for Dentaid in 2014, mostly from stock sales. As oral health educator, Kirsty helped sell lots of oral hygiene products, including 20 electric toothbrushes in one month alone. She has also helped raise funds for Children in Need, and the ARCHIE Foundation.

"We did the ice bucket challenge last year," Kirsty said. "Morven phoned up and said she was looking for volunteers and she knew right away that I would be up for it. I always grab any opportunity with both hands."

That eagerness to help was one of the reasons Kirsty picked up the DCP Star award. And she's thrilled with the recognition. "I was chuffed to win the award. I have been working very hard, but I knew it would be worth it and pay off at some point. I didn't know Morven had put me forward, but she is good at recognising when someone is doing well; she won Employer of the Year for a reason."

The awards proved to be a great exercise in team bonding, with many of their colleagues coming along to support Kirsty and Morven. Featured in the local press, the dual success helped reinforce the practice's reputation.

With those distinctions under their belt, the aim now is to look forward. "At the moment, I'm continuing with practice manager training, and I hope to take some of the pressure off Morven, who also has two young children to care for. We want to see the practice grow and that's happening – we're currently registering more than 25 new patients a week.

"There's a lot happening and we have recently added Six Month Smiles and facial rejuvenation to our offer. As always, we are looking to see what we can do to develop our service."

It appears the practice knows where it wants to go – much like the practice manager.

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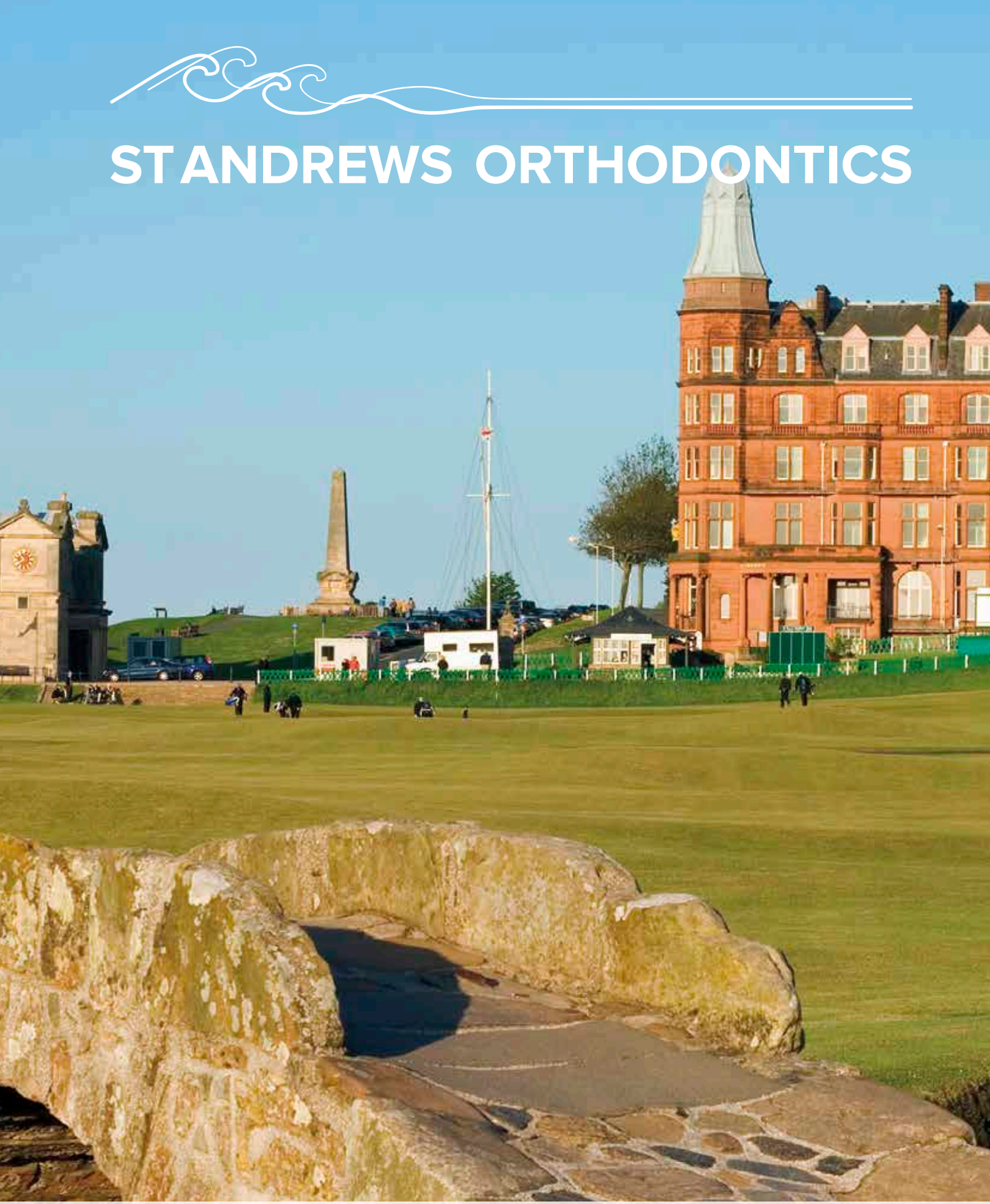

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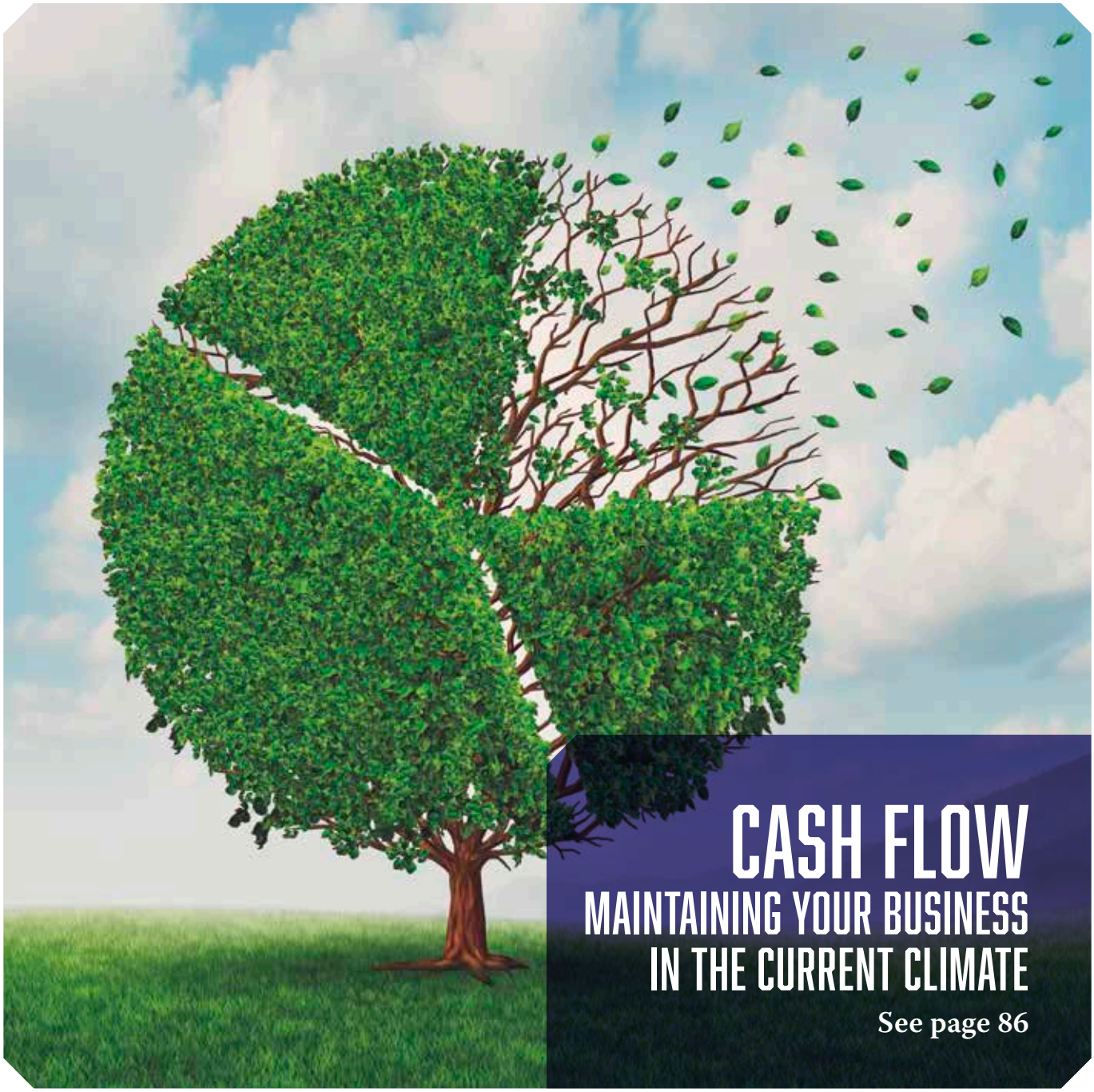

