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Editorial

WITH BRUCE OXLEY, EDITOR →
Get in touch with Bruce at
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A RISE BY ANY OTHER NAME

Hands up who was surprised at the DDRB's latest news?

I don't think there was a dentist in Scotland who was surprised at what the BDA has called a "meagre" one per cent uplift recommended by the Doctors' and Dentists' Review Body.

Disappointed? Perhaps. Disillusioned? Probably. But surprised? Not likely.

The government's own figures have revealed that net profits for practice owners in Scotland are down by 29 per cent in the last five years and 31 per cent for associates. Practices in Scotland also have the highest expenses to earnings ratio in the UK at 70 per cent as well as having the lowest turnover.

No wonder then that last year's SALDC survey found that nearly 90 per cent of GDPs are "adversely stressed" and are progressively becoming more stressed.

And, while concerns over receiving the dreaded GDC letter will be high up many clinicians lists of fears, it is the day-to-day financial pressures that seem to be wearing the profession down.

This is not good for the profession and it is clearly not good for patients either. There are thousands of committed and talented NHS dentists in this country but for how much longer? As our round table discussion hinted at in the January issue, is the government's reluctance to fund a workable NHS dental system a sign that they want dentistry out of the NHS?

Dentists have been saying for years that the SDR is not fit for purpose and it needs to be overhauled as soon as possible. However, even if we didn't have an election coming up, not to mention the EU referendum, I wouldn't be holding my breath that this will change any time soon.

Elsewhere in the magazine we preview the 2016 Scottish Dental Show, the fifth year the event has been held in Scotland. It returns to Braehead Arena on 13 and 14 May and you can see the full lecture and workshop programme starting on page 24. This year's event promises to be the biggest and best yet, so, if you haven't already, get registering at www.sdshow.co.uk

In this issue we also speak to Eaglesham GDP Irene Black and Jill Gillies from Healthcare Improvement Scotland about the dental arm of the Scottish Patient Safety Programme. The world-leading programme has been producing excellent results in secondary and, more recently, primary are for years and now it is dentistry's turn.

Irene, who many will know from her role at NES working as decontamination lead, is at pains to assure her colleagues that this is not a "tick box exercise" and it should not be seen as another onerous task. She explains that the programme hopes to work with dentists to find and share new ways of working that can help them be more efficient and reduce risks to patients.

Disappointed? Perhaps. Disillusioned? Probably. But surprised? Not likely

I'm sure that's something every clinician in Scotland will agree with and I hope it is successful in its aims.

WE COULDN'T HAVE DONE IT WITHOUT...

1

PAT KILPATRICK
(ON THE REFORMS OF THE GDC)
Pat Kilpatrick is the BDA's director for Scotland. Her role involves negotiating with the Scottish Government on behalf of the dental profession.

2

REBECCA WILSON
(ON THE MS AND ORAL HEALTH)
A graduate of Glasgow Caledonian University, Rebecca Wilson currently works as a dental hygiene therapist in Auchterarder and Comrie.

3

ADITI DESAI
(ON SLEEP DISORDERED BREATHING)
The current president of the British Society of Dental Sleep Medicine, Dr Aditi Desai works in Harley Street and London Bridge Hospital.

4

ADAM MORGAN
(ON DEALING WITH STAFF)
An award-winning training specialist, Adam Morgan has worked with dental practices throughout the UK to help them become more successful.

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HAVING HIS SAY →
Arthur Dent is a practising NHS dentist in Scotland
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INDEMNIFIERS NEED TO BE MORE TRANSPARENT

There is a looming crisis over the high costs of indemnity cover, what is actually covered in the small print and when cover might be revoked

There is a looming crisis in indemnity in this country. Costs south of the border are increasing exponentially, in some cases running well into five figures. This is no doubt due in part to the loss of DROs and the GDC actively advertising for complaints.

What happens if you don't have indemnity cover? Well, it depends who your friends are.

A recent well-publicised case concerned a young dentist who opened a "cold squat" in the south of England in February 2015. The information regarding this particular case was not initially available on the GDC website, and indeed a Freedom of Information request was carried out into this. The practitioner was unable to practise while the GDC considered the matter over a nine-month period.

He has since been restored to the register, although he has been forced to sell his practice to meet his legal fees as he was not covered by his indemnifiers. His case resulted in his local Conservative MP Peter Bottomley presenting a report to a parliamentary select committee in which the charges were described as "trumped up", and went on to criticise the GDC. However, the full report has since been published on the GDC website, and it appears that there were periods when he did not in fact have indemnity, which is now a condition of registration.

It did take rather a lot on investigation to come to this point – money was raised by dentists on GDPUK to assist in this case. It was stated on GDPUK that indemnity had been withdrawn from this registrant when in fact he was correctly not represented as he had not been covered. This has not been made clear to members of GDPUK. I have had sight of correspondence from the expert witness who had helped raise the money, (the GDC felt this was a conflict of interest) in which it is claimed that "sometimes it seems that they have been in trouble with the GDC before and the indemnifiers have refused further assistance". The indemnifiers themselves are keen to point out that their cover is discretionary so can be withdrawn at any time.

Determinations on the GDC website do indicate there is a minority of people who are unrepresented by an indemnifier.

It is not unreasonable to expect indemnifiers to withdraw cover when, for example, someone has clearly sought to mislead a patient, but they need to be transparent with their members.

This is also why a rival company has appeared in Scotland in recent years led by a former dentist turned barrister. Happily for the profession, he has decided to set up his insurance-based cover rather than working for the likes of the Dental Law Partnership. The company's website describes "An experienced dentist with legal expertise at the highest levels, providing expert guidance and support to clients including emergency advice 24 hours a day, seven days a week".

In the current climate of fear... perhaps what does reassure practitioners is inexpensive guaranteed cover

And, after a bit of digging it appears that it isn't just a one-man band and the company offers access to a number of solicitors both in Scotland and England.

The main drive for this company appears to be partly due to the publicity resulting from dentists who have been refused representation by their indemnifiers, as well as reduced costs. The large indemnity organisations do indeed cost, roughly, twice as much. However, there is then access to a wide range of advisors from many different walks of dentistry. But it is discretionary cover.

MDDUS, DPL and the DDU were contacted for comment. The DDU said it doesn't comment on individual cases and DPL said that it would be "inappropriate to comment on cases handled by other defence organisations".

The MDDUS were a bit more forthcoming, however, and sent a long statement highlighting their years of experience and the fact that their prices have dropped in recent years. It also stated that "unlike insurers, we have no small print to hide behind" and that they "use discretion positively to provide assistance and meet claims which an insurer may very well turn down. We do not exclude any treatment, simply ensuring indemnity is related to the practice of dentistry".

In the current climate of fear, with the GDC, health boards and PSD looming large in GDPs' stressors (see the recent survey by SALDC), perhaps what does reassure practitioners is inexpensive guaranteed cover.

The dental defence companies need to watch out!

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SURPRISE INSPECTION PLANS CRITICISED

New powers lack clarity and could put patient safety and professional morale at risk, says SDPC

Surprise inspections of Scottish practices could put "patient safety and professional morale" at risk according to the BDA.

Robert Donald, chair of the Scottish Dental Practice Committee, was reacting to news that NHS boards could soon have the powers to subject dental practices to unannounced inspections.

He said: "The Scottish Parliament is poised to pass regulations that could see practices become subject to unannounced inspections by NHS boards.

"These new powers lack clarity, and surprise inspections could put both patient safety and professional morale at risk."

A statement from the BDA read: "The BDA has alerted dentists that NHS boards could soon have powers that enable them to visit practices without warning.

The BDA SDPC had written to the Chief Dental Officer and the Scottish Government to make dentists' concerns clear about these proposals.

"The Scottish Government decided to ignore our concerns and on 28 January, without any further consultation, laid the amendments before Parliament for MSPs to scrutinise over a six-week period.

"The SDPC is extremely concerned by these developments and has requested an urgent meeting with the CDO to discuss a suitable way forward."

However, a spokesman for the Scottish Government said: "Officials wrote to the British Dental Association (Scotland) on 7 January, with the draft amendment regulations.

ABOVE: Robert Donald, chair of the Scottish Dental Practice Committee

"This is in line with standard practice to inform relevant stakeholders of forthcoming changes to regulations in advance of their Parliamentary laying period.

"We can also confirm that the Chief Dental Officer met with the Scottish Dental Practice Committee on 23 February 2016 to discuss the guidelines that will underpin unannounced inspections of dental practices by NHS boards."

NOW TRENDING

9

HOURS

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ABOVE: Raj Rattan MBt

NEW DIRECTOR AT DPL

GDP Raj Rattan MBE has been appointed as the new dental director of Dental Protection Ltd (DPL), replacing Kevin Lewis who is stepping down in the summer.

Rattan, who has been associated with DPL for more than 20 years, is also strategic associate dean at the London Deanery. He was appointed MBE in the Queen's New Years Honours in 2008 for services to dentistry.

He said: "It is a huge privilege to be given the opportunity to lead a very talented team who are dedicated to dentistry. I look forward to working closely with my colleagues in helping to shape a better future for our dental members and for the profession, by listening to their concerns, working closely with key stakeholders and continuing to provide tailored courses and events.

"I believe that by helping dentists in their professional careers, we are also creating a happier and safer environment for patients."

GDC PUBLISHES ACTION PLAN TO IMPROVE PROCESSES IN WAKE OF PSA REPORT

The GDC has published its action plan to improve how its Fitness to Practise (FtP), governance and organisational policies following last year's Professionals Standards Authority (PSA) report.

The latest PSA report centred on concerns raised by an unnamed whistleblower and led to BDA chair Mick Armstrong calling for the General Dental Council chair, William Moyes, to resign.

In response, the regulator has released details of how it plans to improve its FtP processes as well as making changes to the leadership and organisational culture. William Moyes said: "The Council has had time to consider the report, and as a result has developed a clear plan of actions so that improvements can be made. Our Fitness to Practise function has been overhauled with improved processes and procedures providing much more resilience. The improvements will continue to be made with the introduction of case examiners later this year. As important is the fostering of a more open culture that encourages individuals to come forward to raise concerns.

"The leadership has also been fundamentally reshaped so that we can continue to drive forward improvements, as recently outlined in our three-year road map – Patients, Profession, Patients, Partners and Performance. We know there is further work to do but we are fully committed to becoming a high-performing, efficient regulator."

UCLAN STUDENT WINS RCSED SKILLS COMPETITION

The final of the Royal College of Surgeons of Edinburgh's (RCSEd) clinical skills competition has been won by a student from the University of Central Lancashire.

Undergraduate dentist James McParlane won after being put through a series of gruelling tests of his clinical skills abilities. The 25-year-old said: "The importance of winning this amazing competition hasn't really sunk in yet. I would definitely recommend any of my colleagues to join the competition next year as it really challenges you to strive for perfection."

Professor William Saunders, dean of the dental faculty at RCSEd, said: "One of the major aims of the dental faculty of the Royal College of Surgeons of Edinburgh is to set and quality-assure the highest standards for the dental profession, and recognise that with the award of membership and fellowship.

"This competition is a shining example of ensuring that those standards are constantly challenged and updated, with students benefitting from the networking opportunities it brings. RCSEd is very keen to interact with the dental schools in the UK and this competition provides an excellent way for students to become engaged with us."

Dundee Dental School is celebrating its centenary this year

PUNCHING ABOVE ITS WEIGHT FOR 100 YEARS

A remarkable group of former students is helping Dundee Dental School celebrate its centenary in style this year.

The school's dean, Professor Marl Hector, revealed that during the planning stages for the centenary celebrations it was noted that there were 10 Dundee alumni who were either existing or former heads of dental schools or in senior positions with the postgraduate deaneries across the UK.

It was decided that they would all be invited to come and speak at the school for what has become the Centenary Alumni Lecture Series.

The dean of the Dental Faculty at RCSEd and former Dundee dean Prof William Saunders was the first speaker in February last year and he has been followed by Newcastle dean Prof Jimmy Steele; Prof Ferranti Wong of the London deanerie; Prof Jon Cowpe, director of postgraduate education in Wales, University of Cardiff; and Prof Paul Speight, former dean of dentistry at Sheffield.

In 2016 Cardiff dental dean Professor Mike Lewis and outgoing Dublin dean Prof June Nunn have already spoken, with Professor Philip Lumley, head of the dental school at the University of Birmingham (20 April) and Prof Callum Youngson, head of the dental school in Liverpool (10 June), who are still to appear.

The only alumnus on Prof Hector's list who was unable to come up and speak is the new dean at Sheffield Prof Chris Deery.

Prof Hector said that he felt it was quite a remarkable achievement for Dundee to have so many alumni occupying such important positions, particularly in the centenary year. He said: "I think it is quite extraordinary for one of the smallest schools in the country to have such an impact and have an impact which spreads out across the whole of the UK.

"I just hope that the reputation for punching above our weight continues, that is certainly the way we want it to go."

The centenary celebrations will culminate in a special centenary dinner on 11 June where a special publication charting the history of the dental hospital and school will be unveiled. It is entitled: *Dundee Dental Hospital and School – Transforming Lives for 100 years*.

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1 PER CENT PAY RISE IS 'MORE OF THE SAME'

SDPC fears deepening crisis of morale in profession as Health Secretary confirms increase

The 1 per cent increase in dentists' pay recommended by the DDRB will deepen the crisis in morale affecting the profession in Scotland according to SDPC chair Robert Donald.

Donald, who is a GDP in Nairn, said: "We are disappointed but not surprised by DDRB's recommendations. A 1 per cent pay uplift does nothing to address, let alone reverse, the huge drop in income for GDPs that has occurred over the last five years. For Scottish GDPs, 'more of the same' means a deepening crisis of morale, and an inability to deliver investment in practices. At present we have to pay for

ABOVE: Health Secretary Shona Robison

improvements out of our own pockets, and not a single penny has been earmarked to improve equipment, premises or training. Our patients deserve and expect quality care, and these are the foundations it is built on. To run an effective service we require either fair pay or fair funding. At present we have neither."

Health Secretary Shona Robison said: "We are committing nearly £100m next year to ensure all NHS staff groups in Scotland will receive a 1 per cent pay increase. We will also supplement the pay of those currently earning under £22,000 to ensure they receive an increase of at least £400."

While the independently recommended uplift is modest, it comes against the background of substantial cuts in Scotland's budget from Westminster, and will continue to give NHS staff in Scotland a better deal than their counterparts south of the border.

"As well as delivering the fully consolidated pay rise for NHS staff, and guaranteeing that all employees are paid at least the living wage, we are also committed to no compulsory redundancies for NHS Scotland staff," the Health Secretary said.

"Our commitment to this pay increase, and to the living wage, for NHS workers underlines the value we place on front-line staff who work incredibly hard every day to care for the people of Scotland."

PATIENT SAFETY ON PAGE 30

"We have to get the word out and explain that this is not a checklist event, that's not what it is about"

IRENE BLACK

SESQUICENTENNIAL CELEBRATIONS

Edinburgh dentist Yann Maidment has marked the end of his tenure at the helm of the oldest dental society in Europe by announcing details of the group's 150th anniversary celebrations.

The Royal Odonto Chirurgical Society of Scotland (ROCSS), which is also one of the oldest dental society's in the world, was founded in 1867 and has recently welcomed its 108th president in the form of Aberdeen dental dean Professor Richard Ibbetson.

Outgoing president Maidment, who owns and runs Stafford Street Dental Care with his wife Gilly, explained that the society has always existed to "promote the highest ethical professional standards in dental surgery". He continued: "The ROCSS is also about promoting the practice of dental science as a branch of medicine – in other words, bringing the mouth back into the body as part of the health and wellbeing of patients. This is entirely in accord with contemporary thinking and practice, which endeavours to integrate the practice of dentistry and the training of new generations of practitioners with other disciplines, as part of a truly holistic approach to health."

The anniversary celebrations will begin next March with a full-day international scientific meeting and the society's annual dinner.

NOW TRENDING

1.5

FACT

Exposure to second-hand smoke increases the onstances of dental caries in children by one and a half times

*

Source: BMJ 2015;351:h5397 bit.ly/1Ufljve

REGULATION FOR PRIVATE PRACTICES DISCUSSED AT HOLYROOD

The BDA has put its support behind the proposed regulation of private dental clinics but has raised concerns about the definition of 'independent clinics' and the potential costs involved.

Healthcare Improvement Scotland (HIS) issued a public consultation on the proposed fees for the regulation of independent health care services in November last year and the BDA's director for Scotland, Pat Kilpatrick, presented the association's written evidence to the Scottish Parliament last month (February).

In its submission, the BDA said that it agreed that independent healthcare needed to be regulated and inspected but that the use of existing inspection systems should be considered. The association also said that it had concerns that "the introduction of a flat fee for registration was inappropriate due to the range of sizes of independent clinics. We would expect the costs involved to be less for a smaller clinic as opposed to a larger one".

It also noted its concerns about the definition of 'independent clinic' since beauticians working in beauty salons who carry out teeth whitening without any formal training or regulation might avoid the scrutiny of HIS. The BDA asked the committee how they intended to legislate to avoid this.

> BDA supports proposals but raises concerns over fees and definition of 'independent clinics'

One private dentist from Grampian said he felt the proposals were flawed. "Why does a practice that is 100 per cent private face a fee of up to £3,500 per annum, and yet a practice that is 99 per cent private face no fee, as they still fall within the NHS category, as indicated by HIS? Surely a sliding scale based upon NHS commitment levels and size of practice would make more logical sense?"

A spokesperson for Healthcare Improvement Scotland said: "The focus of regulation will be on ensuring safe, effective and high quality care for users of independent clinics across Scotland.

"Where appropriate, regulation and inspection will be used to drive up the standard of care in Scotland to the benefit of patients and the public."

MINISTER PRAISES NEW DENTAL FACILITY

A state-of-the-art clinical skills facility has been unveiled at New College Lanarkshire by MSP Dr Alasdair Allan.

The dental facilities at the Coatbridge Campus include an intra-oral camera linked to an adjacent teaching room and a new phantom-head laboratory. The new equipment will be mainly used by dental nurse students, who will relocate from the stand-alone clinic at Strathclyde Business Park in Bellshill.

Dr Allan, who is the minister for learning science and Scotland's languages, also opened a new science area at the college which boasts fully equipped teaching laboratories for students studying general science, biology, chemistry and physics. He said: "The facilities I have seen will truly offer dental and science students in the area the very best training available and New College Lanarkshire and its staff can be immensely proud of this facility."

Martin McGuire, Principal of New College Lanarkshire, said: "We are extremely proud of our new dental and science facilities, which further establishes New College Lanarkshire as a sector-leading provider of STEM (science, technology, engineering and maths) subjects. We are looking forward to welcoming new students, employers and sector professionals for years to come."

New College Lanarkshire was formed by the merger of Cumbernauld College and Motherwell College in November 2013. Coatbridge College joined the new college in April 2014. The college has campuses in Cumbernauld, Motherwell, Coatbridge, Kirkintilloch, Hamilton and Broadwood.

Above: Gabriele Banuilyte, Gillian White, Amy Hall and Kuber Nadig

GLASGOW STUDENTS' AIM IS TO INSPIRE THEIR PEERS

A group of Glasgow students has hosted the first INSPIRE event in Scotland aimed at encouraging undergraduates to consider a career in dental research.

The event, at the Royal College of Surgeons of Glasgow, involved six speakers from the University of Glasgow Dental Hospital and School as well as Peter Ommer, clinical director for the public dental service in NHS Ayrshire and Arran, who talked to students about their careers.

INSPIRE is a UK-wide initiative co-ordinated by the Academy of Medical Sciences that has been running since 2013. Four Glasgow students – Gabriele Baniulyte, Gillian White, Amy Hall (BDS5) and Kuber Nadig (BDS4) – attended a conference at Kings College London last year and were inspired to spread the message about careers in academia to their peers in Scotland. Gabriele explained that before attending the event in London, she wasn't too aware of the options available to her in terms of research but that she hoped this event would help other students.

And Gillian said: "We hope the younger generation of dentists coming through will have a better appreciation of dental research and the importance of having general practitioners who are involved with research and interpreting it to make better, evidence-based clinical decisions, to improve patient care."

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*NHS Dental Services in England – An independent review, Jimmy Steele, 2009

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EROSION RESEARCH WINS INTERNATIONAL AWARD

Dundee PhD student's innovative artificial mouth model beats off 500 other competitors

Dundee Dental School PhD student Abubaker Qutieshat has received recognition from a top European dental body for his pioneering work on dental erosion.

Qutieshat's SALTUS artificial mouth model won the European Federation of Conservative Dentistry Merit Award, beating competition from more than 500 other applicants.

The model mimics the interaction of saliva and the dental substrate during the process of consuming an erosive beverage. Researchers are able to set variables

Abubaker Qutieshat

such as desirable salivary kinematic behaviour, offensive beverage flow rate and volume of consumption, gathering data using customisable experimental diets.

The model even has room for upgrades and modifications, which could widen the scope of its use in preventive and therapeutic dentistry.

Qutieshat said: "I believe that our research team have created an artificial mouth concept that will benefit dental research today and for years to come. I am very glad it got recognised.

"As this is my first international-level award, I will surely be looking forward for the next to come. SALTUS has the potential to grow further and could provide an even greater level of realistic behaviour."

Qutieshat's PhD work was supervised by the Professor Graham Chadwick and Dr Andrew Mason. Prof Chadwick said: "SALTUS represents a paradigm shift in laboratory erosion testing, because it is based upon real physiology.

"The work shows what can be achieved in pursuit of a Dundee higher research degree supported by supervisors of such diverse backgrounds as material science and oral physiology."

DENPLAN CHALLENGES BAN ON TV ADVERT

Denplan has said it "strongly disagrees" with the Advertising Standards Association's (ASA) decision to ban its recent television advert.

The ASA received 11 complaints about the "Doitforyourselfie" campaign that ran in October last year, with the claimants challenging whether the ad was misleading because cosmetic dentistry was not covered by Denplan.

The ASA ruling said: "We understood that the intended message was that if viewers wanted to love their teeth, they should consider using Denplan which would, through regular treatment, help them to avoid the problems experienced by the character in the ad.

"However, we considered that viewers were unlikely to know exactly which treatments the man required to make his teeth look good again, and were likely to assume, given that his teeth were stained yellow, crooked and cracked, that some of the treatments would be cosmetic. Because cosmetic dentistry was not available under Denplan, we concluded the ad was likely to mislead viewers."

A spokesman for Denplan said: "Denplan strongly believes that the Denplan TV advert was not misleading. Whilst we respect the role that the ASA has to play and fully intend to adhere to the decision, Denplan feels that the ASA's assessment on this occasion was overly subjective.

"There were no exaggerations or claims in the advert and there was a clear call to action to viewers at the end of the advert, which states: 'Love your teeth, ask your dentist about Denplan.'

"Taking this into account, Denplan finds it difficult to understand how viewers could have been misled in the absence of an explanation about the types of treatment Denplan covers."

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DENTAL SUPPLIES: BY DENTISTS, FOR DENTISTS

STRUCK-OFF DENTIST FACING FURTHER LEGAL ACTION

An Ayrshire dentist who was struck off along with his practice manager for a series of infection control breaches, is being sued by more than 600 of his former patients.

Alan Morrison, principal dentist at Millbank Dental Surgery and Drongan Dental Surgery, was found guilty at a GDC hearing in February of re-using matrix bands on different patients, not changing gloves between patients, re-using single-use instruments and for not properly ensuring that equipment was sterilised or disinfected before being re-used.

He was also found to have created false invoices for dental supplies and instruments he didn't buy, in a "concerted effort to deliberately deceive the health board".

Morrison's practice manager Lorraine Kelly was also struck off and dental nurse Dawn Grant was placed under conditions for a period of 12 months. Kelly and Grant both faced allegations of reusing single-use items, for inadequate infection control and dishonestly responding to the investigation by NHS Ayrshire and Arran.

Following the decision by the GDC's Professionals

Conduct Committee (PCC), Patrick McGuire of Thompson's Solicitors revealed that his firm had been approached by more than 600 former patients of Morrison, a number that is increasing on a daily basis, who may be involved in a potential legal action against the dentist.

