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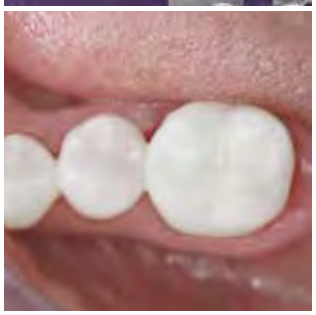

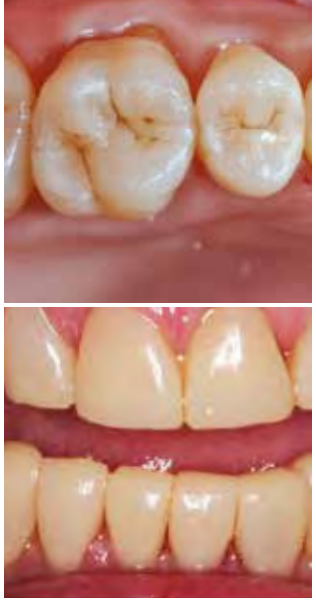

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Editorial

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

Everybody needs a place to go for guidance and support but, up until recently, dental trainers, who are the ones usually relied on to provide support and guidance to undergraduate and postgraduate students, haven't had such a place.

However, with the founding of the Faculty of Dental Trainers (FDT) at the Royal College of Surgeons of Edinburgh (RCSEd), all those involved with dental education now have a place in the college where they can get recognition for their efforts and tailored support on an ongoing basis.

As the first of its kind in the UK, Dr Sarah Manton admits in the interview, that starts on page 26 of this issue, that there is an element of pressure on them to get it right. Let's face it, the other Royal Colleges are probably watching to see what happens before deciding whether they will set up a similar faculty or not.

However, the FDT has been helped somewhat by the existence at the RCSEd of a sister faculty, the Faculty of Surgical Trainers, which is already well established. The two faculties have been working together and they will also be joining forces for a conference in Birmingham in October.

GIVING TRAINERS A HOME

New faculty aims to provide recognition for dental educators

Sarah Manton was at pains to stress that the main driver behind the FDT, as it is for every dental professional working in the UK, is that patient safety is paramount.

The new faculty is currently working on the creation of a Standards for Dental Trainers document, which will, among other things, give reassurance to the public that the teachers training dental professionals have been trained to a consistent standard themselves and are held accountable to the same standards as their colleagues across the board.

As well as this, the FDT will provide much-needed recognition for dental trainers, from university lecturers to VT trainers in general practice. The faculty aims to be inclusive and it is keen to attract associates, members and fellows from across the UK and from a range of backgrounds and experience.

Elsewhere in this issue, we feature an interview with the youngest ever recipient of the Scottish Dental Awards Dentist of the Year award, Ciara Sutherland. She talks about her journey from University College Cork to her current practice in Edinburgh.

The Standards for Dental Trainers document will give reassurance to the public

We also have a short history of the Royal Odonto-Chirurgical Society of Scotland, one of the oldest dental societies in the world. We are planning a few more dental history articles in the coming months, so please do get in touch if you have any ideas for topics or any historical anecdotes you want to share with the profession.

WE COULDN'T HAVE DONE IT WITHOUT...

1

SARAH MANTON
(ON THE FDT)
Dr Sarah Manton is the director of the Royal College of Surgeons of Edinburgh's newest faculty, the Faculty of Dental Trainers.

2

CIARA SUTHERLAND
(ON BEING DENTIST OF THE YEAR)
Cork graduate Ciara Sutherland was named as the youngest ever recipient of the Dentist of the Year award at the Scottish Dental Awards 2017 in May.

3

CHRISTINE PARK
(ON CHILD PROTECTION)
A senior clinical university lecturer at Glasgow Dental Hospital and School, Christine Park is also an honorary consultant in paediatric dentistry.

4

JANET PICKLES
(ON INHALATION SEDATION)
Janet Pickles is the chairwoman of RA Medical Services Ltd, a family company with more than 20 years' experience in the field of medical sedation.

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

DIVIDE AND CONQUER

Arthur argues that general dental practice needs a shake-up and perhaps the future of NHS dentistry could be modelled on general medical practice

Like everyone else in the country, I have struggled to get an appointment with my GP. Unlike in England, my GP does not offer late night or weekend appointments, and I am very reluctant to cancel a session of patients. The solution was to see a private GP. I was offered an appointment that day. I could sit in a lovely uncrowded waiting room, and the doctor had plenty of time with me. I am very fortunate to live in an area where such a service is available and I am lucky that I can afford to pay for it.

Would I have preferred to see my usual NHS GP? Of course! They have my full medical history, and I have a relationship with them. I would very happily have paid them for the service. However, they are not allowed to practice privately out of their existing premises.

Of course, this got me thinking. Margie Taylor wants an emphasis on quality. We want to provide the best possible care for our patients, using good materials and laboratories where the technicians are able to spend time on their work too. And we also want to be paid an acceptable return for our labour. There is nothing wrong with this.