CASH FLOW
MAINTAINING YOUR BUSINESS IN THE CURRENT CLIMATE

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PROFIT VS CASH FLOW

FEW PRACTICES HAVE A FIRM DISTINCTION BETWEEN PROFIT AND CASH FLOW

MARK FOWLER

A practice may return a good profit, based on year-end accounts but the owner may be in despair because the profit does not reflect the true levels of operating cash within the business. This may be leaving the principal with little operating capital.

Operating capital is crucial to maintaining a healthy business. Many large companies, some of which are household names, have very low profit margins, perhaps 5 per cent or lower, but continue operating as healthy ventures simply because they have excellent cash-flow management. In the past, dentists benefitted from healthily profit margins (40 per cent or more), which meant that the large margin essentially buffered perturbations in cash flow. Cash management was simply to budget until the next large injection of cash. As the costs of operation have risen due to VAT increases, compliance, regulation and other costs of running a practice, cash-flow management has become increasingly important. In fact, superficially, one can argue that the smaller the profit margin (and thus a smaller buffer) the better the cash-flow systems need to be. It is no good having a profitable business at the end of a working year if you can't afford to reach this point in the first place.

So, picture your business as a bath with water in it. It is a quarter full. Holes in the bath allow water to leak out and fill cups that allow other people to drink the water and stay alive to help refill the bath and keep it clean and serviceable. These holes represent your expenditure on a monthly basis: salaries, drawings, associate fees, lab and material costs and fixed overheads such as rent, mortgages, loans, telephones, IT, utilities, insurance etc. During the month your bath may receive a single big top up of water (NHS schedules, plan payments etc). The water still leaks out, but some of the holes only leak water when the bath is full (for the pedantic reader, the bath will not leak water FASTER, when it is fuller!). This represents significant monthly outgoings like staff salaries and associate payments. Once the water level goes down then these holes don't leak anymore. However, other holes still allow water to leak and this will keep happening until the bath runs dry. Now no one can get a drink of water and keep the bath clean and serviceable and refill it. They have dehydrated.

The trick is to keep the bath topped up enough to replace the water that is leaking out until it is time for the larger influx of water to fill the bath.

This analogy represents your practice bank account and working capital. Enough money must be reaching your account to service your outgoings, pay your staff and your bills in order for you to keep operating long enough to reach the next large capital injection via NHS payments or plan payments.

There are a few tricks and adjustments to managing cash flow that work very well.

1) ESCORT PATIENTS to the reception area in order that forward appointments can be discussed with the reception team. This way any money outstanding on the patients account can be communicated to the reception team.

2) ASK PATIENTS HOW they would like to pay today, not would they like to pay today. Simple terminology but very powerful.

3) ASK FOR DEPOSITS up front for large treatment plans, treatments that need lab work and indeed for NHS work that requires multiple visits where payments can be broken down.

4) IF YOU CAN OFFER larger treatment plans or private work, consider offering patients interest-free finance options to help spread the cost of treatment. This will help case acceptance by removing objections to treatment based on cost and make paying for treatment much more affordable. Just because you are used to seeing plans that cost large amounts of money, don't expect your clients to think the same way as you. Practices that offer finance options have much better cash flow and treatment plan take up.

5) CONSIDER OFFERING treatments that patients actually want as well as need. For this consider tooth whitening, short-term orthodontics, tooth-coloured fillings etc.

6) MARKET what you can offer in the practice. Patients will not know what you do unless you tell them. Always consider what it will do for the patient rather than talking too technical. For example, an implant is a screw that is placed into your jawbone that supports a crown, but it is also the closest thing to a natural tooth that will enable you to eat apples and steak with your family without fear of a bridge or denture falling out. Sell the sizzle not the sausage!

7) LEARN TO COMMUNICATE and ethically sell your treatments to your patients. There are a number of excellent ethical sales and communication courses available.

8) MONITOR the productivity and overheads of your associates and beware of busy fools who drain your resources and make you no money. We have witnessed several practices where poor associates have literally stalled the cash flow and sustainability of practices.

9) CHASE DEBTS.

10) IF YOU have a pipeline of treatments that patients have not returned for or you have clients that have expressed an interest in a particular (elective) treatment then follow up with these clients. Your software should be able to run reports on patients with outstanding plans and if you use a treatment co-ordinator to talk to patients then they should be keeping a record of these meetings and following up with potential clients.

TEAM TRAINING

INVESTING IN YOUR TEAM WILL HAVE A POSITIVE IMPACT ON YOUR PRACTICE LIFE

MARK FOWLER

Sadly the value of "training" in dental practices is consistently under-valued and the impact is vastly under-estimated. Of course, well-trained dentists are an obvious asset and qualified dental nurses or surgery assistants are (usually) the norm. However, in-practice training must go further than the accepted qualifications, in order to make a real difference. In fact it must move practice leaders out of their comfort zone into soft skills, staff inductions and practice systemisation.

Let me illustrate the power of this philosophy. Last week we visited a practice who had embraced the concept of "systemisation" and the training that goes with it. They had developed a robust induction system that lasted at least a month, after which a personal development plan and monthly reviews to support new team members was the norm. Staff undergo quarterly catch-up chats with personal training plans that support the practice as it moves forward.

Only that morning, their telephone system had stopped working and the practice manager had been off site. The team had been trained to use the systems manual to locate the practice continuity plan and had contacted the telephone company, using the information in the continuity plan, to restore the telephone service.

SO THE NEXT TIME YOU MOAN OR WHINGE ABOUT YOUR TEAM, ASK YOURSELF: ARE YOU EXPECTING THEM TO BE MIND READERS?