In reaching their decision to remove Morrison from the register, the PCC concluded: "Your woeful behaviour, as detailed in this determination, has damaged your fitness to practise and public confidence in the dental profession to the extent that removal of your professional status is the only appropriate and proportionate outcome."

TAX WARNING FOR RETIRING DENTISTS

Retiring Scots dentists are being warned about new pensions information that could help them save thousands of pounds in tax.

The Scottish Public Pensions Agency is warning dentists that they may be affected by the reduced Lifetime Allowance and the pension data will enable them to apply for transitional pension protection by way of mitigation.

Jon Drysdale, an independent financial adviser from chartered financial planners PFM Dental, said: "A Scottish dentist with a personal pension fund of £200,000 and an NHS pension of £45,000 per annum retiring in May 2016 could be £2,900 a year worse off than one who retires in March 2016. Applying for transitional protection prior to retirement could remove this charge.

"The Chancellor has offered quite significant protection against the falling Lifetime Allowance but the rules are

not straightforward and the application window for transitional protection is time-limited. Dentists planning to retire after 5 April 2016 should seek immediate professional advice."

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The Beauty of Dentistry

Dispatches

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

THE DEVIL IS IN THE DETAIL

The profession waits with interest to see how the regulator's new case examiners fare in the new world of a "listening GDC"

No one is happy with the General Dental Council's (GDC) Fitness to Practise process. By April the long-awaited amendment to the Dentists' Act, known as a Section 60 order, will come into force. Will it revolutionise the way the regulator handles complaints?

It's too early to say. At the time of writing, we don't yet know the outcome of the GDC's consultation on its plans to implement the order. The new legislation will take effect from August.

If you took part in the consultation, you'll know that Section 60 means the GDC will soon be able to bring in case examiners. They will aim to screen out the cases that don't warrant a full hearing. That should reduce caseload, expense and time, which is good for patients, and practitioners. We've been calling for them for this type of system for years and it should mean less stress for dentists when complaints are raised. And the GDC.

The BDA supports any moves that makes the process more efficient and fair and reduces the stresses attached to it. But, as ever, the devil is in the detail. How the scheme is implemented will make all the difference. It could render the changes either a massive improvement or a significant threat.

First, the case for improvement. Consider, if you can, a team of highly intelligent, pragmatic and balanced case examiners properly empowered to make reasonable decisions and to separate the wheat from the chaff. The range of outcomes available to those case examiners could really enhance performance and offer genuine opportunities for professionals to reflect on areas of their practice and to raise their game.

Imagine a regime that promoted a culture where performance was improved in a culture of candour and in the absence of blame and recrimination. Implementing such a scheme would help professionals improve the quality of care. It would reduce the costs of trumped-up cases, reduce practitioner stress, and be better for patient protection.

So, why should we be frightened? In the reassuring world just described, there are great expectations, but there are also risks. To quote John Cleese in *Clockwise*, "It's not the despair, I can stand the despair; it's the hope…!"

In any system, success or failure, credibility or collapse turns upon the people who work within it and the systems that drive their behaviours. The 'objectionable practices' described in last year's Professional Services Authority report mean that what we hope for is not necessarily what happens. The GDC will need to demonstrate that it has selected carefully and that its systems hold up to scrutiny. The profession will need to be reassured that the GDC is properly overseeing the practices and intervening when necessary. We hope that the recent criticisms and undertakings made by the council represent a new beginning, where the GDC can be trusted to get it right.

From my reading of the GDC consultation, the most substantial threats arise from the undertakings it may agree with practitioners and the warnings it might be able to issue. Case examiners are likely to have enormous discretion and will decide upon the frame of words that are applied to the registrant's record. As currently written, those words could remain on the registrant's record in perpetuity.

So prospective defendants face a choice. They can undergo the lengthy and painful process of formal investigation with the risk of sanctions. Statistically, the likelihood of falling foul of sanctions in that process is actually very small (last year fewer than 400 out of more than 100,000 registrants were found to have acted in a way that warranted a sanction). The vast majority suffer no sanction in this system; there is no blemish on their record and they can carry on in practice with their reputations intact.

The prospect of an early disposal of a case is appealing but any satisfaction would be short-lived if it results in a permanent blemish on the registrant's record. If the aim is to encourage openness and reflection, isn't that compromised if the respondent suffers an indelible mark on their reputation? As proposed, the note on the record looks more like punishment and humiliation than a serious encouragement to improve performance. We do need some clarity here before we face the prospect of a sizeably larger number of registrants with adverse comments attached to them.

The prospect of an early disposal of a case is appealing but any satisfaction would be short-lived if it results in a permanent blemish on the registrant's record

Could this militate against accepting this fast-track process altogether? Better to take your chances and enjoy the better than 90 per cent chance that you will escape untarnished, rather than sign up to an agreed public statement of your own inadequacy?

This matter is a serious one. It is central to whether the anticipated cost savings will be delivered. Creating a system whereby the reputational damage ensuing is greater than the formal process will do nothing to drive uptake. In the new world of a listening GDC, will the regulator take note? There is real opportunity in these proposals, but only if the difficult and significant by-products are fully evaluated.

In depth

ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

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See page 34

SCOTTISH DENTAL SHOW 2016

ARE YOU READY FOR THE SHOW?

THE FIFTH SCOTTISH DENTAL SHOW PROMISES TO BE THE BIGGEST YET, WITH UP TO 2,000 PEOPLE EXPECTED AT BRAEHEAD ARENA

BRUCE OXLEY MIKE WILKINSON

The 2016 Scottish Dental Show is the largest dental event of its kind in Scotland and it just keeps getting bigger. Last year, it welcomed nearly 1,800 people through the doors and, with pre-registrations nearly 10 per cent up on 2015, organisers are expecting close on 2,000 people will descend on Braehead Arena on 13 and 14 May.

Not only is the show the biggest in Scotland it is also free. Registration is free, entrance to the exhibition is free and all the lectures – which offer up to nine hours of verifiable CPD – are free to attend.

The lecture programme this year features another world-class field of dental speakers. Professor Mike Lewis will give a two-part keynote lecture on mouth cancer on Friday morning and he will be followed by Prof Brian Millar, Prof Jan Clarkson, Prof Peter Mossey, Christine Park, Barbara Lamb, Steve Bonsor and many more.

Within the lecture programme there are 10 sessions of CORE CPD featuring something of value to all members of the dental team. As well as Prof Lewis' mouth cancer keynote, there will be sessions on infection control and decontamination, complaints handling and legal and ethical issues, medical emergencies, radiography, and the latest recommended topic from the GDC, safeguarding and child protection.

The full programme is listed over the page and is followed by a rundown of the workshop programme at the show. As with previous years, while the lecture programme is first-come-first-served, the workshops need to be booked in advance.

All the workshops, unless otherwise stated, will take place in the atrium which is accessed via the stairs in between stands A09 and A11 and D10 and D12. And, while the majority of workshop sessions are free to attend, there are a couple which charge a fee. To find out more, visit the workshop page on the website at www.sdshow.co.uk/workshop

Attendance at each lecture session and workshop will be recorded via badge scanners on the way out of sessions. It is your responsibility to ensure you are scanned at each session you attend in order that your CPD is recorded correctly.

Your CPD certificates will be available after the show by clicking on the link in the registration confirmation email. They will also be emailed out to the email address used when registering. CPDA funding has also been applied for and details can be found at www.sdshow.co.uk


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FRIDAY 13 MAY – LECTURES

	SPEAKERS	TALK TITLE	STREAM	ROOM
09:30 – 10:00	Professor Mike Lewis (University of Cardiff)	Mouth cancer – how to beat it! (Part 1) CORE CPD	Dentists | Team	1
	Professor Brian Millar	Advanced anterior aesthetics, being creative with composite when managing tooth wear	Dentist	2
	Roy Hogg (Campbell Dallas)	Latest developments and hot topics for dentists	Business	3
	Nav Ropra	The 5 secrets to a successful dental practice	Dentists | Business	4
	COFFEE BREAK			
10:15 – 11:15	Professor Mike Lewis (University of Cardiff)	Mouth cancer – how to beat it! (Part 2) CORE CPD	Dentists | Team	1
	 Aubrey Craig (MDDUS)	Once more unto the bleach... CORE CPD	Dentists | Team	2
	Craig Stirling and Dawn Dickson (Davidson Chalmers)	Legal health check	Business	3
	Rob Leggett and Stuart Lutton (New Life Teeth)	New Life Teeth's full arch immediate load protocols	Team	4
	COFFEE BREAK			
11:30 – 12:30	Siobhan Kelleher and Kellie O'Shaughnessy (DENTSPLY)	Successful, productive, profitable practice	Dentist	1
	Laura Wilson (NHS Education for Scotland)	Infection control/decontamination CORE CPD	Team	2
	 Adam Morgan (The Adam Morgan Company)	Don't communicate... connect	Business	3
	Robbie Lawson (Edinburgh Orthodontics)	Orthodontics: the good, the bad and the ugly	Dentist	4
	LUNCH			
13:30 – 14:30	 Professor Peter Mossey (University of Dundee)	Oral health inequalities – what's the problem?	Team	1
	Professor Tim Newton	Identifying and managing the stress of dental practice	Team	2
	Ian Main (Stark Main)	The business of dentistry	Business	3
	Ian Wilson (IWT Services)	Understanding the threats in a digital world	Team	4
	COFFEE BREAK			
14:45 – 15:45	Ian Robertson (University of Glasgow)	New resuscitation guidelines – what you need to know CORE CPD	Dentists | Team	1
	Steve Bonsor (The Dental Practice, Aberdeen)	What's new in applied dental materials?	Team | Dentists	2
	Martyn Bradshaw (PFM Dental), Michael Royden (Thorntons)	Selling a dental practice	Business	3
	Dr Aditi Desai (BSDSM)	The ideal oral appliance for treatment of Sleep Disordered Breathing	Team | Dentists	4
	CLOSE			

SATURDAY 14 MAY – LECTURES

	SPEAKERS	TALK TITLE	STREAM	ROOM
09:30 – 10:00	 Christine Park (University of Glasgow)	Safeguarding and child protection for dental teams CORE CPD	Team	1
	Illona McLay	Motivation – Acknowledged, Ignored, Shredded – What are you? Engagement – The lights are on but is anyone there?	Team	2
	Jayne Clifford, Caralynne Hill, Gavin Curr and Craig McArthur (Martin Aitken)	Getting more from your accountant	Business	3
	Steve Taylor (Taylor Dental Technology Centre)	Occlusal form created by desired function	Technicians	4
	COFFEE BREAK			
10:15 – 11:15	Barbara Lamb	Pixel perfect quality assurance and the digital image CORE CPD	Team	1
	Will McLean (University of Glasgow)	Risk management in endodontic case selection	Dentist	2
	Martyn Bradshaw (PFM), Michael Roydon (Thorntons), Roy Hogg (Campbell Dallas)	Buying a dental practice	Business	3
	Rob Leggett and Stuart Lutton (New Life Teeth)	Assessment of dental appliances in the lab and the clinic	Technicians	4
	COFFEE BREAK			
11:30 – 12:30	Maximilian Maier (DENTSPLY)	Aesthetics made easy – new Ceram.X universal nanoceramic restorative	Dentist	1
	Stephen Henderson (DPL)	GDC – Fit for Purpose? CORE CPD	Dentists | Team	2
	Adam Morgan (The Adam Morgan Company)	Don't communicate... connect	Business	3
	Andrea Johnson (OTA)	From clinic to the lab and back again – infection control for the dental team CORE CPD	Technicians	4
	LUNCH			
13:30 – 14:30	Professor StJohn Crean (University of Central Lancashire)	Risk assessment for medical challenges in dental patients CORE CPD	Team	1
	 Professor Jan Clarkson (University of Dundee)	Taking research into general practice	Team | Dentists	2
	Karin Laidlaw (NHS Education for Scotland)	Dental Sedation – A conscious decision	Team	3
	Paul Perkins (Swift Dental)	CAD/CAM versus conventional non-precious copings	Technicians	4
	CLOSE			

KEY:

DENTIST	RECOMMENDED SPECIFICALLY FOR DENTISTS
TEAM	OF INTEREST TO THE WHOLE DENTAL TEAM, SPECIFICALLY DCPS
BUSINESS	OF INTEREST TO PRINCIPALS AND PRACTICE MANAGEMENT STAFF
TECHNICIAN	OF SPECIFIC INTEREST TO TECHNICIANS

These streams are recommendations – all members of the dental team are welcome at each of the sessions listed on these pages.

Arshad Ali will be back presenting his composite course

WORKSHOPS

Please see www.sdshow.co.uk/workshop for more information and details of how to book.

Places on these workshops are limited to 10-20 delegates max. All workshops are free unless otherwise stated. Please contact the organisers for more information and details on how to book.

Siobhan Kelleher and Kellie O'Shaughnessy (DENTSPLY)
- *Bubbles busting biofilm*

Friday 13 at 1.30pm
Friday 13 at 2.45pm
Please see www.sdshow.co.uk/workshop for more information and details of how to book.

Philip Friel (Philip Friel Advanced Dentistry)
- *Extraction, preservation and implant placement for the GDP*
- *Introduction to basic surgery*

Various times Friday and Saturday – please see www.sdshow.co.uk/workshop for more information and details of how to book.

Jeremy Cooper (Velopex)
- *Aesthetics – a real world approach*

Friday 13 at 10.15 am (2 hrs)
Friday 13 at 1.30pm (2 hrs)
Sat 14 at 10.15am (2hrs)
Please see www.sdshow.co.uk/workshop for details of how to book.

Brian Millar (Coltene)
- *Simplicity and success with posterior composites*

Friday 13 at 10.15am
Friday 13 at 11.30am

Places on this hands-on workshop cost £20. To book, email Pippa.Carolan@coltene.com with your name, GDC number, and the time of the workshop you wish to attend.

Liz Webster and Lezley Ann Walker (Glasgow Dental School)
- *Hands on BLS update for dental teams*

Friday 13 at 10.15am
Friday 13 at 11.30am
Saturday 14 at 10.15am
Saturday 14 at 11.30am

To book, email info@sdshow.co.uk with your name, GDC number, contact telephone number and the time and date of the workshop you wish to attend.

Arshad Ali (SCED/Kerr UK)
- *Posterior composites – fast, easy, reliable placement technique*

Friday 13 at 1.30pm

To book email secretary@scottishdentistry.com or call 0141 427 4530. Alternatively, contact Gillian Callaghan from Kerr on 07711 750 621.

Adam Morgan (The Adam Morgan Company)
- *The relationship edge*

Friday 13 at 1.30pm
Saturday 14 at 10.15am

To book your place on this workshop, email adam@adammorgancompany.com with your name, GDC number, contact telephone number and the time and date of the workshop you wish to attend.

Joe Jackson (Pearl White Dental Lab/DENTSPLY)
- *Impression taking workshop*

Saturday 14 at 1.30pm.

Prof Brian Millar

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SAFETY IN THE SPOTLIGHT

THE SCOTTISH PATIENT SAFETY PROGRAMME IS BRANCHING OUT INTO DENTISTRY AND AIMING TO HELP PRACTICES IMPROVE SYSTEMS TO KEEP DENTAL PATIENTS FREE FROM HARM

BRUCE OXLEY MIKE WILKINSON

With increasing levels of bureaucracy and red tape allied to ongoing regulatory concerns and constant financial pressures, dentists in Scotland could be forgiven a certain level of scepticism when new initiatives are launched.

However, the team behind Scotland's world-leading patient safety programme is assuring dental teams that its expansion into dentistry should not be seen as an added burden.

The Scottish Patient Safety Programme's (SPSP) clinical lead for the dental collaborative, Irene Black, said: "We have to get the word out and explain effectively that this is not a checklist event, that's not what it is about. This is a practice initiative for the benefit of patients and dental staff because they may well find out that there is a much more efficient way of doing something."

And Jill Gillies, SPSP improvement advisor, supported that by saying: "I think efficiency is the key word here. We have found with a number of the safety programmes that the safer your systems are, the more efficient they are and the more cost effective they ultimately become."

Jill Gillies is focused on the benefits of patient safety

The patient safety programme was developed as a result of the Healthcare Quality Strategy for NHSScotland [1] which set out three main ambitions: to provide safe, effective and person-centred care. The SPSP is seen as key to delivering on these aims and supports the Scottish Government's 2020 Vision [2] to provide safe, high quality care, whatever the setting.

The SPSP, which is led and co-ordinated by Healthcare Improvement Scotland (HIS) has been running in Scotland's acute hospitals since 2008, in which time it has produced some impressive results including significant reductions in ventilator acquired pneumonia and central line infections in critical care units in test sites throughout Scotland.

The primary care programme was initially developed in general medical practice from 2010 until 2012 and rolled out to GP practices from 2013, focusing on high-risk medicines and systems issues such as results handling and communication. In 2012, the SPSP received funding to test improvements around high-risk medicines and medicines reconciliation in community pharmacy.

For the past year, community pharmacies across Scotland have been participating in a pilot and implementing interventions around high risk medicines – the results of which could see medicines reconciliation being developed as a process within community pharmacy.

DENTAL PROTOTYPING

Jill explained that the next logical step in the plan had always been to move into dentistry and the first stage of "prototyping

LEFT: Irene Black is working towards improving patient safety by updating medical histories

from the ground up" involved identifying potential harms in relation to dentistry. This is where Eaglesham GDP Irene Black comes in. For many readers she will be a familiar face from NHS Education For Scotland (NES), where she has been an assistant director with the remit for infection control and decontamination for the last eight years. In September she was appointed as the clinical lead for the dental collaborative on secondment from NES.

Irene explained that the first stage of identifying harms actually proved to be quite challenging. She said: "Determining the harms in dentistry was actually quite difficult. First of all, the HIS team carried out a literature search for patient safety in dentistry and, to be perfectly honest, very little came out of this search. This is because there hasn't been a lot of work done in the field."

Irene's role in the scoping exercise involved looking at areas where information could be gathered from places such as defence unions, the GDC and ombudsman's reports. She was also involved in the steering group that included dentists from different backgrounds, as well as other healthcare professionals and staff members from HIS.

Irene said: "It was really interesting because the consensus kept leading back to almost the same topics. It was basically all about high-risk medication and medical histories being accurate and up-to-date and our ability to get that information from the patient and to get it from pharmacies as well."

A stakeholders questionnaire was also sent out which returned 777 responses. Irene continued: "It came out loud and clear that patients' medical histories and collating and collecting the right information was a big issue for dental practice teams in relation to ensuring patient safety and quality improvement. So, for me it was reassuring that we were going in the right direction."

And Jill agreed, saying: "I think the survey was really important. We are not sitting in a building somewhere coming up with the areas where we feel the profession should be focusing on. We've done the review of the literature and we've then gone back out to the profession with nearly a thousand GDPs responding and agreeing, or strongly agreeing, that these are the areas that we should be focusing on. And this really validates the work that has been done so far – these are important safety issues from a general dental practice perspective."

RECRUITMENT PHASE

Towards the end of 2015, the Scottish Government provided funding for HIS to recruit three health boards to take part in the dental pilot. The participating boards are: NHS Ayrshire and Arran, NHS Dumfries and Galloway and NHS Fife. The three boards have recruited, or are in the process of recruiting, five practices to test safety tools and interventions in a practice setting.

CONTINUED OVERLEAF>

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FROM PREVIOUS PAGE>

The health board's clinical leads and quality improvement facilitators have already attended induction events to introduce them to the quality improvement (QI) methodology that is used across all of the safety programmes within HIS. The approach will use the Breakthrough Series collaborative model that was developed by the Institute for Healthcare Improvement in the US [3].

Jill explained: "The boards have been developing what they think the aim will be in their board to make patient care safer in relation to those high risk medicines. And part of that is having an accurate and up-to-date medical history.

"Another part of this is patients' understanding the value of that medical history and patients' understanding of the high-risk medicines that they are on that they should highlight to their dentist when they are going in for treatment."

Irene explained that one of her main focuses from now on will be to frame the QI methodology in a dental setting. She said: "One of the main reasons I am here is really to contextualise it. This is brand new to dentistry, we are quite late to the table.

"The quality improvement methodology is completely new and dentists won't have done things like this before. I have absolutely no doubt about that.

"It is really important that we get a good group together and for the boards to facilitate it really well and get it into context. And that's my role essentially."

WORLD FIRST

Irene and Jill anticipate that there is likely to be significant international interest in the collaboration as this is something that has never been done before. Irene said: "As far as we know, there is certainly no literature about this out there just now. So, in dentistry, this is a first, absolutely."

And Jill said: "I would anticipate that there would be that international interest in what we are doing. This is the first time that we have made other people aware and we are trying to raise the profile of the work. So it will be interesting to see what comes on the back of this, in relation to people being aware that this is currently happening in Scottish dental practices."

Another first for dentistry, Jill explained, is the introduction of a Safety Climate Survey to enable every member of the dental team to provide a snapshot of the perception of safety within the practice. Jill said: "We don't underestimate the challenge in doing this and that some challenging conversations may arise from this. However, we have a number of tools in place and we would offer external facilitation for those potentially difficult conversations that getting this kind of survey back might entail."

Irene and Jill are expecting to receive international interest

Jill explained that the survey highlights perceptions of communication with the practice and that these might be different for clinical and non-clinical staff members. She said that it is important to support some of these discussions. She said: "If we want to have a real focus on patient safety, every member of that general dental practice team has to be aware of that and understand their role in relation to patient safety and that it is part of everybody's role."

LEARNING CURVE

One of the main areas of learning from the GP and community pharmacy work that has already been carried out centred around keeping the focus on what improvements can be made in practice and not in other areas of the system.

Irene said: "It has to be in context and it has to be in the confines and limitations of the contract that we have currently, we are not going to change that. So changes have to be small steps, these have to be practical and we have to be valuable. We have to be valuable for the practice and the patients at the end of the day. They all have to be workable."

Jill explained that, as the pilot goes on, things may well change and that what is eventually rolled out to the whole profession might look quite different to what is planned just now. She said: "I think for us, we have identified these areas and it is important that we focus just on these within the pilot because we are prototyping and we won't be precious – some things won't work and we will need to acknowledge that these weren't the right measures or this wasn't the right area.

"This is the beauty of doing this small scale testing – we have not invested hugely, both time and money. We will learn from that but we will also look at other tools in terms of being able to understand what is below the iceberg."

WHAT NEXT?

The initial pilot will run until December and after then, Jill said, it could be an incremental roll out to four of five health boards initially and then building up over the following two years.

As the pilot progresses, Irene and Jill are keen to make sure that the profession doesn't see this as an additional burden – it is intended to simplify as well as make systems safer. Jill said: "I think that's why there is so much flexibility in the methodology that we use. It is about taking the intervention and implementing it to your context, so that it works and it can be embedded in your everyday practice and it isn't an additional burden."

Irene said: "So it's not about what you have to do or how you must do it. It's not about that. This is going to require a bit of thinking out of the box to a certain extent to enable people to do that. It's part of what you do every day and it fits in to the system that you have got already.

"I know that there are things that dentists don't particularly enjoy doing, around audit for example. It's not their favourite thing. Audit still has a place but, if dental teams were able to adopt these methods as alternative improvement tools this would be positive step forward. These newer methods have the potential to become the 'go to' tool for improvement, providing benefits for both patients and dental teams."

TO FIND OUT MORE,
visit www.scottishpatientsafetyprogramme.scot.nhs.uk

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CLASS OF 33

EDINBURGH COLLEGE PIONEERS COURSE FOR DENTAL CARE ASSISTANTS AIMED AT GIVING YOUNG PEOPLE AND THOSE WITH NO FORMAL QUALIFICATIONS THE OPPORTUNITY OF A CAREER

STEWART MCROBERT MARK K JACKSON

Giving more opportunities to more people makes for a healthy dental sector. A new course run by Edinburgh College is giving those with the right attitude and ambition, and no formal qualifications, the chance to take the first steps in a dental career.

The introductory Dental Care Assistant course claims to be the first of its kind in Scotland and its first cohort of 33 students completed in January 2016.

As Tom MacGregor, Curriculum Manager, Health & Vets, explained, the course is designed to complement the College's SVQ 3 in Dental Nursing and create the option of a pathway for aspiring dental nurses. "This provides opportunities for young people and those with no formal qualifications to get a foot on the ladder. We are giving them a grounding and allowing them to build core skills."