Very few of us will earn what GPs do, and we all work longer hours. In the not so distant past, dentists' and doctors' pay was linked to consultants' pay in the recognition that we were specialists in our own field. Very, very few, 90 per cent or more committed dentists can earn anything like this amount. With, as usual, the exception of the orthodontists.

The NHS could either manage the practices themselves, or perhaps pay the practice principals additional fees

ABOVE: quality and care can come from dividing practices into either exclusively NHS or private

A solution would be to divide ourselves in the same way. Some practices would be exclusively private, and we would refer patients as many of us do already for specialist endodontics or implants. Other practices would be exclusively NHS.

These new NHS practices would have their premises bought by the NHS (like GPs did, many years ago). We would be salaried, and so would our staff. DenPro would supply the approved materials. I understand that DenPro are now promoting laboratory and engineering services – this could be expanded, and the NHS could either own or subcontract these services too.

This would remove us from the NHS treadmill. The NHS could either manage the practices themselves, or perhaps pay the previous practice principals additional fees to do this on their behalf.

The CDO would find that quality would improve when we have more time to spend with our patients, and more time to spend on education. Patients who are not exempt from payment would pay by card only (vanishingly few now pay cash) – so the money would go directly to the NSS bank account. Bad debtors would be given the opportunity to pay and, if they did not, they would no longer be entitled to NHS dental services.

This would have the additional benefit to the CDO that she would know her budget for every year and any negotiations with SDPC would not relate to money, but to improvements in patient care. Yes, there would be an initial expense, but Theresa May recently found £1 billion in her war chest, maybe Margie could find the same in her sweetie tin and she wouldn't even have to deal with the DUP?

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SNP ACCUSED OF 'RAISING THE DRAWBRIDGE' OVER BURSARY CUTS

Dental students whose families are on middle incomes will no longer be eligible for grant support after new scheme is introduced

The British Dental Association (BDA) has accused the Scottish Government of backtracking on its manifesto pledges and cutting off access to dentistry to students whose families are on modest incomes.

The association was reacting to the introduction of the new means-tested Dental Student Support Grant (DSSG), which replaces the Dental Undergraduate Bursary Scheme (DUBS), for students starting dental school this year. The new grant will mean that students whose household earns more than £34,000 would be ineligible for financial support. The DUBS, which was not means-tested, was a universal £4,000 a year from their second year onwards.

The BDA pointed to the fact that the SNP has consistently criticised the UK Government's abolition of bursaries for nurses and allied health professionals and its 2017 manifesto made promises to attract and retain talented young people to work in the NHS.

Paul Blaylock, Chair of the BDA's Students' Committee, said: "The Scottish Government appears to be following Westminster's lead, and risks raising the drawbridge to the health professions to kids from ordinary families. Dental students will be losing out on up to £16,000 over the course of their degree when their finances are already stretched and debt is rising.

"It's a kick in the teeth to the vast majority of students who will spend their professional lives working for the NHS and improving Scotland's oral health. This funding exists because these students face longer term lengths, and significant difficulties juggling their studies with part-time work."

ABOVE: Paul Blaylock

A Scottish Government spokesperson argued that the DUBS was introduced in 2006 to address the shortfall of dentists, but that the focus had now changed. He said: "Bursary support will now be focused on those from the poorest backgrounds applying to study dentistry, ensuring that students from lower income backgrounds continue to be financially supported and encouraged to study dentistry through a new Dental Student Support Grant.

"Students who commenced their degree course in September 2016, or earlier, will continue to be entitled to the old bursary scheme. Students will also continue to benefit from having their fees paid in Scotland."

NOW TRENDING

70%

FACT
People who have suffered from perio disease for 10 years or more, are 70 per cent more likely to develop Alzheimer's disease*

*Source: https://doi.org/10.1186/s13195-017-0282-6

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

MODEST FEES UPLIFT DOESN'T GO FAR ENOUGH

BDA criticises 'decade of under-investment' in NHS dentistry

Scottish dentists have welcomed the modest uplift on item of service fees for 2017/18, but remain concerned that they remain the lowest paid in the UK after confirmation of the DDRB's 1 per cent uplift on pay.

Despite the Scottish Government's announcement of a 2.25 per cent increase in item of service fees, the BDA in Scotland insists it doesn't go far enough. It argues that earnings and expense levels for NHS dentists in Scotland have fallen by nearly 30 per cent in real terms since 2009, for both practice owners and associates, while costs of regulatory compliance and registration have gone up by 1,086 per cent in the last decade.

Robert Donald, chair of the BDA's Scottish Dental Practice Committee said: "A decade of under-investment continues to fatally undermine recruitment, retention and investment. The Scottish Government need to choose between their commitment to pay restraint and the sustainability of an NHS dental system on which our patients depend."

GDC WARNS OF ONLINE TOOTH WHITENING KITS

The GDC is urging dental professionals to educate their patients about buying tooth whitening products online after a man was prosecuted for selling kits containing hydrogen peroxide levels nearly 60 times above the legal limit.

Phillip Alan Palfrey was prosecuted by the Trading Standards arm of Powys County Council and pleaded guilty to three charges of selling unsafe teeth whitening products on eBay. He was ordered to pay a fine and costs, amounting to £4073. The kits he was selling contained up to 5.88 per cent hydrogen peroxide, 58.8 times the legal limit of 0.1 per cent.