The most impressive thing though, other than the team work, was that it was a 17-year-old trainee receptionist who ultimately followed the plan and was taking ownership of talking to the telephone company.

In this case, the practice systems manual formed part of the induction process and training of the staff had up-skilled and empowered them to be able to implement practice systems. Now, one would not normally expect leadership or strategy decisions to be formalised in the same way for a team but it does serve to illustrate the power of training, empowerment, support and a reference manual.

So the next time that you moan or whinge about your team, ask yourself: are you expecting them to be mind readers? Have you trained and communicated with them what your expectations are? The reality is that if there is a problem with your team, then there is a problem with YOU as a leader or manager. Many problems within teams stem from a lack of communication, rules, vision and expectations. The take-home message is that by empowering your team with the correct training you will be investing in the future running of your business, the future of your team members and the future of your practice.

So take team training further than the yearly CPR event and consider some training in customer service or how to operate your practice systems properly. The difference will be amazing.

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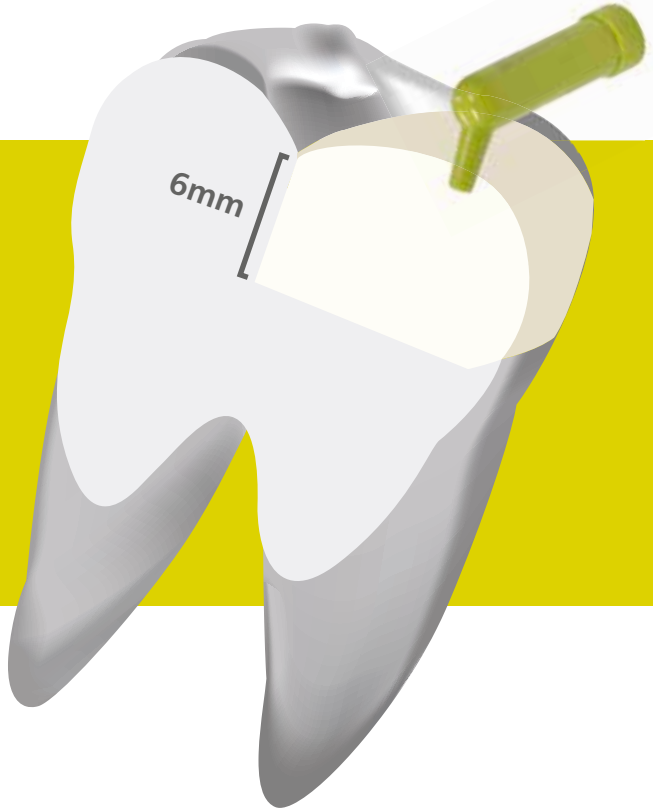

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DON'T REDUCE THE PRICE IN YOUR HEAD

ASHLEY LATTER EXPLAINS HOW A 10 PER CENT REDUCTION IN YOUR PRICES CAN ADD UP TO A 29 PER CENT DROP IN PROFIT

ASHLEY LATTER

Almost all of the dentists I have ever coached have reluctantly admitted to being guilty of the following scenario. Faced with quoting a price for a treatment, they have started off with a figure of £400, which by the time they've actually uttered the words, has somehow come out as just £350. For some inexplicable reason, they've found the prospect of talking money so uncomfortable, that they've actually offered a discount, without even having been asked for one! In this case a whopping £50 – the equivalent of almost 15 per cent.

Those same dentists have also admitted to carrying out a basic procedure free of charge because it would only take them a few minutes to complete.

SOUND FAMILIAR?

Whenever I deliver any of my courses, I am staggered by the number of cases of undercharging that are revealed. At a recent ethical sales course, one of my clients described how he used to knock £30 off each filling. His price listed it at £130 but he would instead ask for just £100. This represents a substantial (23 per cent) reduction, which patients hadn't ever requested. It means that your patient is getting a discount and they don't know about it. If you are going to play the above game, at least tell them that they have had a discount.

By exploring this one example alone, we calculated that it is costing his practice around £10,000 per year! This particular dentist had only been in business for five years but when I pointed out that he'd already lost £50,000 through this one unnecessary discount, he was stunned. He was then ashamed to admit that there were many other treatments where he would regularly undercharge his patients; by now though he was far too embarrassed to admit what they were.

On my programmes I often discuss a concept called the "10 per cent rule". It concerns the harm that a regular discount can do to a business. I ask the question: "What does a 10 per cent reduction in price do to your margins?" Most dentists believe that it will equate to a 10 per cent reduction in profits, but the reality is much worse!

HERE ARE SOME EXAMPLES OF THIS IMPORTANT CONCEPT:

For every £100 of sales, if your costs are £65, it leaves a gross margin of £35. If you were to consistently reduce your prices by 10 per cent it would mean your sales are now reduced to £90, while your costs will remain unchanged. Your gross margin will then become £25.

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I ASK: "WHAT DOES A 10 PER CENT REDUCTION IN PRICE DO TO YOUR MARGINS?" MOST DENTISTS BELIEVE THAT IT WILL EQUATE TO A 10 PER CENT REDUCTION IN PROFITS, BUT THE REALITY IS MUCH WORSE!

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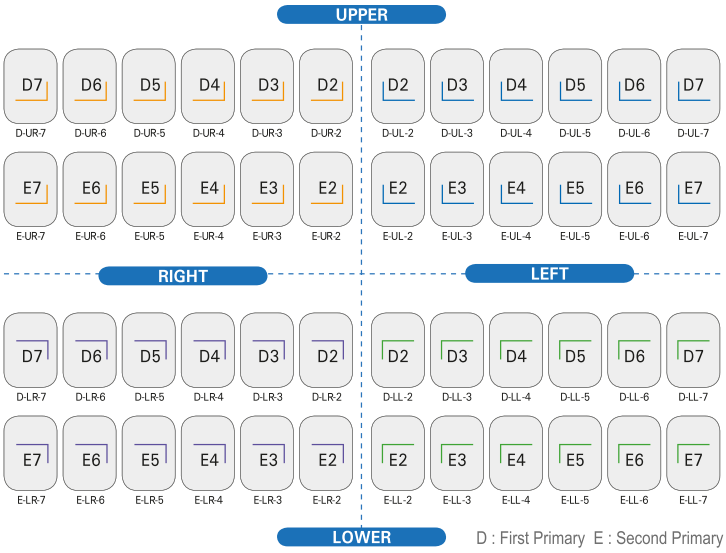

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It means that in effect your profits will have been reduced by a staggering 29 per cent! In this case therefore a 10 per cent reduction in price is equal to a 29 per cent reduction in profit. I am certain that most of you have heard the phrase: "Turnover is vanity, and profit is sanity."

Now let's look at another example of rising costs. The introduction of additional bureaucracy, such as Care Quality Commission south of the border, and a significant rise in overheads over the past few years, have had a major impact on dental practices. Using similar simple figures as before, let's assume that your total sales are £100, while your costs are £65, again leaving a gross margin of £35. Costs then go up to £70, the equivalent of a 7.7 per cent increase. If your prices don't increase to reflect this, then the gross margins will come down from £35 to £30. That equates to a drop of around 15 per cent.