The programme is delivered by dental nurse lecturers Caroline Hairs and Elaine Finnie. Caroline explained its content: "Overall, it's a broad qualification and useful if students want to go further in dentistry, or go on to work in a health-care environment.

"As far as knowledge and understanding are concerned, the core elements of the course are based around oral health. We help students find their way around their own mouths, how to look after their mouth, and understand the four key messages: reduce frequency of sugar intake; visit your dentist regularly; brush your teeth twice a day; don't smoke."

Equally important, particularly from an employability point of view, is the course's focus on prevention of infection.

"This is a key part of a dental nurse's responsibility," added Caroline. "Elaine and I regularly visit local practices and we see people without formal qualifications in infection prevention being employed to work in local decontamination units (LDUs). We provide certificated learning, delivered to SQA Level 5 that introduces students to the microbiology of infection. Among other things, that gives them a head start in the jobs market."

Practical work plays an important part in the course, which also includes a unit on dental check up. Caroline added: "Again, it's very simple. Students learn about the quadrants of the mouth and dental instruments – simple set-ups for a check-up, scale and polish, and filling." Reflective classroom activity, including being presented with specific scenarios, provides students with the opportunity to underpin their learning.

As well as covering the basics when it comes to dental knowledge, the course includes other essential tuition. Tom explained: "Future employment opportunities were at the heart of our thinking when we designed the course. Accordingly, we work very closely with the College's core skills team to incorporate elements of communication, numeracy and IT – every dental nurse registrant must be equipped with fundamental know-how in these areas."

That focus on employment also sees students go through the PVG (Protecting

Tom MacGregor

Some of the first successful cohort of students who are now ready to move on with further learning or go out to work in the profession

Vulnerable Groups) Scheme and Hepatitis B vaccination process.

IN DEMAND

It appears that demand for the course has been clear for some time. Caroline said: "Elaine and I have both recently completed our TQFE (Teaching Qualification in Further Education) at Aberdeen University and I concluded my BA in Professional Development. Working entirely independently, we both identified the need for a lower-level course to give young people the chance to prepare for vocational qualifications."

Fortunately, that point of view chimed with the College's own curriculum reviews, and when Tom joined the team he was of the same mind. All three set about designing the new course – Elaine and Caroline contributing their clinical skills and health knowledge, Tom his expertise in education and college procedures.

During that process the links that have been established with local dentists and dental practices proved useful. Caroline added: "We have set up relationships with a series of practices over time, as graduates go on to work and we look to set up work experience for current students. We were able to conduct market research – talk to practices about what they wanted and needed and where they felt there were gaps in student ability."

> "THIS PROVIDES OPPORTUNITIES FOR YOUNG PEOPLE AND THOSE WITH NO FORMAL QUALIFICATIONS TO GET A FOOT ON THE LADDER"
>
> TOM MACGREGOR , CURRICULUM MANAGER

The team's observations about demand proved accurate. On launch, the course attracted approximately 100 applicants for 40 places. The initial cohort, which has experienced a limited amount of churn (33 out of the initial 40 have completed), saw students travel from as far afield as Biggar to take part in the 18-week, full-time course.

Today's mobile workforce and high levels of immigration from the EU were reflected in the first set of applications received. Tom said: "We get a lot of students from Europe who don't have English as a first language, but we are still able to take that into account by working

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CAREER DECISIONS CONFIRMED

"I've loved the course and it has strengthened my determination to be a dental nurse." That's the view of Jayne Mooney (26), one of the students who recently completed the new Edinburgh College course.

It's a sentiment supported by her classmates. Monica Miranda (31) said: "This has really given us an idea of what you come across day to day in a dental practice. It's been a real eye-opener and given me even more drive to see what the job's really like."

And Pooja Singh (18) added: "I've always wanted to do dental nursing and came here to see if I'd enjoy it. It's confirmed that I do."

All three plan to move on to the College's SVQ (Scottish Vocational Qualification) course. Meantime, there are plans to gain more experience by seeking out trainee or placement roles.

They are at different stages of life; for example, Pooja has recently left school, while Monica is married with two young children. However, they've found that the course has given them the grounding they feel they need.

Jayne concluded: "It's been a great decision to come here and I can't wait to sit the next course."

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with colleagues in ESOL (English for speakers of other languages)."

A new intake began the course in January. Again it was full, and this time around it included one male student.

Although there's no need for formal qualifications, applicants are interviewed. "We look for smart people interested in dental health and hygiene," said Tom. "Crucially, we are also on the lookout for people skills. There are a lot of good people out there with high levels of technical knowledge, but fewer with highly developed chairside skills, and that's an area we concentrate on. We've found that once they've undergone their course our students are very comfortable talking to people about dental health and hygiene."

NEXT LEVEL

On completion it is expected that most students will go on to take the next level of dental nursing tuition at the College. However, they have the option of finding employment as a dental nurse and returning as a day-release student. Alternatively, they could become a clinical support worker in an LDU, work at a lower level within a dental team, or work in other areas of healthcare.

"A lot of people come to us from a background where they have done some care work, community support, or worked in hospitals as domestic assistants," said Tom. "If they want to return to work in that environment that's fine. However, every member of our first intake expected to come back to us in August to continue with their education."

Despite the apparent early success, and the fact that the course has only been up and running for a few months, there are plans to review what has worked well and where improvements can be made. Tom said: "Very soon, we will have a self-evaluation week where we will look at how the course went, what was successful and what wasn't and what we can do to make any necessary change.

"We also invite stakeholder feedback

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and that will include the views of people in the sector. Indeed, we have a lot of information already, a combination of structured and anecdotal feedback from practices. The evaluation process is a very formal one and results will be published in the public domain. The College aims to respond to what employers and the profession needs."

Part of the next moves will be developing the College offer. For the academic year 2016/17 there are plans to incorporate a Dental Care Assistant level 2. "It's important to see what more we can do," said Tom. "For example, we are also exploring the idea of a 'before dental care assistant', in other words, a link between the College and local schools that will allow S3s and S4s to progress onto the dental care assistant programme. Whether that's delivered in school, here at College or a combination of both we can work out."

Should the plans come to fruition the College will be providing a complete pathway: school-level provision, Dental Care Assistant 1, Dental Care Assistant 2 and SVQ Level 3 (the registrable course).

This concept has struck a note with other curriculum managers who, Tom said, are talking about the model that has been developed and thinking about how they can apply it to their area of responsibility.

READY TO MOVE

"The important thing to bear in mind is that we have 33 students who at this time last year had no opportunity to study dental health at Edinburgh College because they didn't have the qualifications. Now, they are ready to move on with further learning or go out to the industry. This year, in total, the course will provide education for around 50 students. Come next year we would look to double that number by following through on our ideas for local school links and Dental Care Assistant 2."

Caroline agreed that there is every opportunity to follow up on that ambition. "From a teaching point of view we will always come across new challenges, especially when we are targeting people with no formal qualifications, or have English as a second language. Whatever the barriers, I'm sure we will find our way around them and give more people the chance to work in this great profession."

ABOVE: the course is based around oral health and the students learn about the quadrants of the mouth, dental instruments and simple set-ups for a check-up

BELOW: The programme is delivered by dental nurse lecturers Caroline Hairs (left) and Elaine Finnie

MAGIC MOMENT

In teaching, tutors often talk about 'magic moments'. For Caroline Hairs and Elaine Finnie just such an occasion occurred before Christmas 2015 when, during a dental-health event staged at the College, their students demonstrated what they'd learnt in public for the first time. "They coped admirably," said Caroline. "It was quite humbling. They were answering questions about brushing properly and so on, and were clearly enjoying it. Although they were nervous beforehand, there were big smiles on their faces during the event."

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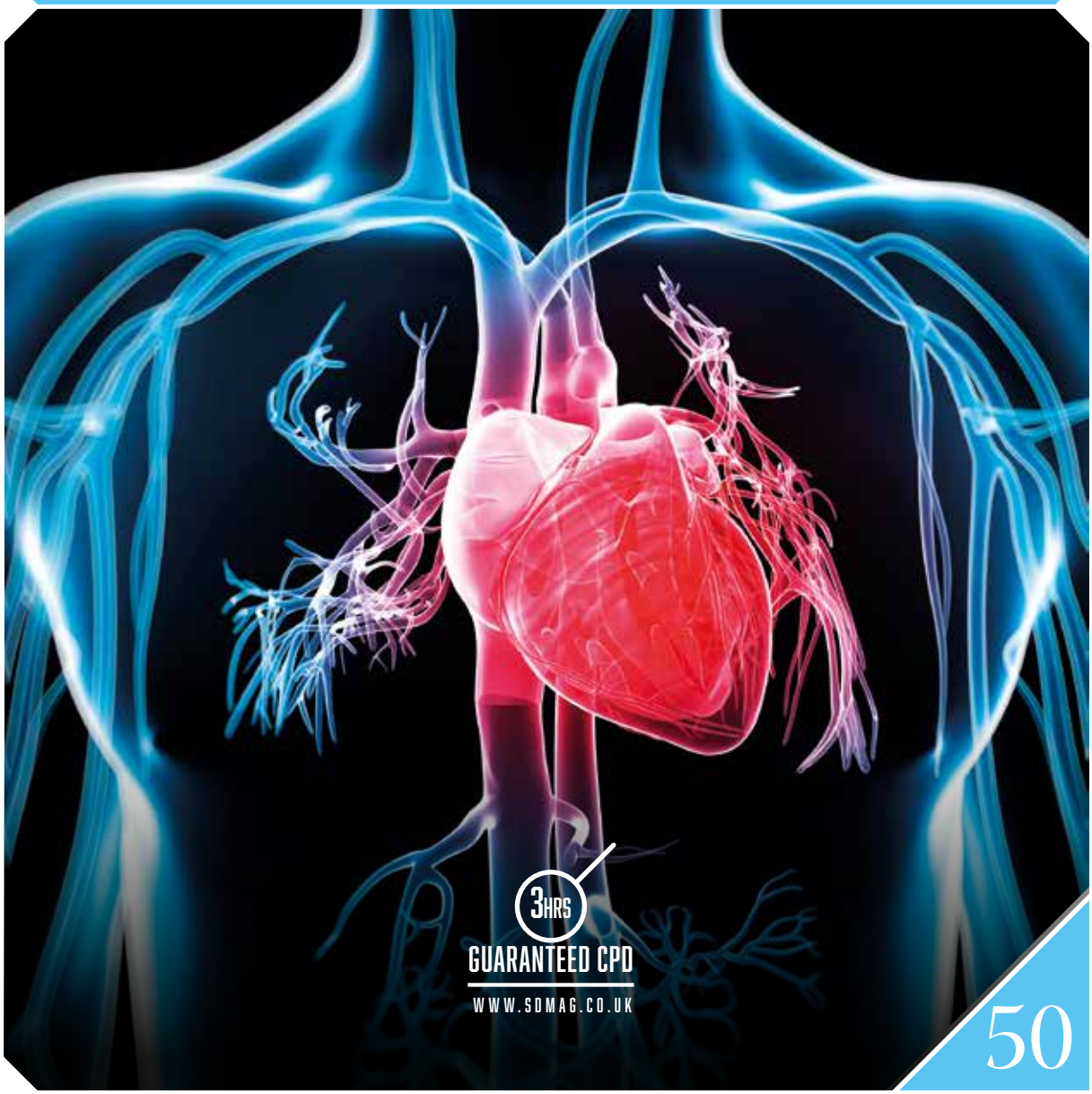


THE EFFECT OF MS ON ORAL HEALTH

CATEGORY

Can the oral health of patients with multiple sclerosis be improved?

REBECCA WILSON

The World Health Organisation (WHO) has defined multiple sclerosis (MS) as a "neurological inflammatory demyelinating condition of the central nervous system, that is considered to be autoimmune in nature".[1]

In people with MS, the immune trigger is unknown; however, the target is the myelin sheath of the central nervous system tracts. The body attacks the myelin sheath and this forms scar tissue, or sclerosis, which gives the disease its name. When any part of the myelin sheath is damaged, the nerve impulses are distorted or interrupted which will produce a wide variety of symptoms, such as fatigue, tremors, numbness in face and limbs, cognitive dysfunction, and neuropathic pain that can affect a person's everyday life[2].

Multiple sclerosis can have a direct or indirect impact on oral health, be it difficulty cleaning teeth due to reduced muscular power, difficulty accessing dental care due to mobility, or the oral side effects of drugs used for the treatment of MS.

My interest in multiple sclerosis began when my mother was diagnosed with the condition in 2010. I had little knowledge of the disease, and when I began my training as a dental hygiene therapist I was curious to know the effect it has on oral health. As part of my final year of study I decided to carry out an elective project to investigate the oral problems associated with multiple sclerosis and the management of these patients within general dental practices throughout Scotland.

I found that carrying out the project gave me a clearer understanding of the disease, and by sharing my findings through this article, I hope that I can raise awareness of MS and in turn improve the care that these types of patients receive.

A study carried out by the University of Dundee estimated that there are 127,000 people with multiple sclerosis in the UK, and that each year 6,000 people are diagnosed with the condition[3]. They found that the highest prevalence and incidence rates of MS were observed in Scotland, with 190 cases per 100,000[4]. Through carrying out a literature review I could see that there is currently a clear lack of studies and research based on oral health and multiple sclerosis. Considering there is such a high population of people diagnosed with MS in the UK, there should be more research into this area.

ABOUT THE AUTHOR
Rebecca Wilson qualified as a dental hygiene therapist in 2015, after gaining a Bachelor of Science in Oral Health Science at Glasgow Caledonian University. She currently works as a dental hygiene therapist at Spring Grove Clinic in Auchterarder and Comrie.

The National Institute of Clinical Excellence (NICE) recently published updated guidelines for MS management in October 2014. The NICE clinical guideline 186 titled: Multiple Sclerosis: Management of Multiple Sclerosis in primary and secondary care[5] has replaced NICE clinical guideline 8 published in November 2003. This

updated guideline offers evidence-based advice on the care of adults with MS, and outlines how people with MS can receive better care and improve access to therapies that benefit the condition. This document outlines how the care for patients with MS requires a multidisciplinary approach which includes a variety of health care professionals, but it has not included dental care professionals within this multidisciplinary team.

A number of studies (Fischer et al.[6] and Fragoso et al.[7]) recommend that there should be a dental professional included in the multidisciplinary care team of MS patients.

A paper titled Oral and maxillofacial manifestations of multiple sclerosis by Chemaly et al.[8] discussed the three most common oro-facial symptoms presenting in multiple sclerosis: trigeminal neuralgia, trigeminal sensory neuropathy and facial palsy. They suggest that dentists should be aware of the importance of this disease in the diagnosis, treatment and prognosis of oro-facial lesions, and have up-to-date knowledge of the disease.

The paper highlights the idea that dental professionals should be prepared to manage a clinically healthy patient that presents with the oro-facial manifestations of MS, and the possibility of referring them for further investigation. They may be involved in the diagnoses of these patients, so it is vital that they have full knowledge of the disease.

Reich and Campbell[9] also looked into the various oral implications of MS and how to provide effective care to these patients. They particularly focused on trigeminal neuralgia and how it may be triggered by routine actions such as tooth brushing and mastication. They suggested that patients may be disinclined to continue oral hygiene practices if they trigger painful attacks, so it may be necessary to manage the patient's systemic disease first, before they can achieve good oral health. This emphasises the importance of dental professionals being included in an inter-professional care team for MS patients, as dental professionals and neurological specialists will be able to work together to successfully manage the patient's condition and symptoms, so we can then focus on other aspects like oral health.

Elemek and Almas[10] raised the topic of MS and periodontal disease in their paper Multiple sclerosis and oral health: an update. They state that "Multiple sclerosis and periodontal disease both have an inflammatory origin", and may be linked. However, this requires further investigation. Their paper also discusses that, due to loss of muscular co-ordination and manual dexterity, there is an increased difficulty in maintaining oral hygiene, and as a result, an increased susceptibility to plaque build up which will affect the hard and soft tissues.

They recommend that patients are given specific support such as recommending to use an electric toothbrush. It is also suggested that treatment should be adapted to the individuals needs, for example, longer appointment times, with breaks for relaxation of the facial muscles and frequent urination (which is a common symptom that can occur with MS). These appointments should be carried out in a relaxed environment, and "in the morning, as these tend to be less stressful for patients with neurological problems"[10].

FIGURE 1
PLEASE SPECIFY WHAT TYPE OF MULTIPLE SCLEROSIS YOU ARE DIAGNOSED WITH

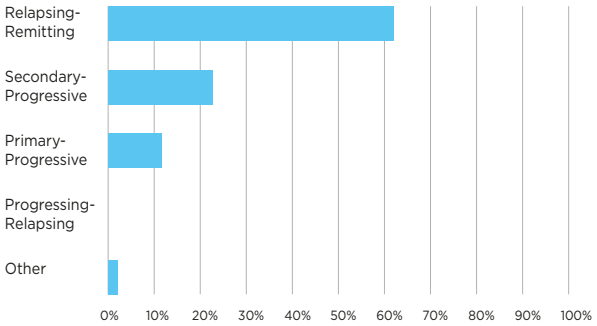
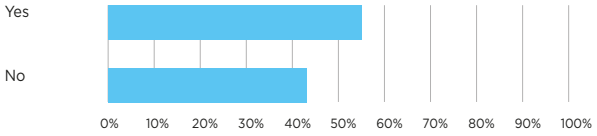


FIGURE 2
DO YOU FEEL THAT YOU EXPERIENCE ANY DIFFICULTY WHEN TREATING A PATIENT WITH MULTIPLE SCLEROSIS



The paper also suggests that treatment should be carried out when the patient is in remission. This is when their symptoms can partially or completely subside for a period of time, which can make treatment easier for them and the operator. The clinician should also consider the referring the patient to a hospital outpatient clinic for care. The study also states that people with MS consider their oral health to be important, as they found that a large percentage visited their dentist regularly. I believe that since these people want to have good oral health, the dental care professionals should provide tailored advice and support to these patients so they can maintain their oral health.

Baird[11] designed a cross-sectional postal questionnaire-based study to determine the impact that MS has on patient attendance at dental practices, and maintenance of oral health in Leicestershire, UK. This study further supports the idea suggested in the previous paper that people with MS consider their oral health to be important. They found that compared to the general population, a higher proportion of people with MS were registered with a dentist (49 per cent compared with

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88 per cent), and they also frequently attended more in the past year (71 per cent compared to 81 per cent). This shows that oral health is very important to these patients, and they may be more aware of their oral health and are conscious to take care of their teeth and mouths.

However, people with MS said that they experienced difficulties attending a dental practice and maintaining their oral health. The greatest problem that was identified which has an impact on attendance was reduced mobility. These patients may face barriers to dental care, particularly as their disability increases.

The study recommends that initiatives are required to increase awareness of the importance of oral health to the quality of life of people with MS, and to ensure that access to dental services for individuals with physical disabilities improves, so that these people receive the same access to care as the able-bodied. It also suggests that patients with a progressive disability may greatly benefit from the provision of preventative oral health care.

A study titled Oral Health Status of a population with Multiple Sclerosis by Santa Eulalia-Trosfontaines et al.[12] aimed to determine the oral treatment needs of patients diagnosed with MS in a community in Madrid. They carried out a cross-sectional epidemiological study with a sample of 64 patients aged 25-77 years. They did not specify the type of MS that each individual has.

To evaluate the oral health status, they used guidelines from the WHO. They found that caries prevalence was 100 per cent in all groups, and on analysing gingival health, 65 per cent of people had calculus, 5 per cent had bleeding, and 30 per cent were healthy. The DMFT index found was very similar to that of the general population in that area. However, the gingival health status was poorer in this group of MS patients, and demonstrated that people with MS require specific assistance with their oral hygiene routine, especially in regards to gingival health.

Fischer et al.[6] listed the various medications that are prescribed for the management of MS, along with the vast range of side effects that can occur, and in particular the oral side effects, such as: mucositis, ulcerative stomatisis, gingival hyperplasia, xerostomia, postural hypotension, glossitis, and immunosuppression. Drugs taken for MS can treat relapses, modify the disease course or manage the symptoms of the disease[13].

Disease modifying medications (e.g Copaxone or Tysabri), and steroids for treatment of relapses are the most commonly prescribed medications. However, there are also various medications taken to manage symptoms of the disease such as Amitriptyline, Carbamazepine, and Baclofen. Alternative therapies such as aroma therapy, acupuncture, vitamins and hyperbaric oxygen therapy are popular.

In order to carry out the study for my project, a series of two questionnaires were given to patients with MS (contacted through the MS Central Online Support Group, and Revive MS Therapy Centre), and to general dental practices (to be completed by dentists, dental hygienists or dental hygiene-therapists) throughout Scotland.

I found a strong correlation between the results I had gained with the evidence I discussed in my literature review.

I found that carrying out the project gave me a clearer understanding of the disease

FIGURE 3
DO YOU FEEL THAT YOU WOULD BENEFIT FROM FURTHER TRAINING OR GUIDELINES ON HOW TO MANAGE THE ORAL HEALTH OF PEOPLE WITH MULTIPLE SCLEROSIS?

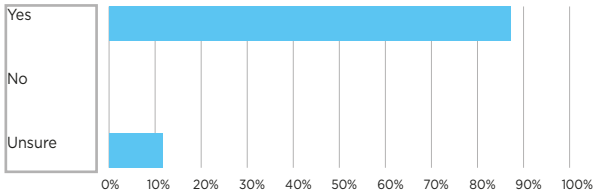
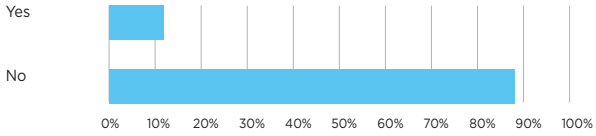


FIGURE 4
DO YOU FEEL FULLY AWARE OF THE EFFECTS THAT MULTIPLE SCLEROSIS CAN HAVE ON YOUR ORAL HEALTH?



The majority of respondents were diagnosed with Relapsing Remitting MS (Fig 1), and the overall majority stated that they attend a general dental practice for care. The respondents with primary progressive stated that they were treated in a community dental setting, which would be expected, as these facilities offer ease of access and more appropriate specialist treatment suited to the individual patient's needs. Baird[11] supports this as he identified that MS patients face increasing barriers to dental care as their disability increases, and so we need to ensure that access to dental services for these individuals improves.

The patients felt that fatigue, weak hands and arms, poor control and co-ordination all affected their ability to clean their teeth and so can affect oral health. This supports what Reich and Campbell[9] found when they looked into the various oral implications of MS and how to provide effective care to these patients. They stated how loss of muscular co-ordination and manual dexterity leads to an increased difficulty in maintaining oral hygiene.

The dental practitioners stated that they advised the use of an electric or large handle tooth brush, adapting the patient's oral hygiene routine, use of fluoride in all forms,

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VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

1. To investigate the oral problems associated with multiple sclerosis and the management of these patients within general dental practices throughout Scotland.
2. Investigate the effects that multiple sclerosis has on oral health.
3. Investigate the oral side effects of drugs taken by patients for the treatment of MS.
4. Investigate the management and advice given to patients with MS within a general dental practice.
5. Evaluate the possible improvements that could be done to make MS patients and dentists/dental hygienists and therapists aware of the oral implications that the disease has.

LEARNING OUTCOMES:

By the end of this article you should be able to:
1. Know what type of disease multiple sclerosis is
2. Know that there are different types of multiple sclerosis
3. State the prevalence of MS in Scotland
4. Be aware of the oral side effects of drugs taken for the treatment of multiple sclerosis
5. List the symptoms of the disease that can affect the ability of a patient to maintain optimal oral hygiene
6. Know the recommendations for the management of patients with multiple sclerosis.

EXAMPLE QUESTION

What kind of disease is multiple sclerosis?
A. Auto immune
B. Viral
C. Infectious
D. Blood borne

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xerostomia advice, and diet advice. The practitioners also stated that when treating a patient they try to ensure the surgery is wheelchair and mobility-aid accessible. They also aim to have lengthy appointment times and to give them lots of breaks. One practitioner stated that they try to keep the appointments to a certain time of day.