Shaun Round, interim head of illegal practice at the GDC, said: "Only registered dental professionals who are permitted to provide teeth whitening treatments can purchase products with a higher hydrogen peroxide content. The effects of using illegal strength tooth whitening products can include: irreversible loss of tooth structure as a result of increased porosity of the enamel, heightened tooth sensitivity, altered taste and chemical burns to the soft tissues of the mouth."

THE FDT ON PAGE 26

The basic need of the FDT is to protect patient safety. That is the key role of the dental team and of this dental faculty

DR SARAH MANTON

GDC DECISION QUASHED AT COURT OF SESSION

Scottish dentist has public warning overturned after indemnity organisation takes case to a Judicial Review

Indemnity provider Dental Protection has successfully overturned a GDC decision relating to a Scottish dentist who had self-reported a driving conviction.

An initial GDC Investigating Committee (IC) was adjourned so that legal advice could be sought on whether, given that the offence occurred in Scotland, the matter would have resulted in a conviction in England and Wales, missing the point that the GDC's guidance applied throughout the UK.

A second IC was then convened and issued a public warning to the dentist.

Dental Protection requested a review of the second IC decision and argued that the GDC had misinterpreted its own guidance in relation to whether this second IC was required, in terms of the guidance, to issue a warning. That review was declined by a further IC.

Given the implications for the dentist concerned of having to declare a GDC warning in future, with the agreement of the dentist, Dental Protection proceeded to a Judicial Review of the case in the Court of Session in Edinburgh.

The GDC did not oppose the granting of the petition and the decisions of the ICs

were reduced, meaning the GDC warning was overturned. Dental Protection's advisers also ensured the anonymity of the dentist involved by enrolling a motion for anonymity.

Helen Kaney (above), Head of Dental Services Scotland at Dental Protection said: "I am delighted that we were able to successfully challenge the unjust decisions made by the GDC Investigating Committees.

"Given the challenges that the dental profession in Scotland has faced in recent years, it is important that inappropriate decisions made by the GDC are challenged. Dental Protection members in Scotland can be assured that we will appropriately advise our members at all times and fight for them where we consider that there has been injustice."

NEW CHAIR FOR SCHOOLS COUNCIL

The Dental Schools Council, which represents dental schools across the UK and Ireland, has elected Sheffield dean Professor Chris Deery as its new chair.

Prof Deery, who graduated from Edinburgh in 1984, worked in Dundee, Bristol and Edinburgh prior to being appointed dean at Sheffield in 2015.

Prof Deery said: "We have seen great strides in public dental health over the last decade and these strides are, in large part, down to the quality of our dental school graduates. We must ensure that the high standard of our teaching and training is maintained and that dental education continues to speak with a strong voice.

"A key issue for dental healthcare is research. We must increase opportunities to conduct research and this includes providing support for those who work in clinical academia. As the recent clinical academic staff survey has shown, progress is being made and we are seeing an increase in the number of dental clinical academics. But more must be done and this will require combined work from organisations across the sector."

TON UP FOR NEW EDINBURGH FACULTY

The newest faculty at the Royal College of Surgeons of Edinburgh (RCSEd) has recently welcomed its 100th member as it celebrates a year since its foundation in August last year.

The Faculty of Dental Trainers (FDT) is the first of its kind in the UK and is a sister faculty to the College's already renowned Faculty of Surgical Trainers, which was itself a first for the surgical profession when it was established in 2013.

The FDT's 100th member, consultant in special care dentistry Ms Najla Nizarali, said: "I believe that a high standard of training and education is fundamental in producing excellent clinicians and high quality patient care, therefore, when I first discovered the Faculty of Dental Trainers, I was keen to be a part of it.

"Through this faculty, I hope that we will be able to bring together both recognised and less recognised dental trainers, so that ideas can be shared and excellence promoted. Not only does this promote our profession and sub specialities, it provides a forum to recognise achievement and share learning points.

"I look forward to working with other dental professionals and to further enhance dental education and training nationally."

MORE INFORMATION
Turn to page 26 to read an interview with the director of the FDT, Dr Sarah Manton (right).

SIX-MONTH WAIT FOR CHILD DENTAL TREATMENT

British Dental Association condemns hospital waiting times for children needing dental extractions

Paediatric patients with extensive tooth decay in Glasgow are waiting up to six months for treatment, according to new figures on hospital waiting times obtained by the BDA.

The association has found that a squeeze on hospital funding and theatre time for paediatric dental cases is leaving children in pain and distress for long periods.

And, while the latest figures from the National Dental Inspection Programme show that 69 per cent of five-year-olds have no obvious signs of tooth decay, clear inequalities still persist. The figures also show that only 55 per cent of children from the most deprived areas of free from decay, compared with 82 per cent from the least deprived.

The BDA also says that, despite the Childsmile programme leading the way in the UK with its nursery toothbrushing programme, tooth decay remains the main reason children are admitted to hospital. In 2015/16, 7,944 children were admitted for dental extractions.

Children in Glasgow face a wait of up to six months

A spokesman for the BDA Scotland said: "Six months is a lifetime for children in pain and distress to have to wait for urgent dental treatment.