These examples demonstrate very clearly that even a small differential in cost can have a dramatic impact on profit. Many dentists I've spoken to have reacted to the ongoing recession by freezing their prices, despite an increase in their overheads. They are fearful that any increase in price would risk losing their patients altogether. Worryingly however, by not increasing prices to keep in line with rising costs, can in time only lead to bankruptcy!

Recently over dinner, a dentist who was half way through my two-day 'Ethical Sales & Communication Programme' admitted to me, because of the credit crunch, that he had not increased his prices for five years. During this time his costs had risen significantly, and his take home decreased significantly.

He was in mid 50s, was working incredibly long hours, with very little time off and, he was extremely miserable. Yet a small increase in his prices would make a significant difference to his bottom line, to his self-worth and also allow him to take some time off and invest in the practice. Because of the loyalty and good will of his patients, I very much doubt whether they would be many complaints either.

STOP REDUCING THE PRICES OF YOUR TREATMENT IN YOUR HEAD. MAKE SURE THE PRICE THAT'S IN YOUR HEAD IS THE SAME ONE THAT COMES OUT OF YOUR MOUTH

IN CONCLUSION

1. Stop reducing the prices of your treatment in your head. Make sure the price that's in your head is the same one that comes out of your mouth.
2. If you do give a discount, at least tell the patient.
3. I am not an accountant, but get a handle on your costs. Know your numbers.
4. Make sure that you regularly review your price structure. If you don't, it will have a serious impact on your bottom line.

ABOUT THE AUTHOR

Ashley Latter is internationally renowned for helping dentists and their teams improve their communication and ethical sales skills, so that practices can create more opportunities to deliver the dentistry that they love to do and their patients want. He writes a fortnightly email newsletter that is read by more than 12,000 dentists worldwide. To register for this free of charge and to read other articles similar to this topic, please visit his website www.ashleylatter.com

STAY OR GO?

IF YOU DECIDE TO REINVEST THE POT ELSEWHERE WILL YOU LOSE OUT OR WILL YOU BENEFIT? IT'S A TAXING QUESTION, SAYS OUR FINANCIAL EXPERT

ALASDAIR MacDOUGALL

SHOULD I STAY OR SHOULD I TAKE MY PENSION IN ONE GO?

The April 2015 pension changes mean that it is now possible to take your entire pension fund as a lump sum to spend as you wish. But, there may be considerable tax implications in doing so. The first 25 per cent of the cash you withdraw from your pension pot will be tax-free, the rest will be taxed as income at the relevant tax rate. However, there may be charges for cashing in your entire fund, and not all providers may offer this option.

Furthermore, some pension companies may require that you take independent financial advice before cashing in your entire pot. The main thing you will need to consider when thinking about taking all of your pension in one go is your tax situation.

Where your combined sources of income along with your pension pot will exceed £150,000, you will pay tax at the highest rate of 45 per cent. It is likely that you will pay tax on your pension at source via PAYE – this could mean you are using an emergency tax code and you will later need to claim back any overpaid tax. Spreading withdrawal of your pension pot over a number of years can greatly minimise the amount of tax you will pay and mean that your tax-free entitlement is also spread over several years.

WHEN TO THINK ABOUT DRAWING YOUR ENTIRE POT

It may be worth considering taking out your entire pension pot if you need the money quickly, if you are suffering poor health and a guaranteed income for life might not be appropriate, or if you have multiple pension pots and want to cash in one or two to give you more retirement income from the beginning.

TAKING YOUR ENTIRE POT MIGHT NOT BE THE BEST OPTION

Taking out your entire pension pot might not be the best option where it is likely you will spend your entire retirement savings in a short amount of time; you are keen to avoid a large tax bill; you would like a regular income for yourself or for your spouse and any dependents after you die.

REINVESTING YOUR PENSION POT: WILL I GAIN OR LOSE?

Research conducted by MGM Advantage earlier this year shows that almost one third of people will look to reinvest their pension pot elsewhere after withdrawal. However, MGM has warned that doing so may substantially reduce its value. Although the figures also demonstrated that only 13 per cent of those surveyed intend to withdraw more from their pension than the tax-free allowance, 28 per cent of these people are planning to invest their pension money elsewhere. Be warned, however, that this could have drastic implications in terms of investment value.

Other investments do not enjoy the same tax benefits as a pension and also you would have to be sure of your new investment's performance to ensure you would benefit from it. Furthermore, you would not receive the same guarantees as you would get with an annuity.

The tax implications of such a move might not be worth the pay off. The first 25 per cent of your pension pot will be tax-free, however the rest will be taxed as income. This means you may be paying more in tax than you reap from your investment.

Don't forget what a pension is. A pension is a tax-efficient, long-term savings vehicle, designed to provide tax-free cash and income in retirement. The phrase "try not to outlive your money" was never truer than it is today. Currently, personal pension contributions can attract tax relief up to 45 per cent, so a gross contribution of £40,000 after 20 per cent basic rate tax relief at source, and up to a further 25 per cent relief claimed via self-assessment can net down to £22,000. Funds are invested in a tax favoured environment and can be accessed in full from age 55.

The new pension freedoms also facilitate generational planning, enabling pension funds to be passed to children and grandchildren. Unused pension funds will never form part of an Inheritance Tax calculation, as long as they remain within the pension plan wrapper. Clients must think very carefully and seek independent, professional advice before electing to take significant lump sums.

"DON'T FORGET WHAT A PENSION IS. A PENSION IS A TAX-EFFICIENT, LONG-TERM SAVINGS VEHICLE, DESIGNED TO PROVIDE TAX-FREE CASH AND INCOME IN RETIREMENT. THE PHRASE "TRY NOT TO OUTLIVE YOUR MONEY" WAS NEVER TRUER THAN IT IS TODAY"

ABOUT THEAUTHOR
Alasdair MacDougall is director of Martin Aitken Financial Services. To contact Alasdair, call 0141 272 0000.

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NSK has built a solid reputation for quality products and service, which are recognised globally as some of the best and most innovative across the industry. By taking advantage of its rental scheme, you could be using state-of-the art handpieces. NSK's only stipulation is that, if renting handpieces, clinicians must have access to an NSK-approved care and maintenance unit such as the NSK Care3Plus, iCare or iCare+, W&H Assistina, KaVo QUAT-TROcare, or use NSK PANA SPRAY Plus care and maintenance lubricant oil.

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The waiting room and reception, and the corridor leading to the surgeries

FEEL AT HOME

SPECIALIST ORTHODONTIST GAVIN CAVES NOW HAS A SPACE HE CAN CALL HIS OWN AFTER MOVING INTO HIS BRAND NEW PRACTICE CONVERSION

BRUCE OXLEY

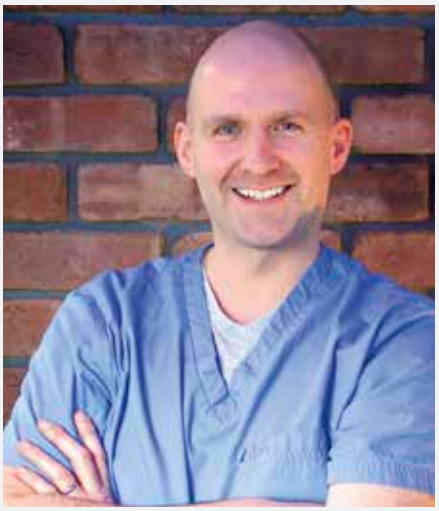
After 15 years as a specialist orthodontist, Gavin Caves has now moved into his brand new state-of-the-art practice conversion of a traditional sandstone property (c1900), right in the centre of Haddington.