From my questionnaires the majority of practitioners stated that they did not feel confident in treating a patient with MS, and felt that they would benefit from guidelines or training. With the clear lack of specific advice and guidelines given it may be hard for practitioners, especially with limited experience, to feel confident in carrying out treatment.

The patient respondents felt that they were not fully aware of the effects the disease can have on oral health.

Both groups of respondents suggested various things that could be done to raise awareness of the oral implications that MS can have – for example, CPD, national guidelines, posters and leaflets.

It is apparent from the results I gained from my questionnaires completed by dentists, dental hygienists and dental hygiene-therapists (Figs 2-4) that some practitioners are aware of the effects that MS has on oral health as well as the effects it may have on receiving dental care. However, with the majority of practitioners stating that they did not feel confident treating a patient with MS, it is clear that there should be more information and training available.

In regards to patients with MS, I can conclude that there should be an increased awareness of the effects that MS can have on oral health, be it the direct effects, such as trigeminal neuralgia, the effects that poor dexterity, facial pain, and fatigue can have on oral hygiene practices, or the oral side effects of medication taken for the management of the disease. Some patients are aware of the effects, but it may greatly benefit the majority patients to have an enhanced awareness.

With the increasing prevalence of multiple sclerosis, especially in Scotland, I believe it is essential that dental care providers have knowledge about the disease, and the effects it has on oral health, so that they can effectively manage the patient in all aspects of dental care.

PATHOPHYSIOLOGY OF SNORING AND OBSTRUCTIVE SLEEP APNOEA

DENTAL SLEEP MEDICINE

An increasing number of dentists are managing sleep-related breathing disorders. What are its causes and consequences?

ADITI DESAI

The upper airway in humans has multiple purposes: speech, swallowing and breathing. It comprises soft tissue and muscle, but, importantly in the context of this article, does not have hard, bony tissue to prevent the muscle or soft tissue from compressing or collapsing.

The collapsible part of the upper airway, which spans the hard palate to the larynx, can change shape and close briefly to allow for speech and swallowing. It is the collapse of this upper airway during sleep that precipitates an apnoeac event.

Sleep-disordered breathing

The upper airway collapses during sleep when there is no compensatory input to the motor neurones of the upper airway dilator muscles – mostly the genioglossus and tensor palati muscles. How often the person compensates for these collapses determines the rate at which the cycle repeats. When airflow is blocked for 10 seconds or more, it is called apnoea (or apnea) meaning suspension of breathing. Hypopnoea (or hypopnea) is a partial collapse of the airway that results in an airflow reduction of greater than 50 per cent for 10 seconds or more (Figure 1).

Although several neurotransmitters and neuromodulators have been identified as contributing to the regulation of the upper airway opening, there has been little progress finding a medicine to prevent its collapse.

Burwell, Robin, Waley and Bickelmann studied the pathophysiology of sleep apnoea-hypopnoea syndrome (SAHS) in the 1950s. They titled an article published in the *American Journal of Medicine* in 1956 'Extreme obesity associated with alveolar hypoventilation: a Pickwickian syndrome'. This was in homage to Charles Dickens, whose main character Joe in *The Pickwick Papers* (1836) falls asleep in any situation at any time of day. Pickwickian syndrome can still be found in medical dictionaries to this day.

In 1964, a study showed that 91 per cent of snoring patients had a narrow pharynx, elongated soft palate and uvula. This led in due course to tracheostomy being the first successful treatment – despite serious disadvantages, including recurrent purulent bronchitis and speech difficulties.

Sleep apnoea

Pickwickian syndrome is now commonly called obstructive sleep apnoea (OSA) and we should distinguish between the two types – obstructive sleep apnoea and central sleep apnoea (CSA).

OSA is the result of the mechanical collapse of the upper airway, whereas CSA arises from a reduction or lack of brainstem activity regulating the respiratory muscles activity in failing to send a message to the respiratory muscles to breathe. Each type of apnoea is managed differently.

Where does airway collapse occur?

The upper (pharyngeal) airway from the hard palate to the larynx is made up of hard tissues – the hard palate, the maxilla and mandible, the nasal turbinates, the hyoid bone (anteriorly) and cervical vertebrae (posteriorly) and a collapse of the tube in between.

The pharynx has three segments: from top to bottom the nasopharynx, the oropharynx and the hypopharynx.

The nasopharynx connects the nose to the mouth and remains open when surrounding muscles flex so that the person can continue breathing. The salpingopharyngeal fold and tubal tonsils surround it.

The soft palate (velum or muscular palate) separates the nasopharynx from the oropharynx, which extends from the uvula to the level of the hyoid bone. The oropharynx is divided into the retroglossal pharynx (from the soft palate to the epiglottis) and the hypopharynx (from the epiglottis to

Ageing may lead to reduced muscle tone and hence greater likelihood of airway collapse

the larynx). In addition, the area between the retropalatal and retroglossal pharynx is also called the velum (Fig 2).

OSA and bony structures

We'll look now at what bony structures can predispose to OSA. Any abnormalities in the hard tissues such as the mandible, maxilla, hard palate and hyoid bone can contribute to the displacement of the soft structures, such as the tongue. This, in turn, can lead to airway obstruction. Bony protuberances along the cervical vertebrae can also lead to airway obstruction.

The most common skeletal abnormally likely to lead to OSA is a short mandible. Shiroh Isono et al published in the *Journal of Applied Physiology* in April 1997 concluded: "The results support the anatomic hypothesis that sleep apneic subjects have a structurally narrowed and collapsible pharynx."

Studies have also found that the more inferior the hyoid bone, the more likely the tongue will be displaced lower and potentially increase the risk of developing OSA (Fig 3).

OSA and soft tissues

Typically, someone with OSA will have a disproportionately higher volume of soft tissue compared to their hard tissue cage and any inflammation of these soft tissues may contribute to airway obstruction. Whether increased fat pads also predispose to airway compression is disputed.

Nocturnal rostral distribution, whereby fluid is displaced from the legs to the neck during sleep, can lead to increased pressure in the blood vessels, hence the sort of upper airway collapse seen in patients with, for example, heart failure.

OSA and general factors

Here, I shall discuss how gender, ethnicity, age and obesity can contribute to the pathophysiology of OSA.

OSA is present in twice as many men (around 4 per cent of the population) as women (2 per cent). Incidentally, these figures are only for those diagnosed with OSA – probably only one fifth of all those who have the disease.

It appears men are more likely to experience airway collapse because of their higher pharyngeal resistance, but the effect of testosterone may also be a factor. Women's risk of having sleep apnoea increases after menopause, and those who have the condition have more severe symptoms than do younger women.

Although there has only been limited research, there are ethnic differences in the prevalence and severity of OSA. For instance, epidemiological studies show African-Americans have a larger tongue and longer soft palate, whereas Asians generally have a shorter maxilla and mandible and lower BMI than Caucasians.

A study by Wen Bun Leong et al published in the *Journal of Clinical Sleep Medicine* (Vol 09, No. 09) concluded: "OSA prevalence and comorbidities was greater in severely obese South Asians compared to obese white Europeans. South

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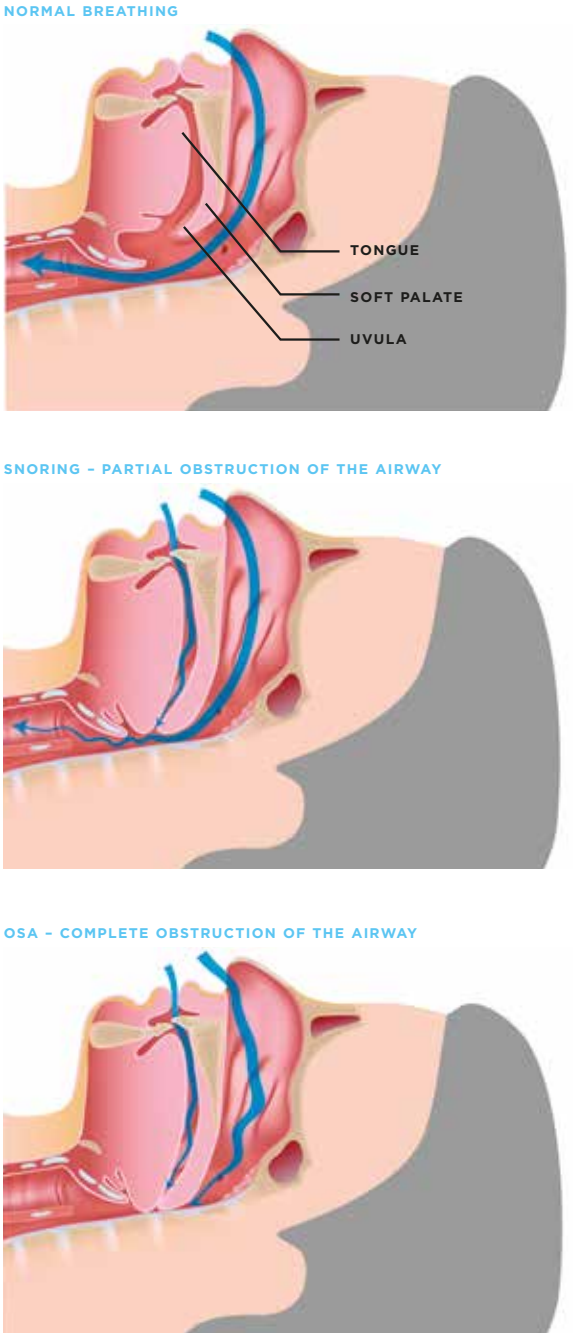
FIGURE 1
The mechanism of airway obstruction



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Asians also had more severe OSA compared to BMI-matched white Europeans."

There is an increased risk of OSA as one gets older. Ageing may lead to reduced muscle tone and hence greater likelihood of airway collapse. NHS Choices states that: "Although OSA can occur at any age, it is more common in people who are over 40."

By contrast, obesity is a significant factor in the development of OSA. This may be due to the increased fat deposits in the neck resulting in greater extraluminal pressure and airway narrowing. Certainly, it has been shown that fat deposition around the neck is more critical than body mass, which is why neck circumference is such an important measure. NHS Choices states: "Men with a collar size greater than around 43cm (17 inches) have an increased risk of developing OSA."

Other general factors that may contribute to the pathophysiology of OSA include high blood pressure, diabetes, genetics, smoking, alcohol and drugs (hypnotics and sedatives).

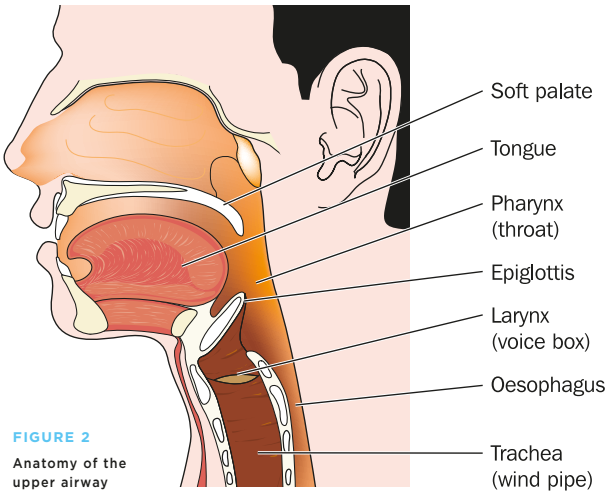


FIGURE 2
Anatomy of the upper airway

So far, so interesting

Before I move on from the physiology to the pathology, I'll summarise what we've learned so far.

For factors contributing to the pathophysiology of obstructive sleep apnoea, I invariably use the table in an article by Deegan and McNicholas published in *European Respiratory Journal* in 1995. Incidentally, I recommend this article, Pathophysiology of obstructive sleep apnoea, because it goes into much greater depth than I have room for here. It is available at http://erj.ersjournals.com/content/8/7/1161

General factors are anthropometric (male sex, age, obesity), drugs (ethanol, hyponotics) and genetics.

Reduced upper airway calibre can be a result of specific anatomical lesions (enlarged tonsils, micrognathia – a lower jaw smaller than normal), neck flexion and nasal obstruction.

Mechanical factors are supine posture, increased upper airways resistance and increased upper airway compliance.

Upper airway muscle function – abnormal upper airways muscle activity; impaired relationship of upper airways muscle and diaphragm contraction.

Upper airway reflexes – impaired response to negative pressure and feedback from the lungs.

Central factors are reduced chemical drives, increased periodicity of central drive and inadequate response to breath loading.

Finally, under the heading of arousal, we have impaired arousal responses and post-apnoeac hyperventilation.

The consequences

Sleep-related breathing disorders (SRBDs) have an adverse effect on the cardiovascular, metabolic, endocrine, nervous and immune systems and the metabolic cycle.

Snoring and obstructive sleep apnoea are serious conditions with possible grave consequences

There have been numerous studies on the relationship between SRBDs and cardiovascular consequences. Originally the coexistence of SRBDs with cardiovascular diseases was thought to be due to shared risk factors such as age, gender and obesity. However, Bananian et al published an article 'Cardiovascular consequences of sleep-related breathing disorders', in which they stated: "...recent epidemiologic data confirm an independent association between SRBDs and the different manifestations of cardiovascular diseases." (http://europepmc.org/abstract/med/12350242).

Kathleen A Ferguson and John A Fleetham published an article in *Thorax* in 1995 which went into great detail about the consequences of sleep disordered breathing (http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1021319/).

In relation to cardiac consequences, they cited systemic hypertension, stating: "In patients with sleep disordered breathing, there are brief phasic changes in blood pressure superimposed on a cyclical pattern which coincide with the upper airways obstruction."

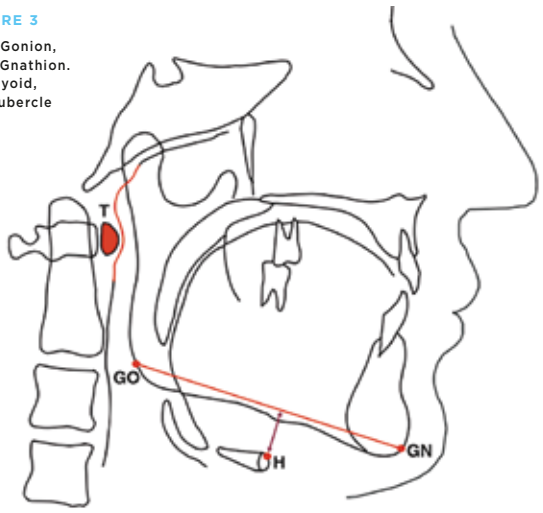
For pulmonary hypertension/right heart failure, they wrote: "The cyclical changes in pulmonary artery pressure parallel the changes in systemic blood pressure."

They also considered cardiac function – "Treatment of sleep disordered breathing can improve cardiac function in selected patients" – ischaemic heart disease (coronary artery disease) and cardiac arrhythmia (irregular heartbeat).

The Wisconsin Sleep Cohort (WASC) is an ongoing longitudinal study of the causes, consequences and natural history of sleep disorders, particularly sleep apnoea, which has been running for more than 20 years. Research into coronary heart disease as part of WASC, published in SLEEP, the joint publication of the Sleep Research Society and the American Academy of Sleep Medicine, concluded: "Participants with untreated severe sleep disordered breathing (AHI > 30) were 2.6 times more likely to have an incident coronary heart

FIGURE 3

Go = Gonion,
Gn = Gnathion.
H = Hyoid,
T = Tubercle



VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To provide an overview of the causes of sleep-related breathing disorders
- To explain the consequences of sleep-related breathing disorders
- To explain the different forms of obstructive sleep apnoea and what causes them
- To describe the factors contributing to the pathophysiology of obstructive sleep apnoea.

LEARNING OUTCOMES:

By the end of this article you should be able to:

- Understand the causes of sleep-related breathing disorders
- Understand the consequences of sleep-related breathing disorders
- Know what the different forms of obstructive sleep apnoea are and what causes them
- Demonstrate a basic understanding of the factors contributing to the pathophysiology of obstructive sleep apnoea
- Show awareness of the British Society of Dental Sleep Medicine and what it offers.

HOW TO VERIFY YOUR CPD

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disease or heart failure compared to those without sleep disordered breathing. Our findings support the postulated adverse effects of sleep disordered breathing on coronary heart disease and heart failure." (see www.journalsleep.org/ViewAbstract.aspx?pid=29996).

AHI stands for apnoea-hypopnoea index – the average apnoeas and hypopnoeas that occur during sleep. Mild OSA is in the AHI scale of five to 15. Moderate OSA is when AHI is between 15 to 30. Severe OSA, with an AHI of 30 or more, could, for example, mean falling asleep while driving.

The metabolic syndrome, including cardiovascular disease, diabetes and stroke, is diagnosed when an individual presents with three or more of the following factors:

1. Increased waistline with high BMI
2. Increased blood cholesterol HDL
3. Increased blood triglycerides
4. Increased blood pressure
5. Impaired fasting glucose.

Other consequences of SRBDs include cerebrovascular disease, excessive daytime sleepiness, personality and behavioural changes, decreased libido and/or impotence and nocturia (the need to urinate during the night).

For clarity and convenience, I list these consequences of SRBDs below:

1. Daytime fatigue with an increased risk of road traffic and work-related accidents
2. Decreased cognitive function
3. Increased risk of cardiovascular disease
4. Increased risk of diabetes
5. Eye complications
6. Memory loss
7. Learning difficulty and growth in children
8. Sleep-deprived partners with ensuing marital strife
9. Complications during sedation and general anaesthetic for surgery
10. Morning headaches
11. Mood swings and depression
12. Nocturia
13. Decreased libido and erectile dysfunction
14. Depression
15. Insomnia.

Conclusion

Snoring and obstructive sleep apnoea are serious conditions with possible grave consequences, including an increased mortality rate. Dentists can work alongside the medical profession to help with the screening, assessment and subsequent treatment process.

The British Society of Dental Sleep Medicine (BSDSM), of which I am president, is a professional organisation for members of the dental team interested in helping patients seeking help for snoring and obstructive sleep apnoea. It advocates medical diagnosis and the provision of the most appropriate therapy.

The BSDSM runs one-day introduction to dental sleep medicine courses and more information, as well as online booking, is at www.dentalsleepmed.org.uk

ABOUT THE AUTHOR

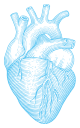
Dr Aditi Desai works with respiratory, chest and sleep physicians, ENT consultants, neurologists and psychologists helping manage patients with snoring and sleep apnoea at the snoring and sleep apnoea clinic at 76 Harley Street, London. She is also a dental surgeon with special interest in sleep medicine at London Bridge Hospital.

Dr Desai has accreditation from the European Academy of Dental Sleep Medicine and is a member of the American Academy of Dental Sleep Medicine. She is president of the British Society of Dental Sleep Medicine (BSDSM).

PERIO DISEASE AND CVD

RESEARCH

Are periodontal disease and cardiovascular disease linked? If so, how strong is the link?



TEGAN DOWLER

This review looks at links between cardiovascular disease (CVD) and periodontal disease (PD). The literature for the review was acquired by searching databases that were available through UHI multisearch, ResearchGate, Pubmed, Wiley Online Library and the NHS Knowledge Network. The search terms used were cardiovascular disease, heart disease and periodontal disease. From an original 24 papers which were initially found, in total 17 papers fitted the criteria and were analysed for this review. The criteria included: the paper must be a free full text, written in English, from anywhere in the world, must be within 25 years of age, from an unbiased source, subjects could be male and/or female and of any age range.

The links between CVD and PD are often overlooked. In recent years a variety of research and studies have taken place and allowed the links to be strengthened. Despite this there is no mention of the connections on well-known websites such as the British Heart Foundation and the NHS, which are often patients' first port of call after diagnosis. In this literature review, the target is to provide a detailed analysis of papers to aid the clinician to be able to give a more holistic approach to the treatment provided. [1,2]

The link between CVD and PD has been a topic which has been well researched over previous decades and many correlation links have been found, suggesting that the bacteria from the oral cavity enters the blood stream when PD is present and gingival inflammation is existent and thus the bacteria in the blood stream can cause cardiovascular problems by contributing to atheroma formation. [1,2]

The effect this has on dental clinicians is that they should have the knowledge to educate and forewarn the patient on the links and increased CVD risks when PD is present. This could help to potentially aid the patient and thus stop the possibility of a fatality. A holistic understanding is the key to first-class patient care. Therefore, the aim of this literature review is to look at how strong the link between CVD and PD is which will then aid clinicians to further their understanding in this area before being competent to pass the understanding on to patients.

Review of papers

The studies that were analysed within this review were no older than 25 years, so as to avoid dated evidence but to keep the selection open for longer studies to be included. They were ranked on the hierarchy of evidence in order to check they were a good source of evidence to be included (Appendices one and two are available in the online version at www.sdmag.co.uk).

Only four of the papers looked at were pre-2000 so much of the evidence gathered was within 14 years of this review. With regards to the references, Grau et al. (2004) [4] had a reference 58 years old at time of publication, which is quite old. However, the other references within this review are up to date, and older references are often required to aid in the basic knowledge present today. The papers (DeStefano et al. 1993 [5], Joshipura et al. 1996 [6], Mattila et al. 1989 [7], Mattila et al. 1995 [8]), which were pre-2000, together had references that were not older than 26 years old at time of publication, meaning they are still relevant and used to date and can aid the reasoning for current research.

The methodology used is similar within the papers, with links between CVD and PD trying to be found by clinical dental examinations and cardiovascular events recorded, although understandably the studies did vary from each other in some areas.

Three of the papers (DeStefano et al. 1993 [5], Hujoel et al. 2000 [9], Wu et al. 2000 [10]) look at the same data

that was gathered from the First National Health and Nutrition Examination Survey in the US. It was a cohort study that included a dental examination recording number of decayed permanent teeth, oral hygiene index, periodontal classification and periodontal index. Recalls of the subjects happened on four occasions. Each paper looks at the data with slightly different interpretation and includes different sample sizes of different subjects involved, depending on what limitations the authors put in place, meaning there was a difference of between 8,032 and 20,749 included subjects among the studies. Despite this, they were in agreement that there was a correlation. However, they found that the data from this study was inconclusive or statistically inconclusive to PD having a causal association with CVD. Due to the difference in participants numbers, the exact percentages of increased risk varies and because each study presents the data differently, this makes it challenging to compare how different these figures are from each other. Nevertheless, findings which were in agreement were that African-Americans and men are higher risk factors, although this could be due to the fact they are more susceptible to PD and thus the correlation of CVD follows.

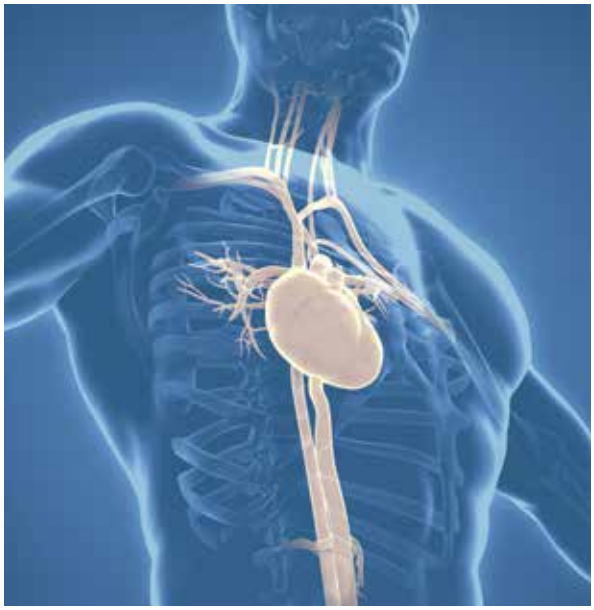
A different, yet similar study [11] with a much smaller sample size of 241 coronary heart disease (CHD) patients and 50 control patients, undertook a dental examination making note of the probe depth, recession and bleeding on probing. This study found that CHD patients had significantly higher loss of clinical attachment, probing depth and missing teeth compared to non-CHD patients.