"The impact of having rotten, septic teeth on a child's health, wellbeing and development cannot be underestimated. Their symptoms are not confined to the mouth, as it can also affect their speech and growth, not to mention their confidence and ability to socialise.

"The longer these children have to wait, the more likely they are to develop an infection, or abscess – and in the meantime they may have to take repeat courses of antibiotics to alleviate symptoms, which is anything but best practice, and could increase the risk of antimicrobial resistance.

"While Scotland has made some progress in improving children's dental health, much more still needs to be done, and this is no excuse for neglecting those vulnerable children most in need of dental care. Funding to free up theatre space for the care of these children must be prioritised now."

CHECK THE SMALL PRINT ON YOUR POLICY

Regulator warns registrants to make sure there are no significant policy exclusions

The GDC has issued a warning for dental professionals to make sure their indemnity or insurance policy provides appropriate cover.

The warning comes after a recent case involving a registrant whose cover contained 'exclusions', which the regulator said could potentially put patients at risk. The GDC said that certain policies may exclude cover for such things as failing to spot an oral cancer and failure to prevent the transmission of blood-borne diseases.

The GDC places the responsibility for assessing the type of cover on individual registrants, saying that it doesn't "make specific recommendations or provide advice on the type or extent of cover registrants take out". The relevant standard for the dental team reads: "You must have appropriate arrangements in place for patients to seek compensation if they suffer harm."

A statement from the GDC read: "We strongly advise all registrants to 'check the small print' of their cover, particularly in relation to exclusions. You need to satisfy yourself that any such exclusions don't compromise your responsibilities to patients. If they do, we expect you to rectify the position promptly and while doing so only practise in a way that is appropriate to the cover you have.

"In providing this advice we are making no distinction between the general effectiveness of different types of cover e.g. indemnity or insurance. What matters is that whatever type of cover you have, it enables you to meet the standard and ensure that patients are properly protected."

MORE INFORMATION
To see all the recent GDC cases, visit www.gdc-uk.org

NOW TRENDING

3.93

FACT
The average number of decayed, missing and filled teeth for children with decay experience. The mean number for all P1 children in Scotland is only 1.21*

* National Dental Inspection Programme

GOODWILL VALUATIONS APPEAR TO BE LEVELLING OFF

The recent 'boom' in the dental practice sales market is on the wane, according to the latest goodwill survey compiled by the National Association of Specialist Dental Accountants (NASDAL).

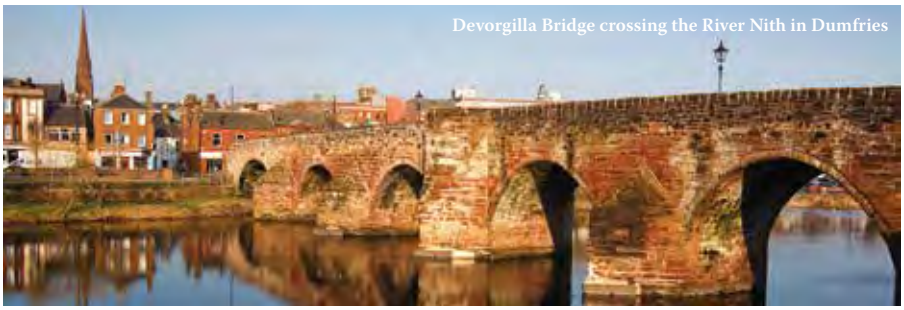
The latest NASDAL figures suggest that following a number of years of impressive growth, there now appears to be a levelling out of prices being paid.

Cliff Fleming, partner at Fife-based Condie & Co Chartered Accountants, said: "In Scotland there is still a very active market if not quite at the levels of London and the South East. In terms of private practice, the UK-wide figures are well in excess of what we are seeing. A recently completed deal in Scotland saw 87 per cent for a private practice with good sustainable profit. The UK-wide figures are at an average of 114 per cent of goodwill as a percentage of fee income.

"The values, I fear, are perhaps based on the appetite within our banks to fund private (care) with the NHS being seen as more 'guaranteed'."

ANGER AS DENTAL CLINIC CLOSURE CONFIRMED

NHS Dumfries and Galloway set to close the final public dental service clinic in the region


Devorgilla Bridge crossing the River Nith in Dumfries

The decision to close a salaried dental clinic in an area of multiple deprivation in Dumfries has been met with a mixture of disbelief and anger among the local community.

NHS Dumfries and Galloway said in a statement that, following a meeting on 7 August, it has approved the "complete withdrawal of routine NHS General Dental Services at Lochside Dental Clinic".

John White, who himself worked in the NHS for more than 40 years, has been registered at the centre for 10 years. He said: "I'm disgusted. It just shows a lack of care for patients. The drive is to save money, even though money is supposedly there to keep it going. It is a totally wrong decision that should be reversed."

He claims that low-income families and people with mobility issues simply won't travel into Dumfries itself for care. He said: "They are all being told they will be directed to an independent contractor in Dumfries but they won't go, it is as simple as that. There will be a lack of dental care for a whole community and, as a result, it will lead to extra expense for the hospital to deal with eventually."