Gavin qualified from Edinburgh in 1993, obtaining the class prize in orthodontics, and after a year of house jobs at the Edinburgh Dental hospital he worked for two years as a maxillofacial senior house officer, initially at the City Hospital in Edinburgh and then at the Queen Margaret Hospital in Dunfermline. He then undertook his VDP year at the dental practice at Southfield Loan in Edinburgh.

In 1997, Gavin was accepted onto the three-year post-graduate specialist orthodontic programme at the Glasgow Dental Hospital – qualifying in 2000 with a Membership in Orthodontics (MOrth) from the Royal College of Surgeons of Edinburgh and an MSc from the University of Glasgow.

Gavin then spent eight years working as an associate at Scottish Orthodontics while also teaching the orthodontic postgraduates at the Edinburgh Dental Institute. In 2008 he left Scottish Orthodontics and moved to Edinburgh Orthodontics, but still kept up the clinical teaching at the EDI.

In 2010, at the "tender age of 39", a vision was born in Gavin's mind of one day finally having his own small and friendly practice. He began by looking around to pinpoint an area that was underserved by a specialist orthodontist service and he soon zeroed in on the historic East Lothian town of Haddington.



It just so happened that a new NHS practice with an OPG machine had opened a few months earlier in the town, and so Gavin approached Ali Bilgrami, the practice owner, to discuss using one of his surgeries as a starting point.

On 7 October, 2010, Gavin Caves Orthodontics was born – the same day as his daughter's birthday, hence always remembered! (Hannah is now coming up for 10).

As referrals increased and word of mouth spread, Gavin gradually grew his business in Haddington and he finally left Edinburgh Orthodontics in January 2014, going full time in his new practice.

The dream had always been to have his own building but the problem he encountered was that there were precious few available buildings in the town and those that were available often weren't suitable for a dental practice – either small shop fronts or huge ex-council buildings.

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However, Gavin was alerted to a former council building that had come onto the market in late 2013 and he went to have a look. Unfortunately, the space was just too big for what he needed, not to mention flats above which he had no interest in acquiring. Despite its size, Gavin knew there was potential there as it was in a great location. So, he asked the council to let him know who bought the building on the off chance that they might be interested in leasing or selling part of the premises to him in the future.

In early 2014, Gavin was put in contact with the buyer who was in the process of setting up a new soft play centre in the building and was interested in selling part of the unit to him. New walls were built to partition off the new space and title deeds were drawn up.

It took until September 2014 before the sale of Gavin's part of the premises went through due to issues with separating the space and getting all the services, such as water and electricity separated off into the new sections.

Gavin had been recommended SAS Shopfitters by colleagues and plans were already under way by the time he got the keys in September last year. Dereck

Lang and his team at SAS were the main contractors at the new practice and undertook all the work from the flooring and electrics through to the cabinets, seating and plumbing.

Initially the building was all open plan, with only had two internal walls, but SAS divided off the space to incorporate a reception and waiting room with staff quarters to the rear, including toilet, shower and locker room, two surgeries, office (which was plumbed and wired to be converted into a third surgery in the future) and LDU.

The branding and many of the ideas and inspiration for the colour scheme and materials came from Gavin's friends Jane and Doug MacDowall, owners of teviotcreative.com It was Doug's idea to have the wall feature in the waiting room,

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Bilal Khan

"My 14 year old daughter has just completed 18 months of braces to correct and perfect her smile and she is over the moon with the results. I can't praise Gavin and his team highly enough. They were kind, understanding, professional and efficient throughout the whole time we were under Gavin's care and, despite initially being a very nervous patient, my daughter came to love her trips to the orthodontist. We are very happy and grateful parents!"

Jo Lee

"My daughters get anxious about all dental appointments and were very worried about a visit to the orthodontist. However Gavin immediately put them at ease and reassured them and talked them through the whole process. He has a natural flair with kids and my daughters were so impressed by him they said they wished he was their normal dentist too. That's a big compliment coming from them as they are not easily impressed!"

Lorna Hill

ORTHODONTIC SPECIALIST GDC: 68917
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LDU complete with washer disinfector and autoclave

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which Gavin admits has definitely grown on him.

The recessed ceiling lighting in the waiting room was a spark of inspiration from Dereck. Gavin explained that he was after a warm and welcoming feel to the practice to make his patients feel at ease and also to give him and his colleagues a nice environment to work in. He said: "SAS were fantastic and I'm really pleased with how it has turned out. Like most orthodontists, I am quite fastidious and I was eager to get it looking just right.

"SAS made the whole experience easy and they were on time and on budget, which was great. I couldn't have asked for more." The whole build took three months.

The surgeries have been kitted out with white corian surfaces and Belmont chairs with LED lights and handpieces by NSK. Throughout the whole practice there is wood-effect Karndean flooring, which gives the surgeries a warmer and less clinical feel.

In the LDU Gavin has installed a top-of-the-range washer disinfector and a W&H Lisa autoclave – which takes the water from the mains, distills it and then drains itself after each cycle – so the nurses never have to fill or empty it, much to their delight.

He also has an ultrasonic bath as a back up, although it spends its time being lent to dental colleagues in East Lothian whose washer disinfectors have broken down!

The reception area has a self check-in touch screen that has been a hit with the younger patients. If the reception is busy, patients can sign in and sit down without waiting.

Gavin is the only orthodontist at the practice and he sees every patient. To help manage the increasing number of patients, his former dental nurse Gemma Smith is currently training as an orthodontic therapist at the Edinburgh Dental Institute as well as in the practice. He also has three nurses: Claire Igoe, who also covers reception; Steph Gray and Emily Weir.

Asked if he would do it again, Gavin said: "Well, hopefully I won't have to do it again! But it has been a great experience. It was really exciting seeing it all come together and I am just delighted with the outcome.

"It's just great to finally have my own practice in my own building and we feel really at home already. The patient's love it as well and I hope that I can continue to provide a great orthodontic service for my patients and colleagues for many years to come."

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The dental associate – self-employed or not?

LANDMARK TRIBUNAL FINDING MAY HAVE FAR-REACHING IMPLICATIONS WITH HMRC

CRAIG STIRLING AND DAWN DICKSON

Speaking at the 2015 Scottish Dental Show, Craig Stirling and Dawn Dickson, from Davidson Chalmers' specialist dental team, addressed the main issues emerging from the landmark employment tribunal decision in Rodrigues v Whitecross Dental Care Limited and Integrated Dental Holdings Limited.

The tribunal considered whether a dental associate engaged by Whitecross Dental Care was genuinely self-employed or whether he was, in reality, an employee entitled to the employment protections afforded by UK employment law.

The tribunal found that, notwithstanding the nomenclature adopted in the Associates Agreement, the relationship between Whitecross and Rodrigues was in fact a contract of employment.

This decision could be of profound significance for the dental profession. It is one of only a handful of reported employment decisions to have expressly considered the employment status of dental associates.

The most significant repercussions for the profession could well be the tax implications of the decision, should HMRC seek to challenge the self-employed status of dental associates.