In agreement with the previous papers discussed, [5],[9], [10], it also found that men were a common risk factor. In addition, diabetes and smoking patients were found to increase this risk further, which is possibly due to the interconnection between diabetes and PD and how smoking effects the wound healing and thus regeneration, both of these would make the PD more severe. This paper again concluded that there was a positive association between CHD and PD, as in all areas patients with CHD had higher figures (pocket depths, clinical attachment loss, bleeding on probing and missing teeth) than the non-CHD subjects. [12],[13]

Some studies relied on questionnaires [14], [15], [16] to gather much of their initial data, meaning sample sizes could be larger as costs of clinical examinations are reduced. After the initial information from the questionnaires was gathered, national databases and medical records could be checked to follow cardiovascular events for the remaining study. This allowed the studies to be over a much greater time period and therefore more cardiovascular events can be recorded and the links looked into by the authors.

The Mucci et al. [15] study lasted for 37 years, in which time 15,273 Swedish twins could be considered. It was discovered that the shared genetic factors were responsible for an association between PD and CVD. In addition, twins with severe tooth mobility were at 30 per cent greater risk of developing CVD than those with no tooth mobility. Having mobile teeth means that PD must be present, so this risk can further strengthen the links.

To oppose this, Howell et al. [14] after studying 22,071 US male physicians, concluded that there was no risk factor between CVD and PD. However, it was noted that men who reported PD at baseline had elevated but statistically non-significant increased risk of nonfatal myocardial



infarction, stroke and cardiovascular death (10-20 per cent). Although the information is non-significant, it still links in from the study on the increased risk men have found by other studies [5], [9], [10], [11].

Oliveira, Watt and Hamer [16] looked at the links between CVD and oral hygiene. As it is known that it is the bacteria in the plaque, which is the cause of PD, this study can be included. With a sample size of 11,869, it was found that there was no clear difference between age, sex and smokers or non-smokers. In this study it was found that there was a significant association between tooth brushing and CVD, a 70 per cent increased risk if oral hygiene is poor. In addition, frequency of tooth brushing and markers of low-grade systemic inflammation found a direct correlation with C-reactive protein and fibrinogen – the more times teeth were brushed, the lower the number of inflammatory markers. However, it was again concluded that the link between CVD and oral hygiene is present but whether it is a casual link or risk marker is not certain.

When looking at clinical measurements, Machuca et al. [17] undertook a 10-year longitudinal study directly comparing CVD patients and healthy control groups. A dental examination was done at baseline, 12 months and 10 years to try to see if there was any significant difference in the two groups. At baseline, CVD patients did have higher numerical values, but this has been classed as non-significant. After just 12 months, pocket depths were already significantly different with 3.0±1.3 (mm) in the control group and 4.1±1.5 (mm) in the CVD group, but by the 10-year follow-up visit this had once again dropped down to non-significant figures, consistent for clinical attachment loss.

The paper summarised by saying that patients with CVD had bad initial periodontal status and presented a worse response to treatment than the control group. Having said

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this the CVD patients had a significantly greater plaque index score in all three examinations, so this would effect the treatment. In addition, the control group was selected due to periodontal problems, so this would mean the figures were not accurately based on truly healthy subjects and actually patients who already had deeper periodontal pockets and thus this cannot be classed as genuine health. In addition to this, there were only nine patients in the control group and 35 in the CVD group which is a very small sample size and may not have a wide enough range of ages, sex, socio-economic group etc.

Grau et al. conducted a similar study, although it was a case-controlled study and patients were only examined once. The way it was completed was by examining 303 patients seven days after the cardiac event, including 300 population control patients and 168 hospital control patients. The results showed that the clinical attachment loss mean is higher in the cardiac patient group than both the control groups and this pattern remains for gingivitis, plaque levels and radiological bone loss.

The number of teeth is significantly lower in cardiac patients than the two control groups also. This shows that periodontitis is more severe in this cardiac patient group. The results were all collected in the same way using well-recognised indexes, e.g. Silness and Loe plaque index, allowing the possibility of bias to be reduced. From the results, it shows that an increased severity of periodontitis was associated with an increased risk factor of 4.3 for cerebral ischemia and thus there was a significant association. Looking at Machuca et al. [17] study in comparison it would be good to see Grau et al. [4] study done on a longer term or with follow up visits to see if and how the results change.

The two papers from Mattila et al. [7], [8] looked at the same study although the 1995 paper included an extra series. And, while the 1989 paper does not state dates of the examinations, it is clear they are the same as the 1995 due to sample size of patients, results and that the papers both have fundamentally the same authors. The dentist measured the severity of tooth infection and periodontium after discharge form Helsinki University Central Hospital due to acute myocardial infarction. Patients were then given a score on dental disease of 0-10.

The 1995 papers results agree with and then go further

HIERARCHY OF EVIDENCE

- SYSTEMATIC REVIEW/META ANALYSES
- RANDOMISED CONTROLLED TRIALS WITH DEFINITIVE RESULTS
- RANDOMISED CONTROLLED TRIALS WITH NON-DEFINITIVE RESULTS
- COHORT STUDIES
- CASE-CONTROLLED STUDIES
- CROSS-SECTIONAL SURVEYS
- CASE REPORTS

The links between CVD and PD are often overlooked. In recent years, research has allowed the links to be strengthened

than the 1989 paper and found that with the additional observations the severity of dental disease correlates with the magnitude of coronary atheromatosis. However, it still only suggests that the association is correlation and not causality. A point that has to be remembered with these studies is that the dentist knew if the subject was a control or patient and so this may cause slightly influenced results.

Joshipura et al. [6] completed a six-year cohort study on 44,119 male health professionals to look at the incidence of coronary heart disease in relation to the number of teeth present and PD. An area, which this study looked at that other studies have overlooked, is the participants diet. Tooth loss can lead to changes in diet and thus increase the coronary heart disease risk. It was discovered that tooth loss was associated with an increased consumption of saturated fats and cholesterol and decreased consumption of fruits, vegetables, carotene and fibre. These food groups are connected with CVD and so this is a possible trigger that has been overlooked in other studies.

At baseline it was discovered that the number of teeth was negatively related to age, smoking and coronary risk factor. There was a significantly higher incidence of coronary heart disease when there were 10 or fewer teeth when compared to full dentition in both groups (positive periodontal history 5.4 per cent to 2 per cent and negative periodontal history 3.74 per cent to 1.42 per cent) with this study having a high follow up rate it thus reduces bias. The overall findings were that no overall association was found between PD and coronary heart disease, although tooth loss may increase the risk, which could mean there was a history of PD.

DeStefano et al. [5] makes a valid point by suggesting that dental infections and coronary artery disease share similar etiological factors, consequently leaving the possibility that it could be poor oral health which is distinctive of an individual's lifestyle that increases the risk of coronary artery disease, which is a type of CVD. Things such as smoking, diabetes and low socio-economic status are these types of factors. Mattila et al. [7] found that the total dental index correlated significantly with social class, subjects in the lower classes had worse dental health, which agrees with the DeStefano et al. [5] argument.

Within Lamont and Jenkinson's [18] textbook (p55) the potential causal bacteria are briefly mentioned. However, it is said that evidence is yet to be convinced. With regards to the mechanism of the bacterium on the cardiovascular tissues, papers are very limited – the oldest paper to be looked at is 2009. The studies are all very new with no older papers, as the research itself is still new.

The reviews [19], [20], [21], [22], [23] looked at the types of bacteria, which could cause the links between CVD and PD. Asikainen [20] made the valid point that obtaining valid causal research is difficult due to both conditions being chronic and progressively advancing asymptomatically over many years. In addition, there are vast amounts of data, which require to

be interpreted; new methods are being looked at to aid this. It is also said that due to the controversial results of studies, doubts of validity have been raised on the relationship. Despite this, there is still a biologically feasible basis and thus research is continued to take place.

The distinct method of the way in which bacteria causes CVD has been very briefly described within a highly recognised textbook by Clerehugh, Tugnait and Genco [3] (p24-25). However, the paper by Saini, Saini and Saini [23] goes into further detail and describes two theories. Number one being that the oral bacteria affects the heart by attaching itself to fatty plaques within the blood stream and this contributes to clot formation. These clots can block the blood flow and thus lead onto heart attack or other problems.

The second theory is that the PD causes inflammation, which increases the plaque build-up which in turn may contribute to the swelling of arteries. Inaba and Amano [20] agree and comment that due to the clear evidence of the association, control of the oral disease is essential for prevention and management of the condition. According to studies [19], [20] this is because as PD progresses, epithelium develops to be ulcerated. This exposes the connective tissues and blood capillaries, thus allowing bacteria from the plaque biofilm to enter the blood stream. To further this, Kerrigan and Cox [21] gave an explanation saying that once this bacteria has entered the blood stream it forms platelet-bacterial aggregates when contact with platelets is made, these bind to heart valves or are involved with atherosclerosis sites.

Saini, Saini and Saini [23] revealed that there are more than 500 bacterial species, which are capable of colonising within the oral environment. Despite this huge number required to be investigated, *P. gingivalis* is a bacteria that has come to the attention by having an etiological role in the mechanism. Kerrigan and Cox [21] are in agreement with this but investigated *Streptococci ssp.* and found that along with *P. gingivalis* these are the two bacteria that are capable of initiating the platelet activation. In addition, a point was made that several bacteria have evolved so that interactions occur at the same time that get the same response. This makes it more difficult to pinpoint the exact bacteria causing the problem, plus most studies to date have been done under static conditions, which may not reflect the same response as in the fluid environment present within the body.

This review... has concluded that the link is present... and the causal factor is closer to being recognised

A final review which gives slightly more information [22] finds that it is the bacteria with strains of serotype-k could circulate through the body more freely and thus there is a possibility that serotype-k *S. mutans* strains are more likely to be associated with the systemic diseases. Having said this, studies are remaining to take place and it is currently an on-going research process. Due to the research, which has been completed so far being sparse and very new, there is a great need for further research to be completed to strengthen the link and validate the findings further.

Conclusions

The results of the review show that there is a link between CVD and PD, with the majority of studies finding conclusive results of a link, even if this link was small. Howell et al. [14] concluded that there was no risk factor between PD and CVD, despite having slightly elevated figures in the results they gathered. This is due to the fact the results are not significant enough to make this a certainty. This is the case that many of the studies presented with non-significant results, due to their only being a slight difference. This makes it difficult to be confident with the results; however, taking into consideration the age and research done since the uncertainty of these few studies it is clear that a link is present. Older papers were required to look at the progression of knowledge.

This topic is difficult to research due to there being many variables which could influence the results; diet, smoking, diabetes, socio-economic class etc. and thus it is difficult to get an appropriate cohort with all aspects the same to be able to complete a fair assessment of the link. This also means that only a correlation can be made as it may not necessarily be the PD which is the cause of CVD it maybe one of the other factors which is common with PD and CVD which influences the disease.

For a cause to be found further studies have to be done. Within the last five years, studies on the exact bacteria, which could be the cause, have commenced. There are, however, hundreds of bacteria to be researched which is a long task to complete and, therefore, further studies are required to look at all the oral bacteria and how they influence PD and CVD. To date it is *P. gingivalis* and the serotype-k *S. mutans* strains which have been found to be the potential cause.

There were a variety of studies analysed in this review. There were a total of five cohort studies that are mid-way on the hierarchy of evidence. Four case-controlled studies were analysed in addition and these fall just below cohort studies. Only one randomised controlled trial was included. However, it was a conclusive study that increases its validity upon the hierarchy further. With regards to the bacterium research, it was mainly reviews which were used – this is due to the fact that there is limited research completed to date on this aspect. Reviews are, however, at the top of the hierarchy so

CONTINUED OVERLEAF>

FURTHER READING

Baratt, H. (2009) The hierarchy of research evidence - from well conducted meta-analysis down to small case series, publication bias. Available from www.healthknowledge.org.uk/public-health-textbook/research-methods/1a-epidemiology/hierarchy-research-evidence (Accessed 1 November 2014).

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FROM PREVIOUS PAGE>

they were good sources from which to extract information. Overall, a good variety of research was used, ideally more randomised, controlled trials would have been included, although they are not available to date.

The papers were difficult to compare due to differences within each study design, e.g. exclusion of different variables, the time period that the study ran for, the number of participants, extent of PD, etc. This could be seen as a positive as it means a greater variety of subjects have been analysed with different study designs at each time which reduces bias.

This review has looked at the potential link between PD and CVD and concluded that the link is present and with studies on the causal bacteria in the initial stages the causal factor is closer to being recognised. Although there are still not enough studies that have been completed to pinpoint the exact bacteria or trigger between PD and CVD. Nonetheless the research process is a long process with this topic in particular as there are so many other conditions within the human body, which need to remain the identical within subjects during investigations.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To look at the possible link between periodontal disease and cardiovascular disease
- To look at how strong the link between cardiovascular disease and periodontal disease is, if present
- To become more educated on recent studies present.

LEARNING OUTCOMES

After reading this article you will:

- Be more knowledgeable on the link between the two diseases
- Be able to discuss the link with competence to patients
- Be able to work with a more holistic approach from an evidence-based knowledge.

EXAMPLE QUESTION

Tooth brushing and CVD has a ___ increased risk if oral hygiene is poor?

A. 30 per cent
B. 50 per cent
C. 70 per cent
D. 90 per cent

HOW TO VERIFY YOUR CPD

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

ABOUT THE AUTHOR

Tegan Dowler graduated from the University of the Highlands and Islands in 2015 as a dental hygienist/therapist. She is currently undertaking her vocational training in Forres within Forres Dental Care.

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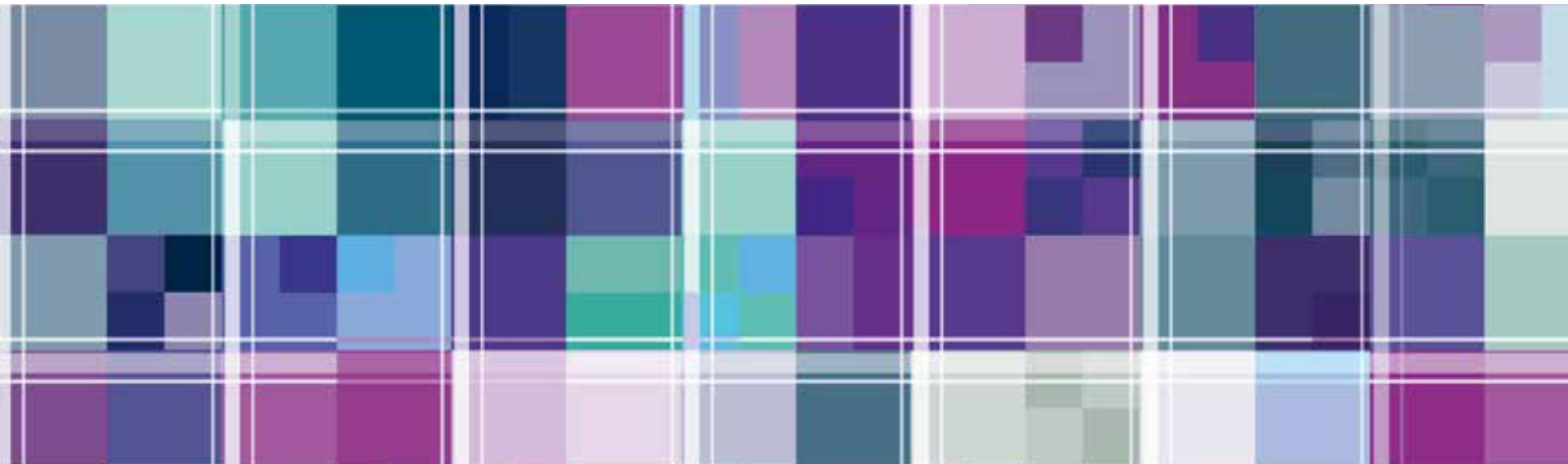

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If progressing the vision for the development of your dental practice, future proofing your practice management systems capability, increasing productivity, eradicating wastage, improving workflows and optimising financial and manpower resources keep you awake at night, then read on, as you'll be interested in the latest thinking for streamlining your practice as a means of improving your bottom line.

As a successful professional in the Scottish dentistry field, moving at a dynamic pace on a daily basis, balancing the needs of work and life can often mean that there is little to no time for thinking of ways to further develop and contemplate how to increase your bottom line and drive up even greater efficiencies for your practice.

But that's really where taking essential time out to consider the benefits of investing in proven and well developed practice management software based on solid development foundations can make a real and sustainable long term difference to the bottom line and future success of your business.

And if you have diarised a visit to the Scottish Dental Show at the Braehead Arena on 13&14 May, then you might like to stop by and see what's on offer in particular from Systems for Dentists, one of the UK's longest established practice management system developers.

The company has nearly 30 years experience in the dental market and this knowledge is being focused to deliver a clear technological development lead with a system that fundamentally echoes what practitioners really need on a daily basis to move their practice forward.

The company's common sense approach allied with powerful technological solutions to drive up practice management efficiencies are adding real value and delivering time and money savings on the bottom line to the Scottish dental industry.

Systems for Dentists is also helping practices in Scotland deliver efficiencies at the touch of a button not only via the robust and tested software interfaces they provide to users, but also through the useful functionality of its systems features.

Consider, for instance, just a few of the ways its V6 Practice Management System could help to streamline your dental practice; real time online appointments, SMS reminders, patient imaging, periodontal charting, clinical notes recording, on line backups, postcode lookups, to name but a few.

But, that's not all, its systems functionality will further help in the future by generating time and money savings and eliminating the paper mountains created by the mandatory paper chase (still inherent in many practices). Its creation and capture of digital signatures will be also a radical and welcome solution accessible in the marketplace moving forward and in their drive to help lead the way to creating the paperless practice.

Add to this, one of the company's latest developments, Virtual Reception, and in the future, 24/7, 365 days a year access for your patients could also be a practical reality.

So, if you are visiting the Scottish Dental Show this 13&14 May, then get hands on with V6 Practice Management System from Systems for Dentists, or ask to try out one of its go-paperless Wireless Signature Pads, and see how to take your practice to the next level in 2016.

Developed by a generation of family business with a long-standing background in dentistry Systems for Dentists certainly understand what practitioners in Scotland truly need and have thought carefully within its product development processes of the systems requirements that will be needed to pivot your practice forward.

Not only that, but its developed solutions proven to improve your patient experience, ensure staff have at their fingertips the automated support they need to eradicate unnecessary manual processes and data recording, and provide automated interventions, are sure to be of interest to assist your practice work at optimum levels and in doing so enrich your staff and patient's experience.

Ryszard Jurowski, is the managing director at Systems for Dentists and a contributing author as well as life-long system development guru with a clear and transparent interest in shaping the future of systems management efficiencies and capability for the benefit of the Scottish dental industry.

His team of specialists will be available to meet those serious about commercial streamlining of your practice on stand G13 at the Scottish Dental Show, 13&14 May, Braehead Arena, Glasgow.

Can't make it to the show? Contact their sales team on 0845 643 2828, email info@sfd.co or download a demonstration of V6 Practice Management Software at www.sfd.co/demo

ADVANCED RESTORATIVE TRAINING

A NEW RESTORATIVE COURSE IS BEING LAUNCHED IN SCOTLAND BY DENTISTS FOR DENTISTS

Bothwell dentist Raymond Murphy is bringing a familiar face back home to launch a brand new restorative course – the first of its kind in Scotland.

The advanced Restorative Course Scotland will be led by Dundee graduate Bob McLelland, a postgraduate lecturer and experienced clinician, with more than a decade of experience, and director of the Centre for Advanced Dental Education in Manchester.

Raymond, who is the principal at Bothwell Dental Care, explained that he was inspired to start the course after working with younger dentists on the MJDF course and undergraduates in Glasgow dental hospital. He said: "These guys were always keen to learn about cosmetic dentistry which is so heavily promoted in the media. Having spoken with them I felt that they needed further training in the basics of occlusion and restorative dentistry and I didn't know any courses in Scotland that fitted the bill. Travelling to courses in England presents significant costs, not just financial but in lost clinical time, which can be quite prohibitive."

Raymond approached Bob McLelland, a colleague he had known and worked with for more than 12 years. He said: "Bob was keen to get involved back in Scotland as he has dentists travelling to his courses from the north and felt that the demand, in Scotland, was on the increase for just this kind of training.

"He was a natural fit for the course as he is an authority in occlusion and this is fundamental to all good restorative dentistry. Bob is particularly enthusiastic about smile design and delegates will be provided with a thorough grounding in this exciting but challenging aspect of dentistry.

"I see a lot of work by other clinicians which is good – my aim is to help my fellow professionals achieve excellence as a routine."

Bob said: "I teach the importance of occlusion as a fundamental basis for the success of all restorative treatments. It is often seen as a mystifying and confusing subject which dentists avoid, but it really is the gateway or hurdle to successfully planning and treating bigger cases.

Raymond Murphy

Bob McLelland

"It is particularly rewarding for me to continue to mentor delegates and interact with them once they have completed the programme. Helping them to achieve amazing results with their patients which they would have previously referred or not treated this gives me immense satisfaction.

"The course will give dentists the opportunity to increase their skills base and knowledge as well as the confidence and ability to treat bigger cases and work to a higher standard. The course is very hands-on and interactive so delegates will learn how to plan and sequence cases from a multidisciplinary perspective."

Raymond said he is looking forward to welcoming Bob back to Scotland and explained why he felt Scottish dentists should get involved.

He said: "On a daily basis, I see the increase in patient demands to improve the health and appearance of their mouths which involves more challenging dentistry. Younger dentists can develop their confidence to meet these challenges if they increase their knowledge and clinical skills, which means they will be well equipped to change with this shift in patient needs.

"This is the first course of its type to be run in Scotland with a hands-on approach and using the excellent state of the art phantom head facilities at New Lanarkshire College. The participants will leave with a new set of skills to enable them to take on more challenging restorative cases. This, in turn, will keep all treatment under their control leading to better job satisfaction as well as an increase in remuneration."

Bob, who has lectured at national conferences in Glasgow, Manchester and London, said he is really looking forward to coming back north of the border too. He said: "It's great to be coming back home to lecture and teach in Glasgow. It has given me a fresh boost of enthusiasm to set this up with Raymond who is always highly motivated.

"Not only that but we will be using the new world-class teaching facility at New Lanarkshire College, which is very exciting."

Delegates will receive products worth more than £500 to take back to their practices courtesy of Optident. This will include samples of: White Dental Beauty, Micerium, Bisco, Ultradent and Zirc.

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- Implant planning. Restoring and maintenance.

Our aim upon completing this unique modular workshop is for you to leave with an in depth understanding of the relationship between function, aesthetics and comprehensive care in all aspects of restorative dentistry.

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Module 2	24th & 25th June	New College Lanarkshire	Art of composite
Module 3	26th & 27th August	New College Lanarkshire	Smile Design – The works
Module 4	30th Sept & 1st Oct	New College Lanarkshire	Advanced treatment planning/TMJ and preparations
Module 5	Nov tbc	Cricklewood hotel and practice	Implants in general practice-restoring and maintenance

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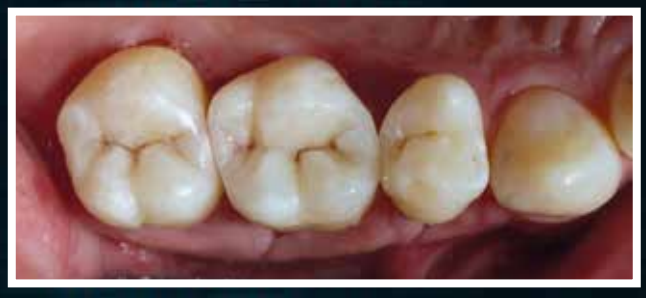

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Management

PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

ALL HANDS

MAKING SURE YOUR STAFF ARE WORKING AS A TEAM

See page 66

IT'S TIME TO CUT OUT THE DEAD WOOD

ADAM MORGAN EXPLAINS HOW IMPORTANT IT IS TO MAKE SURE YOUR STAFF ARE PULLING IN THE SAME DIRECTION

ADAM MORGAN

Do you have a person in your team right now that you really wish was not?! You can often spot these people from a mile away! There are very few businesses where everyone gets along with one another, peace and tranquillity reign and extremely high productivity just happens. Let's face it – people are people and because of that, they bring problems to any workplace; whether it's poor attendance, passionless attitude, little desire to get things done efficiently – the list could go on… but if you do have someone like this in your team, I strongly encourage you to **do something about it now.**

Today, the businesses that are thriving have all cut out the "dead wood." They understand the importance of not carrying people who are happy to be carried. Think about it, the most productive team members are all typically self-sufficient, reliable, operate to a high standard and can be trusted to get things done. This is a stark contrast to those who take most of our time, quite often demand the special treatment and quite honestly are destroying the momentum needed to reach your goals and overall vision – regardless of whether you own the businesses or are part of the team.