South Scotland MSP and Shadow Health Minister Colin Smyth said: "A lack of funding from the Scottish Government has also left NHS Dumfries and Galloway with a £20 million black hole but the local NHS have already agreed funding for the clinic for the year ahead. So, overall, this decision is an unnecessary attack on one of the most deprived communities in our region and shows utter contempt for the local community by members of the health board".

North West Dumfries Councillor Ronnie Nicholson said: "This is a real blow to the community in my constituency. I have no doubt whatsoever that it will mean a lower take-up in dental care by people in the area, where we already have huge health inequalities.

"Given that there are now no dental clinics anywhere in the town north of the River Nith, and no healthcare facilities in the heart of north west Dumfries at all, you have to question NHS Dumfries and Galloway's commitment to the area."

The statement from the council continued by saying: "The NHS board is committed to ensuring that patients of the clinic continue to access NHS dental care.

"It is also focused on supporting improvements in the oral health of those living in the Lochside and Lincluden area through a range of approaches with key partners, as detailed in the recommendations of the Lochside and Lincluden Oral Health Needs Assessment Report."

HISTORY SOCIETY'S FRENCH CONNECTION

Group named after first female dental graduate welcomes French society for annual meeting

The annual meeting of the Lindsay Society for the History of Dentistry will take place on 6-8 October in Portsmouth, before returning to Scotland in 2018.

The society was named after the first woman to qualify in dentistry in the UK, Lillian Lindsay, who graduated from Edinburgh in 1895. It promotes the study of the profession's history and welcomes members from all over the UK.

The group's president, former Glasgow Dental Hospital and School's Professor David McGowan, has revealed that the society will be joined this year by members of the Société Françoise d'histoire de l'art Dentaire, who will also be participating in the programme. In honour of their visit, Prof McGowan will be presenting a paper at the meeting on the French pictures in the Menzies Campbell Collection, which is housed in the Surgeons' Hall Museum at the Royal College of Surgeons of Edinburgh.


An old French print, 'Le Charlatan' from the Surgeons' Hall Museum. The 'dentiste' fired the pistol at the moment of extraction to distract his patient

Prof McGowan said: "The annual meetings are noted for their sociability as well as their scholarship and this year's programme includes a dinner at Portsmouth's 'Mary Rose' Museum.

"New members or even non-members and partners are most welcome and details are available from the secretary, Brian Williams (brianwilliams14@btinternet.com) or from the BDA Museum website."

Next year's annual meeting will take place at the Royal College of Physicians and Surgeons of Glasgow and will feature members of the Glasgow-based Henry Noble History of Dentistry Research Group.

MORE INFORMATION
To find out more about the Lindsay Society and annual meeting, visit www.bda.org/museum/lindsay-society

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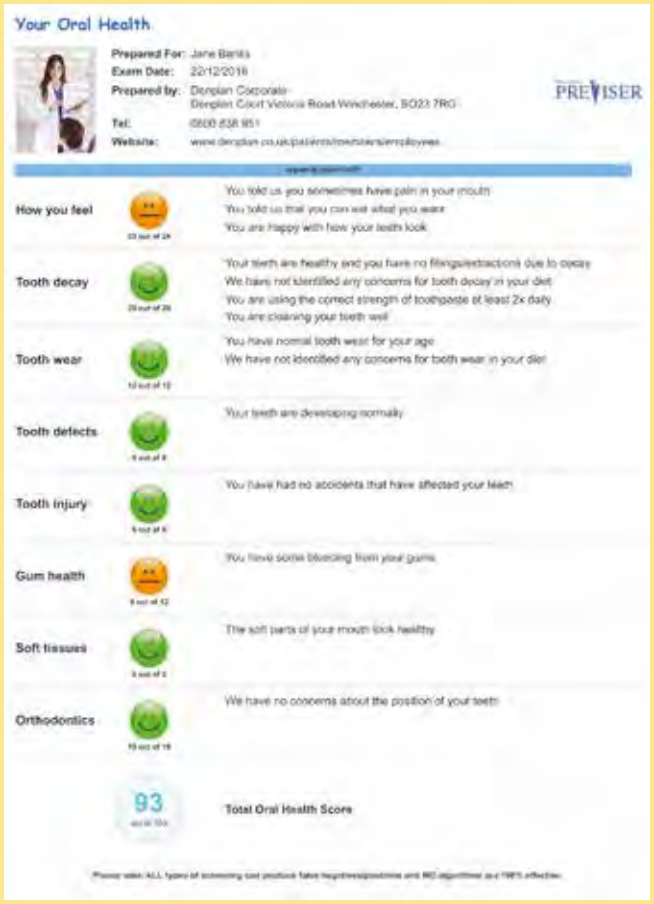

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BDA SCOTTISH CHIEF LEAVES ASSOCIATION

Association's director for Scotland leaves to 'pursue other professional and career opportunities' weeks before flagship Scottish conference

Just two weeks before the BDA's Scottish conference, the association's national director for Scotland Pat Kilpatrick left her post in unexplained circumstances.