Despite challenging the self-employed status of contractors and consultants in other sectors (such as construction and IT), HMRC has appeared to accept that dental associates are self-employed.

Could this be about to change in light of the Rodrigues decision?

The likelihood of future challenge from HMRC would appear to be quite high. The most important factors in determining employment status, according to the HMRC's own guidance, are the very same factors which the Rodrigues tribunal considered in such detail.

The Rodrigues decision should act as a clear call to action for principals and associates alike. Steps should be taken now to revisit associate agreements and their accompanying working practices. Adopting the BDA style for associate agreements is certainly no guarantee of safety.

Obtaining advice from a specialist dental solicitor regarding your associate agreements is a must.

Davidson Chalmers

MORE INFO

Craig Stirling is a Partner at Davidson Chalmers. To contact him, email craig.stirling@davidsonchalmers.com or call 0131 625 9191 Davidson Chalmers are legal specialists and members of the Association of Scottish Dental Professionals, an association of dental experts dedicated to supporting the dental profession in Scotland.

Pensions v ISAs

JONATHAN GIBSON

With the recent shake up to pensions and some changes to ISAs there has been a lot of talk as to where your long-term savings are best accumulated. The answer is… it depends.

The ISA benefits are clear: they offer full control over your investments and unlimited access; they're simple to understand and are ideal for disciplined savers. For those looking for savings and investments that are tax efficient, with no need to declare them on your tax return, and no further tax to pay on any income you receive, an ISA is a perfect choice.

In terms of tax considerations alone, however, pensions qualify as the most efficient investment there is. Higher-rate taxpayers get up to 40 per cent tax relief on contributions, with additional rate taxpayers receiving up to 45 per cent tax relief. The ability to withdraw 25 per cent cash, tax free, from age 55, also make pensions highly tax efficient. Many employees also benefit from employers' contributions on top.

Exit on death raises different tax issues from those which apply when personally drawing benefits. Spouses can benefit from an increased ISA allowance equal to the value of the deceased spouses ISA, while the pension will become exempt on death before age 75. From age 75 onwards the pension suffers tax, potentially at a higher rate (45 per cent flat rate for 2015/16 and marginal tax rate in the following tax years) than the ISA (40 per cent IHT regardless of age).

Politics is a big imponderable as pension tax reliefs are the most obvious low-hanging fruit for the Treasury to pick: the tax cost of income tax and NICs relief for pensions in 2012/13 was £50 billion, while income tax raised on pension payments was £12bn.

In comparison, the outlay for ISAs is much smaller, mainly because there is no upfront tax relief. The 2013/14 figure for the income tax cost was £2.85bn – no amount is given for the CGT exemption. Even the Budget 2014 uplift in contributions and the cash ceiling limit will add less than £0.6bn to the Exchequer outlay by 2018/19, according to HMRC.

Anyone looking for a quick table of numbers to compare pensions and ISAs will be disappointed. There are so many variables that, in practice, an examination of individual circumstances is what is needed.

Whatever your strategy, remember both ISAs and pensions are simply tax wrappers. It's the underlying investment decisions that make the most difference.

However, making the decision to invest is what really matters. Using your tax allowances is just a bonus with the additional benefits of limiting how much of your hard-earned money Chancellor George Osborne gets his hands on!

MORE INFO
Jonathan Gibson is the director of wealth services at AAB Wealth.

The shifting balance of the dental practice market

CHRISTIE + CO'S SPECIALIST ADVISER IN THE DENTAL SECTOR TAKES A CLOSER LOOK AT THE MOST NOTABLE THEMES IN THE PRIVATE PRACTICE MARKET

SIMON HUGHES

The shape and activity of the dental sector is fascinating, with as little as 10 per cent of practices in corporate ownership. This is a particularly low figure when compared to other healthcare sectors such as pharmacy and social care. However, as the corporates accelerate their acquisition plans and become more competitive this figure is likely to increase.

The private practice sales market in particular is one that is seeing the most constant and rapid changes.

While historically, private practices have been seen as less attractive to purchasers than mixed or NHS practices, there has recently been a recognised increase in interest, given the right circumstance and location.

Speaking to practice purchasers on a regular basis, we tend to hear the same things, whether from the most inexperienced first-time purchaser or a more seasoned corporate or group operator. Until recently this would be: "I'm looking for a mixed practice with an NHS contract of at least £300,000, a good UDA rate and potential to grow private income."

However, within the past few months, as NHS and mixed practice values continued to be driven higher due to what is often perceived by many to be "guaranteed income", we have noticed a steady increase in enquiries for quality private dental practices. In spite of the average goodwill value of these practices being significantly lower than for mixed or NHS, they are beginning to be regarded as better value for money.

With years of experience valuing businesses across many market sectors and experts located across the UK, Christie + Co has an unparalleled understanding of the factors that influence the dental sector, and our experts can help you achieve your practice ambitions.

Christie+Co

MORE INFO
To discuss how Christie + Co might help you achieve your future plans, please contact Simon Hughes, director and head of medical, on 020 7227 0749.

Measure what matters

IAN MAIN

I thoroughly enjoyed this year's Scottish Dental Show and commend the organisers for another great event and for improving every year. It was a privilege to lecture again this year and I focused on how to 'Explode with Growth' in your practice.

The feedback was very positive and delegates found that the key message, to paraphrase the McKinsey Maxim, was to 'measure what matters' in the practice and to design and consistently record the performance of the key performance indicators (KPIs) systematically.

I shared with the audience some case studies of dramatic improvements made by adopting this simple methodology. In some examples the difference at net profit level was as much as £300,000! I also gave some insight into the numbers I would suggest as the 'killer KPIs' every practice should focus on and the Scottish average benchmarks for achievement in each.

Are you confident your measurement systems are efficient and well targeted? Do you understand if you are performing well (or not) against the sector averages? I'd be delighted to give you a free bespoke benchmark report on your current performance. Just drop me an email or give me a call and I will be happy to commission your report without delay or obligation. I'd love to help you to make a real difference in the practice.

On a different note, I was hugely honoured to be recognised as Scottish Accountant of the Year at the Scottish Accountancy & Finance Awards 2015 on the 15 June. To achieve this accolade within the profession while focusing on the dental sector means a great deal to me. I look forward to continuing to strive to deliver leading-edge services in the dental sector and to building on this success.

STARK MAIN & CO DENTAL

MORE INFO
Please get in touch by emailing ian@starkmaindental.co.uk or phoning 0131 248 2570

Dental dilemma

HOW MUCH DIFFERENCE WILL BECOMING INCORPORATED MAKE TO YOUR BUSINESS?

STUART PETRIE

Many dentists may have considered the potential advantages of incorporating their practice into a limited company.

Prior to becoming incorporated, it is important to examine carefully whether there will be any impact on entitlement to certain NHS benefits. Seniority payments, vocational training allowances, remote area allowances and Scottish dental grants for practice improvement may no longer be available, and as a result any potential loss of these entitlements must be carefully considered.

However, if appropriate, the key taxation benefits and incentives that follow as a result of incorporating can be significant.

Sole traders and partners will pay income tax at up to a 45 per cent tax rate on their profit share regardless of the level of drawings required. This means that there is potentially limited scope to mitigate income tax at additional rates or to retain personal allowances. There are means of reducing tax exposure through the use of personal pension contributions or charitable donations, but these items must also be posted to drawings as personal expenses.