Now comes the hard part. In order to do something about a poor performer's behaviour, you must get to the point where you no longer accept their level of output. I am tired of hearing the phrase "Well that's just the way he/she is…" – let me tell you, he or she is that way because you have allowed them to be.

When building a solid business that has longevity, it is vital that each team member contributes toward the overall goal for the future. For this to happen there must be:

1. CLEARLY SET GOALS

Everyone needs a goal or goals to be successful. Goals should be Specific, Measurable, Achievable, Realistic and Timed – think SMART!

Ask yourself: Do I know what my goals are for 2016? How will I measure my success or progress? How will the rest of the team know about their progress and success? How will I be rewarded when I reach that goal?

When people do not fully know or understand what is expected of them, they most commonly underperform and bad habits and detrimental behavioural patterns become visible.

> "WHEN PEOPLE DO NOT FULLY KNOW OR UNDERSTAND WHAT IS EXPECTED OF THEM, THEY MOST COMMONLY UNDERPERFORM"
>
> ADAM MORGAN

2. A CLEAR MEASUREMENT OF SUCCESS

Everyone must be rewarded for the right behaviours and for being a "producer." A producer is someone who adds value. They might add value in many ways – for example: they add energy to the team, they are highly relational with patients/customers/suppliers, they spot cost savings, they use time incredibly efficiently, they are great with finances etc.

If you are a business owner, it is ultimately your responsibility to create these measurements of success. They are the benchmarks you set for everyone else to exceed beyond. A simple example would be that as a receptionist, the phone must be answered every time with a "whatever it takes attitude" and a tone of confidence, happiness and friendliness. This must be done every time, without fail – no excuses.

3. TRAINING TO ACHIEVE SUCCESS – NOT A RESULT

Once you have set your benchmark, it is time to train people to deliver results. I find that most businesses do not do a good job of training their people – they expect people to have the skills or know what the right thing to do is.

While this might seem logical, **why would you want to leave it to chance?** Everyone should be taught how to succeed and how their part contributes to the wider vision and goals of the team/business. If you do not teach it, you can't then get annoyed at poor performance – after all,

you didn't set the benchmark in the first place… they did.

When you teach or train your team, look at equipping them to succeed as opposed to teaching them what to do. The main difference here is in the "How to do it" and the "Why we do it". The "How to do it" teaches what is expected – how to answer the phone, how to welcome a customer etc. But the **"Why we do it" is the most important part.** When people understand why something is done (the reason behind what we do and how it relates back to our overall vision or goal), they are then able to contribute even more to the overall team and are "culture carriers." They carry your same passion for excellence because they see the bigger picture – not just the task at that moment in time. This takes a great deal of time but is invaluable once you have people like this.

4. 360 DEGREE ACCOUNTABILITY

Once everyone has been taught how to succeed in their role – each person must be accountable to the rest for providing excellence. When people hold each other accountable, there is no room for under performance as each member of the team has the desire to succeed – the team is truly a team and not just a group of assembled individuals. Focus is always put on the little things that people did that enhanced the overall team or moved us closer to the goal. The whole team must talk about the vision repeatedly and how we are achieving it, with specific examples of what team members have done to push us closer towards success. **Remember, what you focus on develops.**

5. APPROPRIATE REWARDS

Once each person has been trained, the benchmark has been set, success is being measured and it is clear how each person's performance contributes to the overall goal of the team, it is now time to reward individuals for their contribution. **The reward must be appropriate to the contribution** – and this is often where managers or leaders crash to the ground in the eyes of their followers. If someone has truly shown exemplary behaviour and contributed massively towards the team vision or goal, then they must be rewarded for that.

If the reward is not appropriate to the level of input or contribution, this can demotivate and kill the momentum that has been created. For the reward to be appropriate, find out what the individual most values and contribute towards it. For example, if someone lives for their time away on holiday; buy them something to use or do on holiday or if the contribution was great enough, buy them the actual holiday! If someone loves spending time with their family, give them something they can do with their family to create memories with. Use your imagination here – but the key is to **reward people for their contribution towards the goal – it should never go unnoticed.**

If after doing all of this, you have someone that still does not perform or is hindering the performance of others; you must eliminate this from your team. **Today, it is more important than ever to have a cohesive team or contributors, where everyone not only plays their part, but succeeds in their role.** Do not allow others to dictate your success – instead, be the creator of it. The reality is that it is hard to create a highly performing team… but it is even harder to create one with people that do not belong and contribute to the overall vision for the future.

As I said earlier, I am tired of hearing the phrase "Well that's just the way he/she is…" – let me tell you, **he or she is that way because you have allowed them to be.** Choose not to allow other people's performance to hinder your own from now on. Do something about it.

ABOUT THE AUTHOR

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

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

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TIME TO GET AHEAD?

LOOKING FORWARD TO THE NEW TAX YEAR AND A POTENTIALLY VOLATILE SUMMER IN THE RUN-UP TO THE EU REFERENDUM

ALASDAIR MACDOUGALL

As we near the end of the tax year, now is the time to consider not only year-end planning, but also planning for the new tax year and the threat of a potentially volatile summer for share markets in the run-up to the EU referendum.

It is one of the features of the political cycle that the more difficult and less palatable legislation tends to come at the start of a parliamentary term rather than as an election nears. Tax changes are very much a case in point: the rises come soon after an election, the cuts shortly before the election. When 2016/17 starts there will be a number of important tax changes scheduled to take effect which need to be built into your financial planning.

The lifetime allowance effectively sets the maximum tax-efficient value of all your pension benefits. It started life in 2006 at £1.5m, reached a maximum of £1.8m and will be cut from £1.25m to £1m on 6 April 2016. It will be possible to claim some transitional protection, although the final details are still awaited.

The annual allowance effectively sets the maximum tax-efficient annual input to all your pension benefits, regardless of source. It started life in 2006 at £215,000, reached a maximum of £255,000 and is now £40,000. From 6 April 2016, a new tapered annual allowance will be introduced, which may affect you if your total income (not just earnings) exceeds £110,000. The taper will mean that your annual allowance could be as low as £10,000.

The new tax rules for dividends begin on 6 April. If your dividend income is less than

£5,000 you will have no tax to pay, but if you have substantial dividend income – perhaps from a shareholding in a private company – then your dividend tax bill will increase.

The new personal savings allowance will mean that if you are a basic rate taxpayer you have no tax to pay on the first £1,000 of interest, while if you are a higher rate taxpayer, then £500 will suffer no tax. In line with these new allowances, interest from banks and building societies will be paid without deduction of tax (but it will still be taxable).

TURNING NOW TO THE QUESTION OF EU IN OR EU OUT?

February was the month that Brexit (UK exit from the EU) started to hit the headlines in a big way. The Prime Minister finished his negotiations after the traditional late-night arguments and confirmed that the remain-or-leave question would be asked on Thursday 23 June.

One measure of global investors' concern about the impending vote can be seen in the performance of sterling. Shortly before Christmas it was trading at more than $1.50 to the US dollar. By the end of February, it had sunk below $1.40. It was a similar story for the pound against the euro: having started December at over €1.40, by the end of February the rate had fallen to about around €1.27.

The currency's performance is a reflection of the uncertainty felt by global investors about the UK's future and is not directly related to the volatility seen in share markets. For many of the constituents of the FTSE 100, the fate of sterling is largely irrelevant. It is just one of many currencies for the multinationals and a distinctly foreign currency for most mining and resource companies. A fall in sterling is therefore no reason to avoid share-based investment. It could even be argued that it might be a reason for increasing exposure to UK exporters, who generally benefit from a weaker pound.

MORE INFO

The purpose of this article is to provide technical and generic guidance and should not be interpreted as a personal recommendation or advice. This is based on our understanding of current HMRC rules and guidance which may be subject to change. Tax advice, will writing and Powers of Attorney are not regulated by the Financial Conduct Authority. The value of your investment can go down as well as up and you may not get back the full amount you invested. Past performance is not a reliable indicator of future performance. Investing in shares should be regarded as a long-term investment and should fit in with your overall attitude to risk and financial circumstances. Martin Aitken Financial Services Limited is authorised and regulated by the Financial Conduct Authority.

ABOUT THE AUTHOR

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As well as dental nursing and practice management experience, recruitment consultants April and Angela also have more than 15 years' experience in dental recruitment. This means that they have first-hand knowledge of what is required from candidates and what practices are looking for in their prospective employees.

PS Newjob ensures that recruitment is carried out with as little disruption as possible and its consultants are on-hand to provide professional knowledge and expert help at any time. April said: "We will source the right candidate for your practice and support you in all aspects of the recruitment process. Our specialised consultants will be able to provide you with hints and tips on how to interview the candidates to make sure you offer the right person the job.

"At PS Newjob we are passionate about dental recruitment and passionate about finding the perfect person for your practice. We have a large database of candidates who have all either been recommended to us or we have tried and tested them. We make sure that all their registrations and checks are up-to-date and that they have good references before you meet with them."

And, if you find yourself in a staff crisis, due to illness, family emergency or other reasons, PS Newjob can step in a save the day. April said: "We offer a 24/7 service for all temporary staff, meaning that if you need someone there for the start of your surgery in the morning, you can contact us on the 24-hour mobile and we will endeavour to get a temporary member of staff to you before your patients arrive.

"We want to help you with your full recruitment, so please feel free to call the number at any time. We pride ourselves in getting the right candidate for the right job, so get your ducks in a row and call us now."

MORE INFO

To find out more, contact April or Angela who will be able to explain how PS Newjob can help you. The 24/7 telephone number is 07970 964 174 or you can email info@psnewjob.com

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Practice sales – an expert overview

MARTYN BRADSHAW HAS VALUED AND SOLD DENTAL PRACTICES IN SCOTLAND FOR MORE THAN 10 YEARS. HE SHARES HIS KNOWLEDGE AHEAD OF HIS TALKS AT THE SCOTTISH DENTAL SHOW

Martyn Bradshaw has an in-depth understanding of the market for goodwill and the latest valuation techniques for corporate and individual buyers. A CPD speaker every year since the inception of the Scottish Dental Show, Martyn's talks are always popular and well received. We asked Martyn some questions about the current market for practice sales.

ARE GOODWILL VALUES STILL RISING?

Goodwill values have certainly increased over the last decade, although my concern is that values now seem to have reached a peak – both due to the demand for dental practices and the way they are valued. Historically, the value of the practice used to be based on a percentage of turnover. However, now this is not the case. The values are now based on a multiple of the (adjusted) profitability of the practice and we always work with practices to look at the costs and profitability – which often allows an increased value to be achieved, so unearthing the true potential of the practice.

ARE CORPORATE BUYERS PAYING THE HIGHEST PRICES?

A lot of dentists believe this but it is certainly not the case. Unfortunately, we have heard of some people having lost out tens of thousands pounds by going it alone and dealing directly with the corporates. I certainly think that corporates have their place. However, there are many dentists looking to purchase dental practices and they are willing to pay higher amounts to secure the practice that they can work in. There are also a number of mini corporates, mostly owned by dentists, and, again, these generally pay higher values.

HOW EASY IS IT FOR BUYERS TO ARRANGE FINANCE?

The banks are very keen to lend, with healthcare being one of the most secure industries to lend to. Therefore, they are very keen to lend to the right individual and practice. There are generally unsecured limits with some of the main banks and some larger practices may not be viable for a single dentist to purchase. However, I am seeing two or three people deciding on purchasing a practice together to get the 'corporate style' practice. As I mentioned earlier, there are also mini corporates who have the available cash to purchase larger practices.

HOW LONG DOES THE AVERAGE PRACTICE SALE TAKE?

Finding a buyer will vary depending on the location of the practice and the type of treatments provided. Typically, an NHS practice in Edinburgh or Glasgow would have a number of offers within a month of marketing the practice. The legal work, due to the higher practice prices, is a little bit more detailed and typically we would expect this to take between three to four months. I always urge people to allow plenty of time and to act early.

IS 100 PER CENT OF MY TURNOVER A REALISTIC VALUATION BENCHMARK?

As I mentioned above, the value of a practice is actually determined by a multiple of the profitability of the practice, not the turnover. Assuming two identical practices both with a turnover of £600,000, due to different rental costs and other fixed expenditure one has a profit of £120,000, the other has a profit of £180,000. Everyone would expect the latter to achieve a higher value – and it would.

Basing the value on turnover is like saying that every three-bed house in Scotland would achieve the same value. The values are based on the location/demand, size of practice, treatment type and, most importantly, profitability.

MORE INFO

Martyn Bradshaw is a director of leading practice sales agents, PFM Dental, with offices in Edinburgh and York. Martyn will be speaking in the afternoon of Friday 13 May ('Selling a dental practice') and the morning of Saturday 14 May ('Buying a dental practice'). For information on practices for sale in Scotland, visit www.pfmdental.co.uk

The business of dentistry

IAN MAIN FROM STARK MAIN & CO DENTAL EXPLAINS THE BENEFITS OF CREATING A SUCCESS CHECKLIST

IAN MAIN

Regular readers of my column will know that I am a great advocate of running your dental practices in a businesslike manner.

With unprecedented challenges being placed on the profession from a raft of regulation, not to mention commercial pressures from increasing operational costs, taxation and, in some areas, an over supply of general dentistry services, it can feel like pushing water up a hill at times. It is no surprise, therefore, that we are regularly introduced to practice owners who may have lost their drive for the profession or to quote Austin Powers if I may, their 'mojo'.

It is a commonly held opinion that the amount of business knowledge delivered during the dental training process is minimal. That brings with it the risk that, when you realise your ambition to be a practice owner, you can be underprepared and isolated without the tools and skills to excel in the business of dentistry.

My strong advice is that you include some business training in your CPD programme and surround yourself with strong advisers (professional or perhaps family or friends) who can help you to maximise your potential.

Our Dental Success Checklist can be a great place to start and allows you to rate your abilities and indeed blind spots in the areas of leadership, financials, operations, marketing, sales, team, HR, personal finance and implementation plans. In the time it takes you to complete with a cuppa you will have a clearer direction on where the practice could be taken, allow you to find your passion for the profession again and get your team on board.

If you would like a free copy of our checklist do get in touch. I wish you all the best of luck in achieving success in your dental businesses.

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

Buyers beware! The price may not be right

GEORGE NISBET FROM DM HALL LOOKS AT THE GAP BETWEEN THE SELLER'S ASPIRATIONS AND THE BUYER'S EXPECTATIONS

GEORGE NISBET

We are undoubtedly in a particularly "hot" market in terms of dental businesses. While this is good news for existing practice owners, it is potentially not good news for purchasers.

Market conditions are as strong as they have been for more than a decade with many stakeholders "talking up" prices. As a result, vendors' price expectations have increased, sometimes to levels which are possibly not achievable despite these strong demand conditions.

Many prospective buyers are now finding themselves being priced out of the market despite robust and aggressive support from lenders.

The gap between vendors' price aspirations and buyers' expectations is leading to an unpredictable market. Transactions can often take a long time to complete and in many cases, the original price is reduced as purchasers are faced with funding challenges.

In my experience, the dental sector seems to be the only sector where prospective purchasers rely on "valuations" issued by selling agents as part of marketing particulars.

Sales agents acting for vendors are engaged to get the best price for their clients; it is therefore their job to achieve as high a price as possible. Why then would any buyer rely on that valuation?

The main lenders obtain independent valuation advice but actual purchasers often choose not to seek the same advice from valuers who are independent of the purchase process and have no financial interest in the sale.

Ultimately, the majority of sales complete at sensible prices and within reasonable timescales but, nevertheless, many prospective purchasers do seem determined to pay too much despite advice to the contrary.

The morale of the story is that prior to committing to purchase, buyers should seek the correct independent advice from experienced, independent professionals and not to rely on information or advice provided by parties with an obvious financial interest in the outcome.

MORE INFO
George Nisbet FRICS is a consultant to DM Hall LLP. To contact George, email george.nisbet@dmhall.co.uk and to find out more about ASDP, visit www.asdp.org.uk

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Look to the future

NOW IS THE TIME TO CONSIDER THE SALE OF YOUR PRACTICE, SAYS MICHAEL EDWARDS FROM ANDERSON ANDERSON & BROWN LLP

For practice owners, succession planning should be considered well in advance of your planned exit date to ensure a smooth transition to retirement, or perhaps returning to an associate position without the worries of running a busy practice. There are several reasons for this.

To maximise the value of the practice at the point of sale, the key decisions taken in the preceding period will have an impact on the attractiveness and value of the practice to potential purchasers.

Furthermore, the ownership structure of dental practices can be complex and there may be a requirement to discuss and align objectives with fellow partners or shareholders. A practice sale won't necessarily be the right solution for every owner.

Once you arrive at the point where the practice is ready for sale, the marketing process, negotiations and due diligence can take much longer than is necessary if the correct advice and support is not sought at the outset. The longer the process takes, the more likely the proposed sale could fall through.

AAB's experienced commercial advisors can shorten the process using a pro-active approach, discretely approaching the most likely acquirers and taking control of negotiations to not only achieve the best price but also drive the process forward to a successful completion, while allowing owners to continue running their practice.

Depending on the purchaser, there may be a requirement for sellers to remain in the practice post-sale. This period could be anything from a few weeks to several years, which emphasises the importance of considering your retirement plans well in advance with professional advisors, allowing them to support you through to retirement and giving you the peace-of-mind to continue running your practice and caring for your patients.

Contact AAB's expert corporate finance team today to discuss your future plans.

MORE INFO
Michael Edwards is a senior analyst at Anderson Anderson & Brown LLP. Contact Michael at michael.edwards@aab.uk

Trusted business specialists

WITH DENTAL BUSINESSES STILL MUCH IN DEMAND, THERE ARE OPPORTUNITIES TO CAPITALISE ON STRENGTH OF THE MARKET

Across all medical sectors, demand continues to outstrip supply and prices have generally increased due to an undersupply of quality stock. Demand is coming from all groups of buyers, including first-time buyers, expanding multiples and corporates.

Bank funding is still relatively easy to obtain for experienced operators with a solid business plan and there is a huge amount of third-party investment, typically from the "Bank of Mum and Dad". Private equity is circling all medical sectors, though so far this has translated into more interest rather than actual deals. All types of investors are attracted by the monopoly income that the NHS-funded dental sector offers.

The dental sector is extremely buoyant, with Christie & Co arranging an average of 12 viewings on every practice offered to the market. On top of this, 80 per cent of what we sell goes for above asking price, showing the appetite among buyers and the current imbalance of supply and demand. Our prediction last year that the private dentistry market would see more activity this year has proven to be correct, as many buyers are priced out of the NHS sector and have turned to higher-risk but lower-priced business opportunities.

All the signs are that 2016 will be another busy year with no apparent let-up in demand for dental businesses of all types

Christie & Co has been providing dental professionals with expert business advice for over 80 years, with specialists located across the whole of the UK and the advantage of a national database of buyers.

Should you be interested in taking advantage of the current market situation, but are unsure of the best course of action, it would be prudent for you to enlist the services of trusted business specialists who can guide you through the process. With Christie & Co's assistance, you will be able to capitalise on the strength of the current market and achieve your future plans.

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

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NEW GLASGOW PRACTICE OFFERS BOTH NHS AND PRIVATE DENTISTRY AS WELL AS A REFERRAL SERVICE FOR LOCAL DENTISTS

With practices already in London and Surrey, Michael Fahami has recently made the move north of the border and opened a new mixed practice in Glasgow's west end.

The graduate from the dental faculty of the University of Gothenburg has opened St Vincent Smile which is situated on St Vincent Crescent, a short walk from Exhibition Centre train station in Finnieston. Michael has overseen the planning, building and fit-out of the new practice but, while he will still be based down south on a day-to-day basis, the running of the practice will be down to practice manager Marisa Heede.

Marisa has nearly a decade's experience working in practices across Glasgow, including Kieran Fallon's Royston Dental Practice and locum work in both NHS and private practices across Glasgow. Marisa came into dental nursing later than most, doing her qualifications in her early 30s and initially doing work experience in Royston to improve her skills.

And, while this is her first practice management role, she believes her life experience, allied with her dental experience, has given her the right mixture to make a success of her new role. She said: "What can be quite difficult for younger dental nurses, especially those who have started out straight from school or college, is talking to people and finding things in common with patients. I think it is an important part of the role as you can help calm anxious patients simply by asking questions and listening.

"I started dental nursing having already had kids and having done other jobs including factory work and waitressing, so I really appreciate the profession I am now part of and I think that life experience makes me a better dental nurse and practice manager."

The practice itself has been designed and fitted out by a specialist dental surgery design company with a portfolio of more than 300 practices and the result is a stunning three-surgery practice – two dental surgeries and a dedicated hygiene/therapy room. A fourth room doubles up as a consultation and a cosmetic surgery space. The waiting room and reception is open-plan and curves around the centre of the building, with the surgeries on the outside wall. Contemporary seating sits on a wood-effect floor with refreshment facilities and flat-screen televisions available both for entertainment and patient information.

Behind reception is a staff room and kitchen with adjacent changing room and shower facilities. The practice also features an OPG room and the obligatory LDU.

Marisa has recently recruited Glasgow dental graduate Rebecca Trayner as the practice's first associate and she is hoping to announce the appointment of a second dentist in the coming weeks.

Rebecca and her fellow associate will work at building up the NHS list and they will be supported by Michael, who plans on coming up on a regular basis to carry out any implant-related cases.

Michael has completed postgraduate training in dental implantology at the University of Central Lancashire and has placed thousands of dental implants. He has also completed more than 550 cases of complete smile makeovers.

One of his main focuses has been in helping younger colleagues refine their skills over many years. He has previously worked as vocational trainer and has been employed by both the Oxford and Wessex deaneries .

Marisa revealed that, while the principal dentist is based in England Michael is keen for the practice to become a really integral part of the local community and there are plans in the pipeline to do community work in local schools as well as holding an open day for local businesses.

Marisa also explained that the ethos of the practice is to be friendly and dynamic, offering exceptional treatment for both NHS and private patients. She said: "We want to be seen as an exceptionally friendly practice and I want every single patient walking out that front door to be happy."

REFERRALS FOR IMPLANT AND RECONSTRUCTIVE DENTISTRY

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

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

email **referrals@dentalfx.co.uk**,
refer via the website **www.dentalfx.co.uk**
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We encourage our referring clinicians to restore their implants and restorative training courses are run for those referring clinicians who wish to restore the implants


Stephen Jacobs


Gareth Calvert

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A DECADE OF DEVELOPMENT

BEARSDEN CLINIC HAS JUST UNDERGONE A MAJOR REFURBISHMENT AS WELL AS WELCOMING A NEW MEMBER OF STAFF

Dental FX has come a long way since it was founded by Dr Stephen Jacobs in April 2006.

"We are celebrating our 10th birthday and I am delighted at how the practice has developed," said Stephen.

"We have just completed a major refurbishment and launched our brand new website and we are always looking at ways of moving the practice forward and enhancing the patient experience.

"Starting the practice back in 2006 was the next logical step in my career," Stephen explained. "I treated my first implant patient in 1991 and, since then, it has become a life's work, not to mention my passion. So, to move from a mixed general dental practice to setting up Dental FX, focusing on dental implants, was really me achieving my goal."

Stephen's passion for implant dentistry is reflected in his biography and list of achievements, which includes being past president of the Association of Dental Implantology (ADI), a committee member and UK Ambassador for the Academy of Osseointegration, and a key opinion leader for Dentsply Implants and Osstell.

Stephen said: "My involvement with the exciting field of implant dentistry has resulted in many invitations to speak at meetings around the world and, in 2015,

I lectured in San Francisco and Tokyo, something I could have never imagined when I completed my undergraduate training nearly 30 years ago.

"Last year, I was also scientific chair for the ADI biannual congress, a very successful meeting where we hosted many speakers from around the world."