Kilpatrick joined the BDA in 2013 following a career in education, government and NHS management, before setting up her own consultancy firm and working with NHS Trusts in England and Northern Ireland. On the day of her departure, 18 August, it is understood that she was due to attend meetings with BDA committees, who were unaware of her departure until an email was sent by the BDA's Chief Executive Peter Ward.

He wrote: "Pat Kilpatrick has decided to pursue other professional and career opportunities and will be leaving the association with effect from the 18 August. Pat joined the BDA from a career in healthcare and consulting and brought a range of skills and expertise to the role of national director.

"Pat has asked me to thank her colleagues at the Association and particularly the policy team at BDA Scotland for their support and hard work over the last four years. I know you will join me in thanking Pat for her commitment, hard work and professional achievements during her tenure at the Association and, on behalf of the staff and the PEC, we wish her every success in her future career."

The BDA Scottish Dental Conference was held on 1 September at the Crowne Plaza Hotel in Glasgow. It was opened by Chief Dental Officer Margie Taylor, whose session, entitled 'On the way to a new action plan' generated a lively discussion on the future of NHS dentistry.

Former National Director of BDA Scotland, Pat Kilpatrick

Taylor said: "I thought the discussion was good. The more opinions we get the better and the more we ask people, the more it either reinforces the original opinion or provides more opinions, so it is really helpful from my point of view.

"This debate is important because it is going to influence the next generation, not only of patients but of dentists as well."

COUNTERFEIT GOODS CAMPAIGN WINS AWARDS

A campaign to raise awareness of dangerous counterfeit and substandard equipment has won two awards.

The 2017 British Dental Industry Association (BDIA) Counterfeits and Substandard Instruments and Devices Initiative (CSIDI) won the Highest Believability Award and was a joint winner of the Highest Information Value category in the latest BDJ Readex Research.

Edmund Proffitt, Chief Executive of the BDIA, said: "We are really pleased that our CSIDI campaign is having such an impact on BDJ readers. The campaign not only conveys useful and relevant information to the profession, but serves to highlight the very real and significant dangers associated with counterfeit and non-compliant instruments and devices across the dental sector."

CHILDSMILE PROGRAMME IS EXPANDED TO REACH POOREST CHILDREN

Oral health initiative rolled out among some of Scotland's most deprived communities

The hugely successful Childsmile oral heath programme is being extended to reach more children from deprived areas.

The Scottish Government's Fairer Scotland Action Plan, which was published in October last year, included commitments to extend the coverage of the programme to reach more of the nation's poorest children.

At the launch of the expansion, at Annette Street Primary School in Govanhill, Glasgow, Scotland's Chief Dental Officer Margie Taylor said: "We are very proud of the Childsmile programme and the difference it is making to oral health for children across Scotland – fewer children are requiring treatments such as extractions, fillings and general anaesthetics.

"I was really pleased to visit Annette Street and see the pupils taking pride in their oral hygiene. Picking up good habits at a young age means less tooth decay, which in turn means less toothache, fewer sleepless nights and less time off school. Not to mention these good habits will last a lifetime."

Health Secretary Shona Robison said: "The Childsmile programme, with its emphasis on prevention, rather than treatment has resulted in significant improvements in children's oral health across Scotland. Our aim is that every child has access to Childsmile.

"Reducing inequalities in health is critical to achieving the Scottish Government's aim of making Scotland a better, healthier place for everyone, no matter where they live – and the expansion of Childsmile, through our Fairer Scotland Action Plan, provides a good illustration of this in practice."

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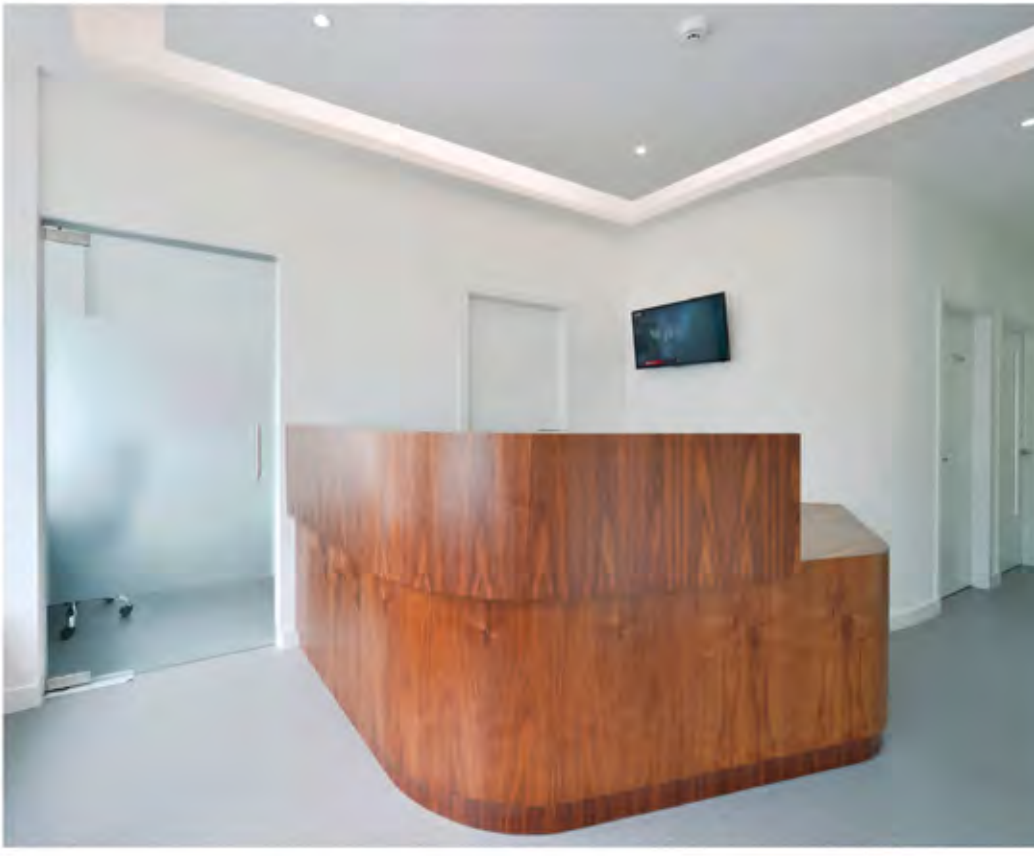