Alternatively, by operating as a limited company, business profits will be taxed at a flat rate of 20 per cent – potentially producing considerable annual tax savings in comparison to owners of unincorporated businesses. Moreover, profit can be extracted through a number of options, including salary, dividends, loans and employer pension contributions.

Therefore, in addition to lower tax rates, flexibility also exists in respect of how or when profits are extracted, providing opportunity to mitigate and defer personal tax payments. This means that any profit in excess of current requirements can either be reinvested into the business or retained as reserves for taxable distribution to shareholders at a later date.

Looking forward, Entrepreneurs' Relief is a valuable tax relief available when the time comes to sell or wind up the business. A number of qualifying conditions do exist but, where these conditions are met, the relief reduces the rate of Capital Gains Tax payable to 10 per cent up to a maximum lifetime limit of £10 million, as opposed to the 28 per cent Capital Gains Tax usually payable by higher rate taxpayers. It is therefore a highly valuable relief when considering any exit strategy.

As can be seen from this article, there is no existence of 'one size fits all' with regards to incorporation and there are particular complexities for dental practices. All potential factors should therefore be considered to ensure that it is in the best interests of the practice and the dentists concerned. However, with the right set of circumstances and professional advice, there can be major tax benefits for practice owners.

MORE INFO
Stuart Petrie is the Private Client tax senior manager at Anderson Anderson & Brown LLP.

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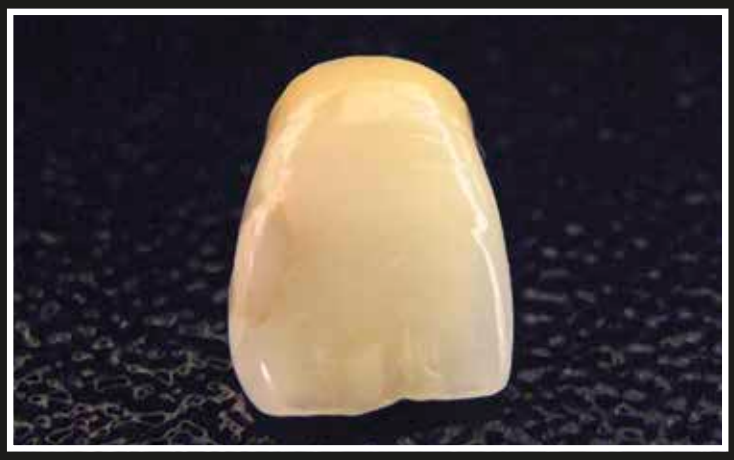

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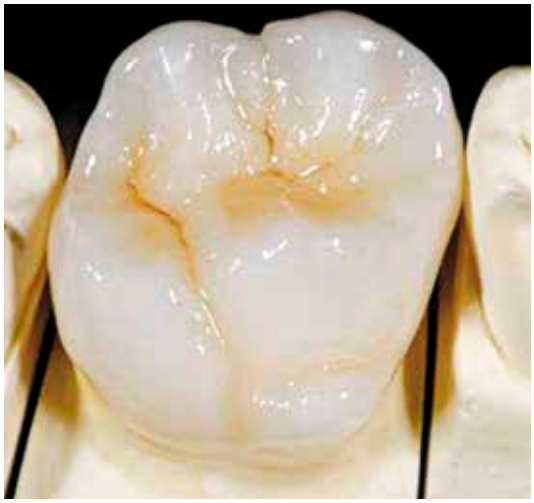

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MHRA registration number CA013738

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Heather Arni

"The treatment I received from staff at this clinic was first class.
Diane was very friendly and helpful and put me at ease from my first visit.
Rob, who was the Clinical Technician that I saw was excellent. He took time to explain my options, prices and benefits. Rob also asked for a photo to get an idea of what my teeth had been like which was a great idea.
I was delighted with the service I received from start to finish and would certainly recommend the clinic."

Jo Peffers

Robert Leggett
Clinical Dental Technician
RDT Dip CDT RCS Ed

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BE THE CDT

CLINICAL DENTAL TECHNICIAN ROBERT LEGGETT DESCRIBES HIS MISSION TO PROVIDE GREATER TRANSPARENCY TO THE ROLE OF THE CDT

ROBERT LEGGETT

In November 2012, Scottish Denture Clinic opened in Edinburgh city centre. There have been some expected outcomes and some twists in the road since then. It has been a very challenging, but rewarding two and a half years, and we are looking forward to continuing to grow our business.

One of the biggest challenges facing a clinical dental technician (CDT) while working remotely is finding a general dental practice to work alongside in order to fulfil the GDC scope of practice. As a CDT cannot make partial dentures without a treatment plan they must have a referral path for partially dentate patients.

We needed to find a practice willing to work alongside the newest member of the DCP team. One of the hurdles to this was the wider dental team being unsure of what a CDT is. To a certain extent this is still the case, however, in the five years since I qualified as a CDT I have tried to champion the CDT profession to allow greater understanding of the role. It is now apparent that understanding and attitudes to the CDT role are now changing. There was a certain level of scepticism about the role possibly due to some dental technicians working as denturists illegally in the past. Hopefully this is a dying practice with education pathways available to allow dental technicians to do the appropriate training.

It is our goal to be as open and transparent as possible. We spent time visiting the surrounding practices and giving presentations in our clinic about a CDT's role and Scottish Denture Clinic's ethos; explaining the potential advantages of working in conjunction with a CDT.

For the most part, Scottish Denture Clinic was well received and it was more about selecting a practice we felt we could have good communications with and most importantly give the best care to our patients. When we officially opened our doors to the public in January 2013, it took 30 minutes for our first enquiry and subsequently our first patient in the diary.

As part of our initial consultation with new patients, we sit in a comfortable, non-clinical environment where patients can feel at ease to express their expectations and past problems and concerns before sitting in the dental chair. One of our main advantages is we have more time to spend with our patients. Time is key when making dentures for a patient whom it may be difficult to achieve patient satisfaction within the time constraints of general practice. It also makes sense that to achieve the best result a CDT has full responsibility, both clinical and technically, to meet the patient's high expectations.

As it happened, our first patient was edentulous so there was no need for a referral just yet but it wasn't long before the first partially dentate patient arrived and the process of involving more of the dental team began.

We began working with Ivy Dental, which is only a short drive for Scottish Denture Clinic patients. One of the most important factors is good communication. It has to be clear to the patient why they are being referred and what to expect at the referring practice i.e. who will be seeing them, what their appointment will involve, will there be a fee, and what will happen next. The other line of communication is between myself and the GDP, it is important the GDP knows why the patient has been referred to them. Once the GDP has created the treatment plan and design for the patient, it is essential that this information is passed back to the CDT to continue treatment.

We have been very fortunate with Ivy dental and the communication couldn't be better, we regularly do complex cases where the dentists will visit the lab to be involved in the technical stages. We also attend Ivy to see patients with the GDP on regular occasions, especially for implant work.

Scottish Denture Clinic also accept referrals from general practice and it has been reassuring that the number of dentists referring patients continues to grow. Scottish Denture Clinic advertise consistently over a range of different media and patients travel to see us from the length and breadth of the country.