Keeping up with technological developments has also been an important part of running a successful referral clinic. Stephen invested in a Cone Beam CT machine in 2010 and, more recently, purchased a Trios Digital Impression Scanner to "take the restorative phase to the next level by completing the digital workflow".

Stephen said: "We also have a visiting oral and maxillo-facial surgeon, Jeff Downie, who carries out more complex oral surgical procedures, including hip-grafts. We are delighted to introduce Gareth Calvert to the practice and he visits twice a month accepting referrals for all aspects of restorative and periodontal work. It's great to have Gareth on board.

"Dental FX also offers a range of courses including a comprehensive one-year course in basic implant dentistry, implant restorative courses, advanced implant courses, sinus bone grafting and one-to-one mentoring."

Stephen continued: "I encourage our referrers to restore the implants we place for them. We are happy to train dentists to treatment plan and restore their patients' implants, so I urge those interested to look at our courses. My aim is to continue to grow the practice and improve the service we provide to both patients and referrers."

Stephen is lecturing at the Academy of Osseointegration meeting in San Diego in February and the North Eastern Gnathological Society in New York in May.

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A REVOLUTION IN PATIENT MARKETING

BEN FLEWETT, MANAGING DIRECTOR OF SOFTWARE OF EXCELLENCE, EXPLAINS HOW, FOR THE FIRST TIME, DENTISTS CAN NOW CONNECT THEIR MARKETING AND BUSINESS FUNCTIONS

In the last 12 months, Software of Excellence has undertaken extensive research into the behaviour and attitude of dentists in regard to some of the key criteria that affect practice performance. In one such study, data revealed that, although there was good awareness of the need to attract new patients, only 60 per cent of practices were using any sort of marketing activity to achieve this goal. Success rates were even less impressive, with half of practices attracting fewer than 30 new patients per month. In addition, we also discovered that 30 per cent of practices have no process to routinely track the source of their referrals. As a result of our findings, we have formed a picture of a profession that knows they have a marketing challenge, but for various reasons is failing to address the problem adequately.

The solution, in the form of EXACT V12, signals a pivotal moment for the dental profession, as for the first time they are presented with the means by which they can connect their marketing and business functions, enabling them to truly understand their marketing return-on-investment and take full advantage of new digital communication platforms.

The power and influence of internet searches for dental practices is no longer a factor that can be ignored. By way of example, Google reports that the search for 'dentist Glasgow' was made on average 480 times every month last year and 'dentist Dundee' was made a total of 2,500 times during the same period. This change in climate has precipitated a preoccupation with two burning questions that now face dentists. Firstly, "How do I get to the top of Google's ranking?" and secondly, "Once there, how do I make my practice stand out from others in my local area?"

The aim for practices should be to appear on page one of any internet search for practices in their local area, but once achieved, this is not the end of the story. Google now returns results which favour those sites which are local and

have high- quality, fresh content. Within this equation, Google assigns substantial weighting to customer reviews when considering where to rank respective businesses. As a result, the relevance and importance of online reviews is growing. Research by Michael Luca, assistant professor at Harvard Business School, has already shown that a difference of just one star on a business's online profile can lead to a 5 to 9 per cent increase in revenue*.

Managing your online reputation is a key part of EXACT V12 which automatically manages your patient review process. It helps to gather reviews in practice and then automatically emails those patients who have left positive reviews, asking them to post via their Google+ account. The software also manages the publication of reviews both on your own website, and on reputation.com (Reputation Manager's own website). Effectively, this strategy secures your domination of the results page when a prospective patient makes a search for practices in your area.

Using the new Patient Marketing Manager module in EXACT V12, practices can also target specific patients with treatments and track results, including numbers of phone enquiries, appointments and treatment uptake. This ability to accurately monitor results and calculate revenue gained is known as Return on Investment (ROI). We categorise three types of return: Direct return – when a targeted patient takes up a promoted treatment; Indirect Return – when an untargeted patient takes up the treatment; and Secondary Return – targeted patients who take up another type of treatment in addition to the promoted treatment.

By establishing a structured and dynamic plan for each communication, it is possible for dentists to identify where and why a particular campaign might be faltering. Campaigns can also be allocated a unique telephone number which, via our Channel Track module, records calls and monitors which campaigns are being most successful. The Patient Marketing Manager dashboard enables dentists to assess expenditure on a particular campaign, indicating success by reference to the treatment code. The dashboard also indicates whether the return is direct, indirect or secondary, enabling reflection on the quality of the original marketing messages.

The creation of effective communication is a vital part of patient education, helping to ensure that practices fulfil their obligations with regard to compliance and enabling patients to make the optimum treatment choice to meet their needs. EXACT V12's focus on patient marketing enables dental practices for the first time, to take control of an integrated patient communication plan, optimising their online presence and using digital platforms to maximum effect as part of a fully co-ordinated marketing strategy.

MORE INFO

To find out more about Patient Marketing Manager as part of EXACT V12, visit Software of Excellence at the Scottish Dental Show (Stand D05).

Alternatively, visit www.softwareofexcellence.com or call 0845 345 5767.

* Luca, Michael. Reviews, Reputation, and Revenue: The Case of Yelp.com Harvard Business School Working Paper, No. 12-016, September 2011.

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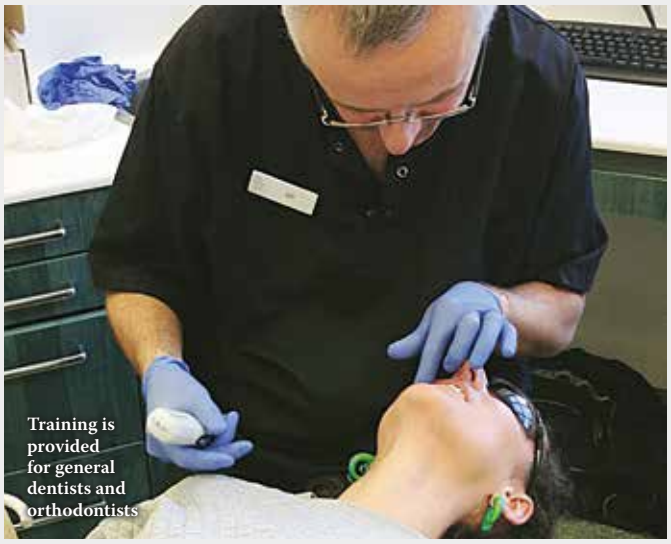
Training is provided for general dentists and orthodontists


A wide range of courses are available


Courses provide hands-on learning

BREAK FREE FROM SYSTEMS

USING THE LATEST TECHNOLOGIES AND TECHNIQUES, WHILE NOT FAVOURING ANY PARTICULAR SYSTEM, WIRED ORTHODONTICS' COURSES ARE AN ESSENTIAL FOR GENERAL DENTISTS AND ORTHODONTISTS

Wired Orthodontics is an orthodontic training provider and laboratory manufacturer of lingual braces, cosmetic and invisible braces for dentists and orthodontists. They offer orthodontic courses, training and comprehensive support to dentists and orthodontists in the UK and abroad.

The company was formed by technical director Sue Bessant and world-renowned award-winning UK specialist orthodontist, Ian Hutchinson BDS FDSRCSEd MOrth(Ed) MSc PGA. Their courses and laboratory services use the latest technologies and techniques where every case is assessed and reviewed by Ian.

Wired's training services are designed to complement the clinician's knowledge base, allowing them to add the skills and techniques they require. The company doesn't favour any particular system as their ethos is strongly tied to the mechanics and biology of what appliances allow us to achieve. They have several courses available, each designed to complement the clinician's orthodontic knowledge, from beginner to experienced.

SIMPLY SMILE LABIAL ONLINE COURSE

Simply Smile Online is aimed at clinicians looking to take a safe first-step in fixed orthodontics, where the time and cost of travelling to a course isn't practical and where GDPs can obtain skills at their own pace. The course is a lifetime purchase which provides detailed transcript with step-by-step HD video content.

SECRET SMILE LINGUAL COURSE

A one-day introduction into lingual orthodontics is suitable for both general dentists and orthodontists and covers biomechanics and how treatments differ from labial orthodontics. A practical session familiarises clinicians with the kit you receive from the lab while giving them the opportunity to bond and ligate a case.

NINE-DAY CORE OF KNOWLEDGE

The aim of the nine-day course is not just to provide clinicians with facts but to apply them to their own patients and craft their knowledge based on fundamental principles. Wired does not promote one appliance or technique but gives delegates the skills to be able to create a treatment plan based on biomechanical principles and then select appropriate materials.

ORTHO RESTORATIVE AND TCO

The restorative course is designed to help dentists integrate and implement their orthodontic skills with their restorative or cosmetic treatments.

The three-day TCO course runs alongside the ortho restorative course, covering detailed treatment planning and ensuring predictable results for ortho restorative outcomes.

MINI SCREWS

A one-day intensive course exploring the use of temporary anchorage devices in short-term orthodontic treatments. Open new treatment possibilities with absolute anchorage provided by this revolutionary device. Indications for use, how to place, direct and indirect anchorage, practical session placing TADs in typodonts.

Wired Orthodontics staff will be attending the *Scottish Dental Show* on 13 and 14 May at Stand C4 and will be available to answer any questions regarding their training or services. They will also be handing out their free highly acclaimed book *Getting What You Want From Orthodontics* which is aimed at GDPs looking to break free from systems.

FOR MORE INFORMATION

On Wired and their services, go to their website at www.wiredorthodontics.co.uk

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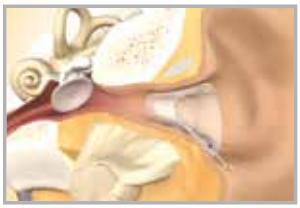


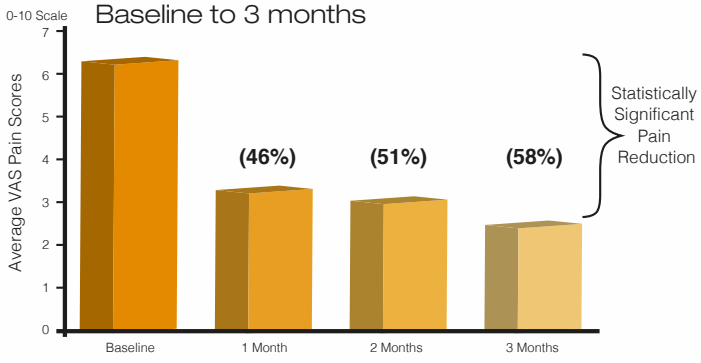
A New Approach

The Cerezen™ devices are custom ear canal inserts that support the temporomandibular joint and reduce pain. They also provide a "cognitive awareness" to the patient that discourages grinding, clenching and other para-functional behaviour.

Patient Outcomes

In a clinical trial, subjects experienced statistically significant pain reduction while using Cerezen™ devices. Visual Analogue Scale scores showed a 58 percent pain reduction after three months of use. At the end of the trial, 100 percent of subjects reported good to excellent results.*

VAS Pain Reduction Score*
Baseline to 3 months



Visual Analogue Scale (VAS) scores range from 0 (no pain) to 10 (worst) pain imaginable

Benefits of the Cerezen™ Device

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*Tavera A, et al: Approaching Temporomandibular Disorders From a New Direction. A Randomized Controlled Clinical Trial of the TMDes Ear System. J Craniomandibular Practice July 2012; Vol 30, No 3, 172-181.

200010 Rev 0

Visit us on Stand F2 at the Scottish Dental Show on 13 & 14 May at Braehead Arena, Glasgow

HALF A CENTURY OF TREATMENT

SOUTH GLASGOW PRACTICE HAS BEEN SEEING PATIENTS FOR NEARLY 50 YEARS

The Queens Park Orthodontic Centre has been undertaking orthodontic treatment in the southside of Glasgow for almost 50 years. At present, All 1 Smile specialist orthodontic associate Imran Shafi treats a wide variety of patients and currently there is not a waiting list for referral to the practice. Though the vast majority of patents are children, he does treat adults if they have appropriate orthodontic need within the NHS rules.

Generally, referrals to specialist practise are made for patients that present with malocclusions that require routine orthodontic treatment including: crowding; increased overjet; increased overbite especially with evidence of gingival trauma; posterior and anterior crossbites with displacements and mild hypodontia, which is classified as missing no more than one tooth per quadrant.

Imran graduated from the University of Glasgow, and after working as a general dental practitioner in Newcastle and in Australia he returned to Scotland to undertake his hospital and specialist orthodontic training. He is on the orthodontic specialist list, a member of Edinburgh and Glasgow Royal Colleges and a MFDS examiner.

CLINICAL TIPS FOR GDPS

Class II division 2 incisor relationships have a higher incidence of impacted canines, hypodontia and microdontia. There is a genetic link with all of these dental features, so relevant family history is important to look for generational or sibling patterns.

Examining a patient at 10-11 years of age with a lack of palpable canine bulges buccally indicates possible palatal impaction of canines and referral to specialist practise for advice is advised.

Asymmetry in the pattern of eruption, especially upper incisors, with more than six months difference is an indication for referral to specialist practise.

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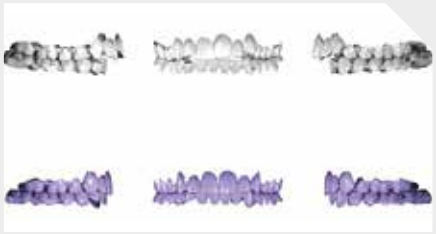
THE DIGITAL REVOLUTION

AFTER 40 YEARS, PARK ORTHODONTICS CONTINUES TO EVOLVE TO DELIVER OUTSTANDING RESULTS

Park Orthodontics has been providing specialist NHS and private orthodontic treatment for more than 40 years in Glasgow's west end. During those decades, the specialty of orthodontics has changed as public demand for treatment has increased along with the expectations of the finished result. The practice has always adapted and we believe we now find ourselves at the next evolutionary stage.

THE POWER OF DIGITAL ORTHODONTICS

Patients are now more aware of orthodontic treatment options and are often looking for the holy trinity:
1. A less visible or invisible appliance
2. As little treatment time as possible



3. An excellent result.

Traditionally, the first two points have worked against the quality of the finish but new digital software used in appliance systems such as Harmony Lingual (above), Invisalign and Insignia, are bending the rules.

By producing fully customised appliances set up to achieve the best results, we can fulfil the patient needs without compromise. Over the last three years our clinicians have been developing their knowledge and skills in this exciting field and the happy patients speak for themselves!

WANT TO KNOW MORE?

We are located in the Finnieston area of the west end with ample on-street parking and accessible via all transport links (Underground, train and bus). We can be contacted via our website, phone, e-mail or you are welcome to pop in for a chat with one of our friendly staff members.

Finally, due to high demand, we are pleased to offer further extended opening hours until 8pm midweek and Saturday mornings.

We look forward to making your patients smile!

ADVANCING DENTISTS' KNOWLEDGE

FOR THE FIRST TIME, THE PHANTOM HEAD COURSE FROM TIPTON TRAINING IS NOW AVAILABLE IN SCOTLAND

A renowned course from one of the UK's leading dental training academies is now available in Scotland for the first time.

The Phantom Head Course from Tipton Training is now being taught at New College Lanarkshire in Coatbridge, in addition to its original residencies in London and Manchester.

Tipton Training has been sharing its wisdom with dentists for more than 25 years now. During this time, many dentists have taken the opportunity to take on the Phantom Head Course, including one of the UK's youngest private practice owners, 25-year-old Dr Parag Shah.

"You only know what you don't know, once you know it. Tipton Training showed me the potential within dentistry to develop pride and enthusiasm for your career," says Parag, principal dentist at Wye Dental.

"As you move further from graduation, your time becomes more valuable and the opportunity cost of doing the courses later on in your career grows.

"As an associate, my time was far less valuable than it is now as a principal, so in real terms the courses would have cost me more had I waited."

The Phantom Head Course builds on the theoretical, scientific and engineering principles of restorative dentistry – giving delegates the confidence to take on significant restorative cases and keep valuable work in-house.

"Becoming a successful dentist can unlock many benefits, such as financial freedom and more spare time to share with family and friends. With Tipton Training dentists have to opportunity to learn more and become more experienced in different fields of dentistry," explained Professor Paul Tipton, founder of Tipton Training.

"It's a pleasure to bring the Phantom Head Course to Scotland. We've already received a substantial amount of interest from dental professionals who want to attend the course. Delegates can expect to gain the clinical skills required to prepare and restore teeth for both basic and advanced restorative procedures, so that they can stop referring valuable work elsewhere.

"The Phantom Head Course is 90 per cent practical so, for 90 per cent of the time, delegates will be perfecting their techniques under the guidance of the Tipton Training Faculty.

"By completing the course, delegates can expect an increase in their income as they will have the ability to take on complex restorative work. Performing just one extra treatment a month of this nature covers the cost of the Phantom Head Course."

Spaces are available for April 2016. To register for the Phantom Head Course, please visit www.tiptontraining.co.uk or call 0161 348 7849 to book a place.

MORE INFORMATION

Tipton Training aims to provide the best courses for dental professionals in the UK by drawing on the experience of their talented dental team. It aims to increase levels of confidence and self-belief in its delegates and to teach them excellence in dental techniques so that they can achieve their career ambitions. Tipton Training provides access to specialist guest speakers to ensure that delegates receive the most advanced knowledge available.

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DENTAL EDUCATION AND TRAINING – LIFELONG LEARNING

DR MALCOLM EDWARDS, DIRECTOR OF POSTGRADUATE DENTAL EDUCATION AT THE UNIVERSITY OF CENTRAL LANCASHIRE, ON HOW TO DISTINGUISH THE COURSES THAT WILL BE A SOUND INVESTMENT

Postgraduate education and training is an essential component of all dental careers – we cannot progress very far without it, but we have to make sure that we plan carefully to ensure that it is tailored to meet our needs.

HOW DO I CHOOSE?

One only has to open a dental journal these days to see the number of postgraduate courses available, and knowing which one is the right one for you can be a tricky and often expensive decision to make. Pick the right one and your career could really take off, pick the wrong one and you could feel frustrated by what has turned out to be a waste of your time and money.

WHAT DO I WANT?

The first question to ask yourself is what it is you actually want from the course. Is it merely to learn one particular technique, or the use of a new material? If so, then a straightforward industry-supported CPD event may be all that you need.

If you want to enhance your career, then a broader more substantial course would be the right step. Apart from the clinical knowledge and skills, look for one that also allows you to develop your academic writing and presentation skills as these are important tools in raising your professional profile locally, and maybe nationally.

FULL-TIME OR PART-TIME STUDY?

For the vast majority of dental practitioners, a full-time programme is not a realistic option, and a part-time model allows you to keep earning while you are studying.

PHANTOM HEADS OR PATIENTS?

Although there are undoubted benefits to training on phantom heads, this is no substitute for treating patients. Try to find a course that provides some supervised clinical training, that way you will be guided and supported when carrying out more complex procedures perhaps for the first time. There should be constructive feedback and the opportunity to reflect, so that your skills can develop as you move through the programme.

UNIVERSITY OR PRIVATE SECTOR?

There is little doubt that a higher award from a UK university is recognised and valued by professional colleagues as well as patients. It can be your passport to developing a referral practice, a part-time teaching post, or guest lecturing opportunities. It is this national and also international recognition that adds value to studying at a recognised university.

At UCLan we offer a range of part-time MSc courses that are designed to improve your clinical skills and knowledge, as well as develop your appraisal and presentation skills. These three-year courses are based at our Preston campus. Preston has excellent transport links and is close to the main airports in the north west.

The first year of the course provides under-pinning clinical knowledge via seminars and small group teaching, critical appraisal skills, and also the opportunity to develop new clinical skills in our phantom head laboratory.

Teaching in the second year is based mainly in our state-of-the-art, on-campus UCLan Dental Clinic. We provide patients for you to assess, plan and treat under specialist supervision. This is the ideal environment in which to put into practice those skills acquired in the phantom head laboratory, with the back-up and support of experienced clinicians. This approach will give you increased confidence in your ability to tackle more complex cases in your own practice, providing the perfect bridge between the phantom head laboratory and the real world of dental practice.

The third year is your opportunity to research an area of interest within your chosen discipline, and to write your professional project. Successful completion of this will lead to you graduating with the degree of MSc, an award that is universally recognised as a mark of your hard work and achievement.

MORE INFO

To find out more visit www.uclan.ac.uk/dentistry or visit the UCLan on stand B12 at the Scottish Dental Show on 13 and 14 May – www.sdshow.co.uk

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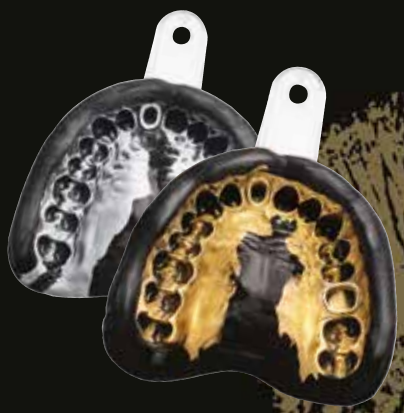

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GAME CHANGER IN THE PRACTICE

GRAHAM LITTLEJOHN, OF DENTAL TECHNOLOGY SERVICES GROUP, IS EXCITED ABOUT THE GAME CHANGING NEW ORAL SCANNER FROM 3SHAPE

TRIOS 3 Pen Grip

I have been working with digital scanners for almost 20 years and I have always been excited about what the future could bring.

The main obstacle has always been that companies creating digital systems tend to forget that these are tools for making restorations and they sell them into the market without a solid list of indications and workflows. Only a few have mastered the workflow that changes an oral scanner into an essential piece of equipment. There is a huge lack of good-quality advice and education to ensure they deliver to their full potential in a dental practice.

However, with the launch of the TRIOS 3, from world leaders 3shape, we have a game changer. The scanner is easy to use. It is also full colour, with a HD camera and a shade-taking device. With full arch scanning speeds of around 20-30 seconds, it knocks everything else out of the park.

Add a knowledgeable laboratory to the existing advantages of most oral scanners (accuracy, consistency, patient acceptance) and I believe 3shape have developed the very first everyday-use oral scanner for crown and bridge, orthodontics, implants and, soon, prosthetics.

It's not just the scanner that makes the time right: the modern materials available make CAD/CAM restorations more aesthetic, stronger, more consistent and, in some cases, cheaper than traditional dentistry.

Core3dcentres, Dental Technology Services (DTS) and Cordent are proud to be the UK specialists in this exciting new future.

DDU

You can't buy a great reputation.

Robust defence

Online CPD support

Dedicated dento-legal team, experts in Scots law

Personal support

But you can defend it.

Visit us on stand D12

The Scottish Dental Show
13-14 May, Braehead Arena, Glasgow.

theddu.com/scotland

ETHICAL PROMOTION

WITH DENTAL PRACTICES INCREASINGLY RELIANT UPON A WIDE RANGE OF MEDIA AND MARKETING TECHNIQUES TO PROMOTE THEMSELVES, ANGELA HARKINS, DDU DENTO-LEGAL ADVISER, EXPLAINS THE NEED TO BALANCE COMMERCIAL AND ETHICAL CONSIDERATIONS

While advertising and marketing material can be of assistance to patients in making informed choices about their dental care, it is important that information is carefully considered and regularly reviewed. Misleading information about your practice not only undermines the very purpose of marketing, but may give patients a negative impression or even lead to a complaint. Fortunately, if you know the rules, you can successfully advertise your services to new patients and inform current patients about your services.

GDC GUIDANCE

When advertising or promoting a practice, the GDC's Standards for the Dental Team 1.3.3 states that: "You must make sure that any advertising, promotional material or other information that you produce is accurate and not misleading, and complies with the GDC's guidance on ethical advertising."

Central to this guidance are the requirements for registrants to avoid any offer or claim which could be seen as misleading and to put the interests of patients above their own or their business. In general, the GDC disapproves of the use of superlatives or 'grandiose' statements to describe the services offered. Dentists cannot use the words 'specialist', 'specialises' or 'specialising' when referring to themselves or their practice unless they, and any other dentists in the practice, are on a GDC specialist list. And even then, this term should only be used in relation to the particular specialist list(s) upon which their name(s) are entered.