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VULNERABLE PATIENTS ARE BEING IGNORED, SAYS BDA

The BDA has claimed that new research from the University of Glasgow shows that the oral health needs of vulnerable patients are being disregarded.

The research, published in the *Archives of Disease in Childhood*, compared data from 622,280 children from Scotland, 10,924 of whom were currently or recently looked after and found 49 per cent of children in care do not attend the dentist regularly, in comparison with 38 per cent of the general child population.

The study also found that 9 per cent of children in care have had a tooth extraction under general anaesthetic, compared with just 5 per cent of other youngsters.

This reseach follows on from recent studies from Healthwatch that found wholly inadequate provision of dental services for elderly care home residents in England.

The BDA's Michael Cranfield said: "Children in care are facing hospital extractions in such numbers because dentistry has been treated as an optional extra. This research adds to a growing body of evidence on the UK care system where the oral health needs of vulnerable patients, both children and adults with additional needs, have simply been disregarded.

"Government has a duty to provide structure to these children, many of whom come from chaotic backgrounds. The onus is on the authorities to ensure all their health needs are met."

MORE INFORMATION
To read the Glasgow University research in full and other articles from the *Archives of Disease in Childhood*, visit adc.bmj.com

To see the Healthwatch reports on care homes in England, go to www.healthwatch.co.uk

NATIONAL SMILE MONTH EVENT IS DECLARED THE BIGGEST IN THE WORLD

The University of Glasgow Dental School has achieved a Guinness World Record for the World's Biggest Smile after 756 participants, including local school children as well as Scotland's Chief Dental Officer and Glasgow's Lord Provost, took part in the event at the SEC.

The event, which was two years in the planning to mark National Smile Month, was the result of a light-hearted conversation between Glasgow Dental School dean Professor Jeremy Bagg and Dr William McLean who is the lead for alumni development at the school.

Prof Bagg, said: "I am delighted that we were able to achieve our aim of setting a Guinness World Record by assembling more than 750 participants in the shape of a big smile as Glasgow's contribution to National Smile Month. The event was a huge amount of fun to organise and our sincere thanks go to all of the many partners and organisations involved who helped to make this happen. The promotion of oral health, particularly in children, is an important message to get across. We hope that our record breaking event has been both fun and educational for all involved."

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HAVING THEIR SAY →
Our columnist is a young dentist from the West of Scotland. Any correspondence should be directed at the editor: **bruce@sdmag.co.uk**

THE TRIALS OF DENTAL SCHOOL

Our new columnist looks back on their time as an undergraduate and reflects on the lessons they learned, and have taken in to life as an associate

I started dental school aged 17 and I stayed at home for the first two years. I was used to working hard in school, my achievements and attitude being acknowledged. I did some extra curricular stuff including fundraising and sport clubs as well as my part-time job. Should be plenty of grounding for my first year of dentistry…

All this confidence I gained in my mid-term years was quickly quashed with the realisation that I wasn't the biggest fish in the pond anymore. I was surrounded by high achievers. Plenty seemed to know exactly what to expect having relatives who'd been to university and, specifically, dental school before them. My parents hadn't been to university nor had I a relative who was a doctor, never mind a dentist.

For me to assume that I was ready for the challenge and could continue to study as I had and expect exams to be straight forward like they had been previously was a mistake. An assumption. Unfortunately I didn't pass first year and had to resit over the summer.

You'd think being in that awkward situation would motivate and prepare me for the following year. Nope. Failing second year, I went to an oral exam. I came out of the oral exam in tears. Fortunately, I must have been on the border of passing as the information I gave during the oral exam was enough to scrape me a pass. Anatomy was like a living nightmare. I was deeply disturbed at handling cadavers. The smell of formaldehyde literally made me cry! I found gaining a three dimensional understanding of something with two dimensional text books incredibly difficult.

I got to third year and things seemed to be getting in hand. I spent far too much time trying to memorise the things we learned in the microbiology aspects of the curriculum but, by fourth year, my grades started to reflect my effort and the elective at the end of the year was a great treat.