Since Scottish Denture Clinic opened in November 2012 with a staff of two, we have grown to a team of 10. The team includes two CDTs, four prosthodontic technicians, two crown and bridge technicians, a practice manager and receptionist. We have clinics in Edinburgh and Glasgow and we also work sessions in specialist and general practices in Leith, Glasgow and Ayr.

In the next issue Robert will go into more detail on the type of work and different technologies that are used at the clinic. To contact Scottish Denture Clinic, call 0131 228 6650 or visit www.scottishdentureclinic.co.uk

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For more information about gigazyme foam, email mail.uk@schuelke.com or visit www.schulke.co.uk

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Created with biocompatible materials for maximum stability, the FCZ Implant Crown allows you to increase the number of high-quality screw-retained restorations you place.

You can also use the FCZ with the innovative Angulated Screw Channel (ASC) abutment and OmnigripTM tooling.

What's more, delivering natural-looking tooth colour with eight shades available, the FCZ Crown is easily adjustable.

To find out more, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com

TRANSFORM DIAGNOSES AND TREATMENTS

The CS 8100 OPG unit from Carestream Dental offers a perfect blend of simplicity and sophistication. Designed to produce the highest quality images in the shortest amount of time, the CS 8100 delivers crystal clear, optimally exposed images in seconds.

Dr Robert Watson (pictured) of Dollar Street Dental uses the CS 8100. He said: "Our new CS 8100 3D has transformed the way we diagnose and treat patients.

"We are a general practice with a special interest in implants and endodontics. Both procedures are transformed by viewing the proposed treatment in a 3D image. There is no steep learning curve and the huge benefits are instantly available. Well done Carestream for bringing quality panoral and CT scanning to the general practitioner at a cost that makes sense."

For more information, call 0800 169 9692 or visit www.carestreamdental.co.uk

NEW HEAD OF WORLDWIDE PRODUCTION

Markus Heinz is the new chief production officer of the Ivoclar Vivadent Group. He succeeds Wolfgang Vogrin, who retired in July.

Markus, who has comprehensive management experience, has been working for Ivoclar Vivadent since 1985. He took over the responsibilities for the global tooth production in 2002 and, since 2014, he has also been responsible for the production site in Schaan/Liechtenstein.

Robert Ganley, CEO of Ivoclar Vivadent, praised Markus Heinz as "a proven production expert, manager and leader".

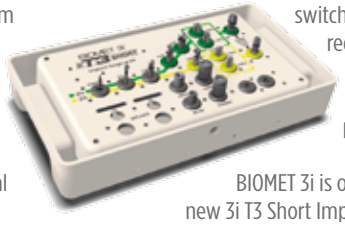
Robert, and chairman of the supervisory board Christoph Zeller, thanked Vogrin "for his contribution as manager to the rapid development of Ivoclar Vivadent on a global level".

The build-up of the ceramic production centre in USA as well as the expansion of numerous other production sites can all be credited to the retiring Vogrin.

NEW 3I T3 SHORT IMPLANT: EURO LAUNCH

BIOMET 3i is pleased to announce the launch of its new 3i T3 Short Implant in Europe.

The new 3i T3 Short Implant is available in 5mm and 6mm lengths and 5mm and 6mm diameters. The reduced length makes it an option for areas of minimal bone height without the need for vertical grafting procedures and the blasted and acid-etched 3i T3 surface creates an average mean surface roughness of 1.4Qm.



Also, the dimensions of the surgical instrumentation and the 3i T3 Short Implant provide a tight implant-to-osteotomy fit.

And manual platform switching is recommended for crestal bone preservation.

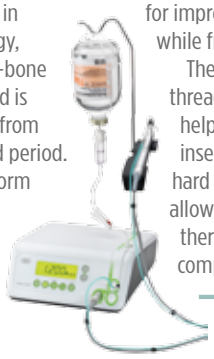
In addition, BIOMET 3i is offering a new 3i T3 Short Implant compact surgical kit designed specifically to support site preparation and placement of 3i T3 Short Implants.

To find out more, call 0800 652 1233.

BEHIND EVERY SUCCESSFUL IMPLANTOLOGIST IS AN IMPLANTMED... NOW ON SPECIAL OFFER

The Implantmed from W&H gives you the most effective tools for oral surgical procedures in the fields of implantology, microsurgery and small-bone surgery. The Implantmed is currently on promotion from only £2,300 for a limited period.

It allows you to perform implant procedures with maximum precision. The unit guarantees longer working without fatigue, thanks to the lightweight, yet powerful motor and the ergonomically shaped contra-angle handpiece. The easily operated foot control allows for improved infection control while freeing up both hands.



The integrated automatic thread cutter function helps you especially when inserting implants into hard bone. This function allows for thread tapping, therefore minimising compression of the bone.

To find out more, call 01727 874 990, email office.uk@wh.com or visit www.wh.com

DOLBY AWARDED DENTAL CHAIR CONTRACT

Scotland's leading dental products and servicing company, Dolby Medical, has won the contract from world-renowned Italian dental solutions business Cefla to supply and service the Anthos range of dental chairs in Scotland.

Anthos dental chairs are recognised worldwide for their exceptional quality, style and configurational flexibility.

Derek Gordon, managing director of Dolby Medical, said: "Anthos is a natural partner for us. As part of the Cefla Dental Group, Anthos is very highly regarded and Cefla is very selective when deciding who to do business with.

"Our experience, expertise and engineering skill positions us perfectly to sell, install and service these dental chairs. The dental chair is at the heart of every practice and is critical to patient comfort and care so keeping this equipment in top condition is of exceptional importance."

ZIMMER BIOMET MERGER ANNOUNCED

David Josza, Zimmer Biomet general manager dental division, said: "An important milestone was reached between Zimmer and Biomet. The two companies have joined forces to form Zimmer Biomet, a leading innovator in musculoskeletal healthcare.

"I want to reinforce our commitment to providing you with high-quality products, service and support. We put our customers first and will continue to actively pursue ways to earn your trust and exceed your expectations. We look forward to continuing the strong relationships already established, and expanding them in the future.

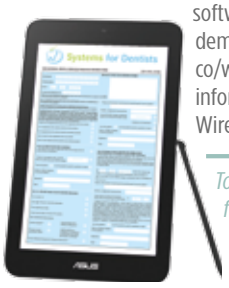
"Zimmer Biomet recognises the importance of education and has established state-of-the-art training centres throughout the world. We offer a broad spectrum of educational courses each year, focused on the latest clinical developments in implant dentistry. By unifying resources as Zimmer Biomet, will be able to provide you with premier education to fit your needs."

For more, visit www.zimmerbiomet.com or call 0800 652 1233

SAVE TIME, REDUCE ADMIN – GO PAPERLESS

At the Scottish Dental Show back in May, one of the UK's leading dental practice management software solutions specialists, Systems for Dentists, demonstrated how it is revolutionising the way to a paperless dental practice.

Its latest product, Wireless Signature Pads, reduces admin, saves time and money, and is a reality for forward-thinking dental practices looking to streamline daily management.



The signature pad technology is creating a buzz among dentists in Scotland, keen on allowing patients to read and sign all mandatory documentation electronically.

Interested in going paperless? Download a full demonstration of the Systems for Dentists software at www.sfd.co/demo or visit www.sfd.co/wsp.html for further information on the Wireless Signature Pad.

To find out more, or for an appointment, call 0845 643 28 28. Quote SDMJuly.

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