PATIENT PHOTOGRAPHS AND TESTIMONIALS

Patients need to give consent for the use of their confidential information, such as photographs or testimonials, in marketing material and this should be contemporaneous and specific. They need to understand precisely what information will be retained, displayed or published, where and when, who will see it and the likely consequences. The patient should not be identifiable unless absolutely necessary. Even if the patient cannot be identified, their consent should still be sought.

Angela Harkins

The patient must know that they can withdraw their consent at any time, meaning the practice must maintain control of the information.

PROMOTIONAL VOUCHERS AND GIFTS

Although the GDC permits dental professionals to offer practice promotions, discount vouchers have drawn critical attention from the GDC, and the DDU has in the past advised members about this type of promotional activity. In general, the GDC would not disapprove of incentives, provided the conditions attaching to them are abundantly clear, none of the content is potentially misleading, and any offer made is honoured in full.

Offering gifts to patients who refer others is fraught with dento-legal problems and risks. For example, to pass a gift to patient A for recommending patient B, would involve breaching the confidentiality of both patients. The DDU would, therefore, strongly advise against such an approach.

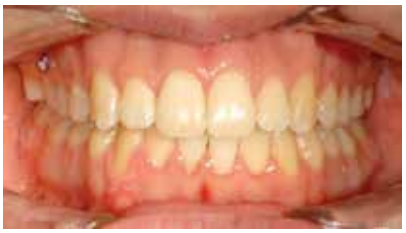
LEGAL, DECENT, HONEST, TRUTHFUL AND UP-TO-DATE

All marketing material must conform to the Code published by the Committee of Advertising Practice (CAP). The Advertising Standards Authority (ASA), which enforces the Code, can demand the withdrawal of adverts. Offenders can also be referred to the Office of Fair Trading. The ASA has previously ruled against dentists using the title Dr in any promotional material, on the basis that this could cause confusion with medical practitioners.

To avoid misunderstandings and complaints it is vitally important that marketing and advertising information is regularly checked and updated. This includes the practice website and any social networking site. Dental professionals are advised to test promotional material against the current guidance and standards in force at the time and, if in any doubt, to contact their dental defence organisation for specific advice.

Edinburgh Orthodontics

Expert care for beautiful smiles



Edinburgh Orthodontics is now in its fifteenth year at our Gilmore Place practice.

While our core activity is providing quality outcomes and service to your NHS patients, we have also developed a reputation for optimal treatment for adult patients, both as "stand alone" orthodontic cases and as combined orthodontic / restorative cases with the referring practitioner.

Our comprehensive approach to treatment planning and delivery can allow you to treat your patients to optimal restorative outcomes. Excellent communication with the referring dentist is key to the success of these cases. We are always happy to discuss treatments with you by phone or e-mail.

We have years of experience in aesthetic ceramic appliances and using Invisalign for a wide range of malocclusions. We have unparalleled experience in the use of hidden Lingual Appliances, offering a truly invisible option for your patients without any compromise in treatment outcomes.

Our practice has embraced new developments, such as self-ligation, miniscrew implant temporary anchorage devices and digital technologies to help us in our "no-compromise" approach.

Our team contributes locally and nationally to general dental and specialist societies and committees.

All our orthodontists are GDC registered specialists, who will provide continuity of care for your patients, from beginning to end of treatment.

We can offer your patients:

- Efficient, professional NHS care
- No waiting lists
- Convenient city-center location with excellent bus route access
- Full range of aesthetic appliances for your adult patients
- Unparalleled experience with Lingual Appliances
- Commitment to long term maintenance of treatment results.

Edinburgh Orthodontics
38-44 Lochrin Buildings, Gilmore Place,
Edinburgh EH3 9ND

Tel: 0131 229 4004
Email: info@edinburghorthodontics.co.uk
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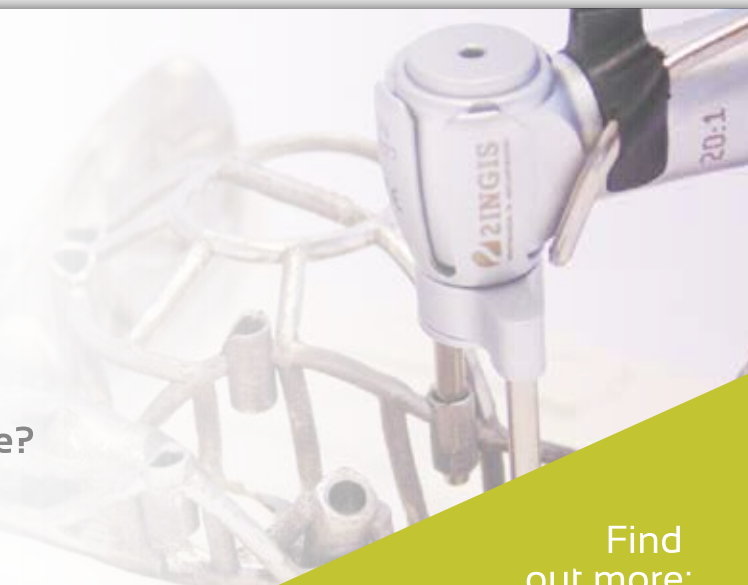

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IT'S ALL HAPPENING AT SCED

IT IS SHAPING UP TO BE A GREAT YEAR FOR THE SCOTTISH CENTRE FOR EXCELLENCE IN DENTISTRY TEAM, REFERRING DENTISTS AND THEIR PATIENTS

On 26 February, Arshad Ali gained membership to the American Academy of Fixed Prosthodontics in Chicago and has also been inaugurated as President of Glasgow Odontological Society for 2016-2017. Scot Muir is delighted to have been appointed lead clinician for Smiletube, the flexible implant e-learning platform.

SO MANY COURSES TO BENEFIT FROM

The team at SCED have always offered additional services to referring dentists and this year there is an abundance of courses to choose from to keep updated. The short seminars are free, take place on an evening and the subjects include treatment planning, refer and restore, implants, endodontics, oral surgery, orthodontics, hygiene therapy and nurse implant seminars.

Another complimentary service is in-practice lunch and learns.

Working with Nobel Biocare, SCED are offering two opportunities for enhancing skills:

Implant and golf /spa day – this is being held at the prestigious Loch Lomond Golf Club on 29 April 2016. There will be a morning seminar, which is an update on crown and bridge work and implant treatments, lunch followed by golf or spa, then dinner and finally prize-giving. The cost for this is £195 for the full day or £75 for the seminar and lunch. Places are limited so book ASAP at secretary@scottishdentistry.com

Esthetic Alliance Programme – this will be held at SCED and the objectives of the course are to consider treatment planning options for missing teeth and to gain hands – on experience for single and multiple implants. This will be over two days and the next dates are Saturday 22 and 29 October 2016. The cost is £495 including a Nobel Biocare restorative kit. Contact yvonnemuir@scottishdentistry.com

PUTTING PATIENTS FIRST

Dr Marie Glavin from Woodview Dental Practice comments on what it's like to work for Rodericks. She said: "I have worked with Rodericks since 2011 and have experienced a lot of support within the team at Woodview. As a dentist in a very busy practice, I rely hugely on nursing and reception staff to facilitate all that I need to do – this is integral to the provision of good dental care. With their experience and training, it means a lot to the patients too. The management is very supportive of the dentists in the daily running of the practice, which allows us to concentrate on the clinical side of our job.

"I have also been able to attend a number of course days organised through Rodericks, including recently the use of Botulinum toxin. Further training is always highly encouraged."

For information, call 01604 602491, email info@rodericksdental.co.uk or visit www.rodericksdental.co.uk

SAME-DAY RESTORATIONS

Digital dentistry... it's here now! The Planmeca FIT system for chairside digital impression dentistry provides clinics with a completely digital workflow from start to finish. Seamlessly integrating intraoral scanning, 3D designing and on-site milling into one software platform, allowing production of restorations in a single visit. Scanning is now 40 per cent faster than before, with colour scanning featured for the first time.

The Planmeca FIT system is all about integrated efficiency. Comprised of the PlanScan scanner, the PlanCAD Easy software and the PlanMill 40 milling unit, the system

enables dental clinics to create high-quality restorations, either choosing to perform the entire workflow in-house or flexibly outsource parts of it.

Same-day dentistry has arrived!

Visit us on stands G4 and G5 at the Scottish Dental show (13 and 14 May, Braehead Arenea) and see how easy it is to scan, design and manufacturer your own restoration!

PAPERLESS SOLUTIONS FOR SCOTLAND

In the run-up to the Scottish Dental show, one of the UK's leading dental practice management software solutions specialists, Systems for Dentists, are looking forward to demonstrating how they can revolutionise the way to a paperless dental practice.

One of their most popular products, Wireless Signature Pads, reduces admin, saves time and money and will be a reality for forward-thinking Scottish dental practices if you are looking to streamline your practice's daily workload. This fabulous wireless technology is set to create a buzz among dentists 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, visit http://www.sfd.co/wsp.html for further information on the Wireless Signature Pad or call 0845 643 28 28 for an appointment. Quote SDMwinter

PLANNING FOR THE FUTURE

Where do you want to be in your dental career in 10 years' time?

It may seem hasty to have to decide straight away, but in today's competitive profession if you haven't started to think about the way you would like to see your career progress, you might be at a disadvantage.

This is precisely why Step Education was created – to help young dental professionals learn fundamental clinical and business skills to help them on the way to a more rewarding future.

Designed to be as flexible as possible, the modular programme allows students to learn as and

when they can, at a pace with which they feel comfortable.

The range of exciting modules includes everything from treatment planning to oral surgery and business and marketing strategies.

To learn more visit www.stepeducational.com email booking@stepeducational.com or call on 0800 130 3573.

TRIPLE ENZYME GIGAZYME FOAM

Schülke's gigazyme foam is a ready-to-use spray foam designed for the immediate cleaning and disinfection of dental instruments, before reprocessing. The unique formulation includes three different enzymes for cleaning and disinfection.

In recent tests, using the state-of-the art ProReveal system, gigazyme foam removed more than 70 per cent of the protein residue on instruments before reprocessing. The ProReveal system is 100 times more sensitive than other currently available tests in detecting proteins on instruments.

Containing a unique mix of three enzymes plus surfactants to enhance cleaning, gigazyme foam maintains a moist environment around the instrument to help prevent blood and other organic materials from drying before cleaning.

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

WORLD FIRST – ADMIRA FUSION

VOCO will present several innovations at the Scottish Dental Show (stand G03) on 13 and 14 May, such as Admira Fusion, the world's first purely ceramic-based universal restorative material.

This unique "Pure Silicate Technology" offers several remarkable advantages in one. For example, the fact that Admira Fusion, in comparison with all restorative composites of market relevance, shows by far the lowest level of polymerisation shrinkage (1.25 per cent by volume) and, coupled with that, extremely low shrinkage stress.

Special offer 4+1: If you order

four packages of Admira Fusion/ Admira Fusion x-tra/Admira Fusion Flow via a VOCO dental consultant, you will receive another package for free.

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

MAKING IT BETTER THAN NEW

From high-speed overhauls to replacement turbines, air motors and sonic scalers, Quintess Denta will repair your dental handpieces using nothing but the most superior parts.

Aiming to return your handpieces to you in a better condition than when you first bought them, the Quintess Denta team works quickly and efficiently to minimise the time you are without your handpiece – and will keep you informed throughout the entire process.

Enjoying a strong relationship with all the leading handpiece manufacturers and suppliers,

the range of expertise that the Quintess Denta team has is extensive, meaning they can ensure whatever product you send them will be repaired correctly and effectively.

For more information, visit www.quintessdenta.com, email info@quintessdenta.com or call us on 028 6862 8966

SUPERIOR QUALITY

Maintaining your dental handpiece properly is of the utmost importance. With extended use, the vital bearings within the turbine can begin to wear – causing the device to vibrate more than it should.

With increased vibration comes the increased risk of hand-arm vibration syndrome which can cause chronic tingling and discomfort, as well as compromised muscular dexterity.

Quintess Denta uses only the best materials when repairing your handpiece. Preferring superior ceramic bearings to traditional stainless steel parts,

the highly trained team of technicians can ensure your handpiece continues working the way it should, for longer.

For a dental handpiece repair service you can trust, contact the team at Quintess Denta today.

For more information, visit www.quintessdenta.com, email info@quintessdenta.com or call us on 028 6862 8966

THE SHADE SELECTION SYSTEM OF CHOICE

Michael Thomas, senior teaching fellow, conservative and MI dentistry, KCL, is just one of the clinicians who has started to see the benefits of using GC's NEW Essentia seven-shade universal composite range, which enables clinicians to break free from conventions and EYE-Match intuitively.

He said: "My impressions of Essentia, so far, are that it is a high-quality composite system with excellent handling properties that make it easy to place and sculpt.

The aesthetic properties are superb. With only seven shades,

the technique of selecting a shade based on value rather than hue and chroma is unconventional, but becomes instinctive after a short time.

"For the use of direct restorations, I see this as being the shade selection system of choice."

For further information, contact GC UK Ltd on 01908 218 999, e-mail info@gcukltd.co.uk or visit www.gceurope.com

LUXACORE Z-DUAL – A PREFERRED PRODUCT

LuxaCore Z-Dual, DMG's premium composite for core build-ups, has once again received the highest possible 5+ rating by the professional journal, The Dental Advisor (vol. 32, no. 01, January – February 2015).

LuxaCore Z's decisive advantage is its authentic dentine feeling because its mechanical properties are similar to that of the natural tooth. Consequently, dentists cannot feel any difference in the transition from dentine to the material during preparation and their hands move smoothly from one to the other. This ensures controlled substance

removal, as well as a precise preparation line.

In addition to this top 5+ rating, LuxaCore Z also received the title "Preferred Product".

Please contact your dental dealer or DMG Dental Products (UK) Ltd on 01656 789 401, fax 01656 360 100, email info@dmg-dental.co.uk or visit www.dmg-dental.com

DISCOVER LIFE MADE EASY

To discover how your life could be made easy, don't miss Carestream Dental on stand H45 at the Dentistry Show 2016. With cutting-edge digital technologies and innovative software programmes ensuring an integrated and seamless digital workflow, you can simplify your diagnostic and treatment planning processes.

The new CS 8100SC, for example, is the fastest and most compact ceph unit on the market. The new CS 7200 imaging plate system simplifies the transition from traditional to digital techniques and the exciting CS 8100 3D brings the power of

3D imaging within the reach of every practice.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk follow us on Twitter @CarestreamDentl and Facebook

WRIGHTS AT THE DENTISTRY SHOW 2016

With its wide range of cutting-edge products available at unbeatable prices, Wrights is not to be missed on stand H60 at the Dentistry Show.

Ahmed Zaher, head of marketing at Wrights, said: "We will have a big presence at the 2016 show, demonstrating our full portfolio with products from leading brands such as 3M Oral Care, A-dec, Belmont, Planmeca, DENTSPLY, Kavo and Kerr.

"We will also have information on practice management software from Dentally, our exciting new orthodontic range from G&H Orthodontics and sophisticated

dental units and CAD/CAM solutions from Planmeca. We will also be revealing some exciting new products and services."

For more information, contact Wrights on 0800 66 88 99 or visit the easy to navigate website www.wright-cottrell.co.uk

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SCOTTISH DENTAL SHOW 2016

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Dental management software for the 21st Century

Thinking about a practice management system? Have you looked at WYSdom ICONic® lately?

Widely acknowledged to be the easiest system to learn and use, WYSdom ICONic® gives you everything to manage your practice effectively, from easy to use image-based charting to electronic capture of patient signatures.

We supply, set up and install all the hardware and software you need so you have just one point of contact for support and maintenance.

More reasons to choose WYSdom ICONic®

- Patients update their own details and medical histories using a wireless tablet device - reducing reception queues and staff-time
- Electronic signatures are captured for PR forms and estimates
- Patients can log themselves in on arrival and are told where to wait
- The Traffic system tracks patient waiting and treatment times
- All forms, patient data, X-Rays is held digitally - reducing storage needs
- NHS approved for all of the UK including Northern Ireland
- SMS reminders reduce FTAs and increase recalls
- NRPB recording and reporting - unique to WYSdom
- Automated SMS reporting to fill cancelled appointments

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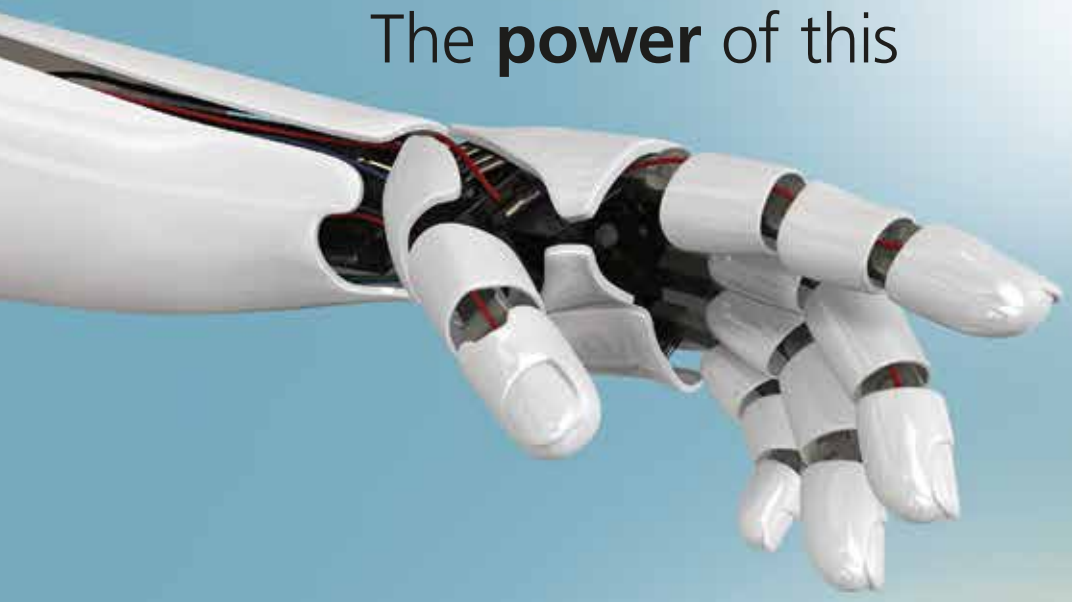
Carestream DENTAL

The **power** of this



Packed into this

Because we're not born with robotic arms

MADE EASY FOR YOU

To make dental scanning easy, we could have built the world's first automatic, clearance controlled high-speed bionic appendage. Instead we packed it all into our new CS 3600 to make acquiring digital impressions easier for you.

Find out more at:
www.carestreamdental.co.uk/CS3600
or call **0800 169 9692**.

COME AND TAKE A SEAT WITH A-DEC

Make sure you don't miss A-dec at the Dentistry Show 2016. Exhibiting on stand L60, A-dec will be giving delegates the chance to speak to its expert team – and learn more about its renowned range of dental equipment solutions.

From its exceptional collection of dental chairs, including the premier A-dec 500, the new and improved A-dec 300 and the entry level A-dec Performer, to its diverse selection of dentists' stools, delivery systems, lights and cabinetry, all A-dec equipment is known for its reliability, functionality and style.

Delegates will also have the chance to learn how all products could benefit the entire dental team as well as patients, and will be able to discover exclusive offers and deals.

For more information about A-dec Dental UK Ltd, visit www.a-dec.co.uk or call 024 7635 0901.

TAKE YOUR PRACTICE TO NEW HEIGHTS

Nobel Biocare is not only a leading supplier of innovative dental implant products, but it can also help you grow your business.

Top-class solutions on display at the Dentistry Show 2016 will include: the new NobelParallel Conical Connection and NobelActive Wide Platform implant systems; the Angulated Screw Channel (ASC) abutment and unique Omnigrip tooling; Full-Contour Zirconia (FCZ) Implant Crown; and NobelClinician – the comprehensive software that facilitates simple treatment planning and efficient implant placement. To find out more about

and to discover how your business could benefit, don't miss the Nobel Biocare team on stand F50 at the Dentistry Show 2016.

For more information, contact Nobel Biocare on 0208 756 3300, or visit www.nobelbiocare.com

MORE POWERFUL THAN CONVENTIONAL FLUORIDE

The positive effects of fluoride-containing toothpastes as a defence against dental caries are well documented. .

Oral-B Pro-Expert toothpaste uses stabilised stannous fluoride, which is more powerful than conventional fluoride. Stannous fluoride, the first scientifically recognised fluoride, has been stabilised and combined with sodium hexametaphosphate, to provide additional protection.

Stabilised stannous fluoride protects teeth against caries in two ways. Firstly, it strengthens enamel and dentine to inhibit deminersalisation and promote remineralisation. Secondly, it has the ability to reduce the incidence of streptococcus mutans. Thus the anti-caries effect of such formulations includes a combination of physical chemical effects and antimicrobial actions.

For more information, contact your Oral-B representative.

THE NEED FOR SPEED

Time is a precious commodity. We want faster wi-fi, faster transport, and faster delivery times and so the list goes on. Demand is also evident in dental treatments too, particularly cosmetic ones such as teeth whitening.

Oral-B 3D White Whitestrips promises a speedy treatment. Used as directed, their whitening strips can remove ten years of stains in just two weeks. They are a safe, easy home-whitening treatment, with results that lasts for up to 12 months!

James Goolnik, practice principal at Bow Lane Dental Group in London and an international lecturer in teeth-whitening protocols and techniques, was the first dentist to use the system commercially in the UK. He said: "Many of my patients do not have the time to undergo teeth whitening in the chair or indeed wait for impressions to be taken and trays prepared. Whitestrips are the perfect solution offering swift results with minimal fuss. They can take them away at that appointment."

MOUTH TO MOUTH

Until recently, reusing a toothbrush that's been in a patient's mouth would have been anathema. However, this is exactly what you can do with Oral-B's Test Drive trial programme as they have developed specialised handles and replacement heads to ensure the safe trial of their toothbrush.

A sealing insert within the head prevents saliva from entering the handle. To provide extra protection a disposable sheath covers the handle itself. After cleaning and disinfecting, the handle is then ready to be used again with a fresh head.

As consumers we can all be reluctant to embrace new technology unless we've experienced it and can see for ourselves the benefits afforded by its use. The new TestDrive trial programme allows both you and your patients to try Oral-B's power toothbrushes without having to worry about cross infection concerns.

If you are interested, please contact your local representative or call 0870 242 1850.

THE PERFECT WAY TO A PAPERLESS PRACTICE

Practice management systems specialists Systems for Dentists are expecting interest in its Wireless Signature Pads to soar at this year's Scottish Dental Show due to changes in legislation affecting the GP17 in Scotland.

And, for forward looking dentists looking to revolutionise their practice by embracing the prospect of going paperless in the future, the opportunity to get hands on with a demonstration of this technology at the upcoming show at Braehead Arena should prove to be a popular attraction.

For those dentists visiting the show, getting an insight into what going paperless could mean in terms of streamlining their practice and saving time and money in the future, the company's try before you buy approach is a winning strategy.

Simply download a complimentary system demonstration at www.sfd.co/demo visit www.sfd.co/wsp or arrange an appointment on 0845 643 28 28. Quote SDM05.

Membership of the Faculty of Dental Surgery MFDS RCPS(Glasg)

Royal College of Physicians and Surgeons of Glasgow

- **Have you successfully completed the Membership of the Faculty of Dental Surgery (MFDS) exam or an equivalent exam?**
- **Are you a member of another UK or Irish Royal College?**
- **Have you completed a Specialty Membership Examination?**
- **Can you demonstrate equivalent knowledge, clinical competence and experience?**

MEMBERSHIP BENEFITS

If yes apply now and start benefiting

- Use of internationally recognised qualification – MFDS RCPS(Glasg)
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- Free online access to Orthodontic Update
- Continued professional development opportunities
- Access to our library resources, including a free Athens Account
- Access to our free mentorship programme, which matches members with trained College mentors
- Access to TC White Dental Awards to broaden your skills and knowledge

Visit us stand G2

Scottish Dental Show
13-14 May 2016
Braehead Arena

How to apply?

Details of how to apply are on our website:
http://rcp.sg/dentalmember

If you have any further questions about applying for fellowship please contact our dental team:
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