Fifth year felt like being invited to the grown ups' table. We were pretty much expected to be as good as 'real' dentists and I felt the shift of the supervising clinicians generally treating us like colleagues. I really struggled to keep to time with writing notes for example. I remember staying late at an outreach centre writing up radiographs and the supervising clinician telling me I wouldn't have time to write as many notes in general practice. I asked 'what should I leave out then?' And got no response. A sentiment mirrored by the indemnity companies, happy to tell us what we should have included in our notes, not so happy to say 'you can leave that bit out'.

It's very Scottish of me to tell you about my failures first

When I reflect on my years in dental school, I can't help but think how easy I had it. It felt like a struggle at the time, a scramble to the finish line. I wish I had worried less, studied more and took part in more of the extra curricular aspects. I was so bogged down with the worry of what I didn't know that I had limited confidence with that which I did. Often, my supervising clinicians presumed me a distinction student given my diligence in tutorials and my hard work on clinic. I believe I over-thought a lot of aspects and that, for me, it takes longer than average for the proverbial penny to drop. Even though I was terrible at anatomy, I remember getting some real acknowledgement for the professional quality of my formative anatomy essay. When I came across my references from the supervising clinicians recently I couldn't help but glow with pride.

It's very Scottish of me to tell you about my failures first. I can't help but think dental school really teaches you to be self critical and so you focus on how you can improve. No wonder so many of us struggle with our mental health.

So many decide that they'll use dentistry as a means to an end. One of my good friends says 'no dentistry talk' when we all get together. If we were happier in our day-to-day practise, it'd be great to talk about dentistry. To share experiences.

If we see each day for the positive gift it really is then silly little things like complaints or disagreements or the GDC would be seen for the nonsense it is. Sometimes, we should just take a step back and think 'I worked really hard today and I did my best, so I'm proud'.

I hope every dental student starting in the autumn gets some perspective and is mindful of what's happening now, not just planning for the future. Let's try to celebrate the wins, not just learn from the losses.

UPCOMING EVENTS

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4 OCTOBER
Faculty of Dental Trainers First Annual Conference
RCSEd, Birmingham
To find out more, visit fdt.rcsed.ac.uk/2017-conference

6-8 OCTOBER
Lindsay Society Annual Conference
Portsmouth
Find out more at bda.org/museum/lindsay-society

19-21 OCTOBER
BDIA Dental Showcase
NEC Birmingham
See www.dentalshowcase.com for details.

3 NOVEMBER
Mouth Cancer Conference
Royal College of Physicians and Surgeons of Glasgow
To find our more, visit rcpsg.ac.uk/events/orcan

3-4 NOVEMBER
Orthodontic Society of Ireland Autumn Meeting
Dublin
For more information, visit www.orthodontics.ie

3-4 NOVEMBER
BSDHT Oral Health Conference and Exhibition 2017
HIC Harrogate International Centre
Visit www.bsdht.org.uk to find out more.

9-11 NOVEMBER
BACD Annual Conference 2017
London
To find out more, visit www.bacd.com

26-29 NOVEMBER
Greater New York Dental Meeting 2017
New York
For more information, visit www.gnydm.com

8 DECEMBER
British Society for Disability and Oral Health Winter Conference
Royal College of Physicians, London
Find out more at bda.org/events/conferences

6-8 FEBRUARY 2018
AEEDC Conference and Arab Dental Exhibition
Dubai
Visit www.aeedc.com

28 FEBRUARY – 3 MARCH 2018
Academy of Osseointegration Annual Meeting
Los Angeles, USA
For more information, visit www.osseo.org/annual-meetings

20 APRIL 2018
Osteology UK
Royal College of Physicians, London
To find out more, visit www.osteology-uk.org

27 APRIL 2018
Scottish Dental Awards 2018
Hilton Glasgow
Visit www.sdawards.co.uk

27-28 APRIL 2018
Scottish Dental Show 2018
Braehead Arena, Glasgow
For more information, visit www.sdshow.co.uk

10-12 MAY 2018
British Dental Conference and Exhibition
Manchester
Log onto bda.org/conference for more.

20-21 JULY 2018
World Dental and Oral Health Congress
London
Find out more at www.worlddentalcongress.co.uk

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AN INTERNATIONAL LINE-UP OF SPEAKERS

THE BRITISH ENDODONTIC SOCIETY'S EDINBURGH MEETING WILL FOCUS ON ENDODONTIC INFECTIONS AND SYSTEMIC HEALTH

November's Regional Meeting of the British Endodontic Society, in Edinburgh, will feature an international line-up of speakers.

The two-day event takes place on 17 and 18 November, at the Sheraton Grand Hotel

The Friday programme will begin with a choice of four 90-minute Masterclasses, on subjects ranging from root canal instrumentation, to the current status of CBCT in endodontics.

Friday afternoon will feature two lectures from Prof Martin Thornhill, from the University of Sheffield, firstly on focal infection theory and then on antibiotic prophylaxis and endocarditis.

Friday night's conference dinner will take place at the Royal College of Surgeons of Edinburgh, and will include a viewing of the dental collection at the Surgeons' Hall Museum.

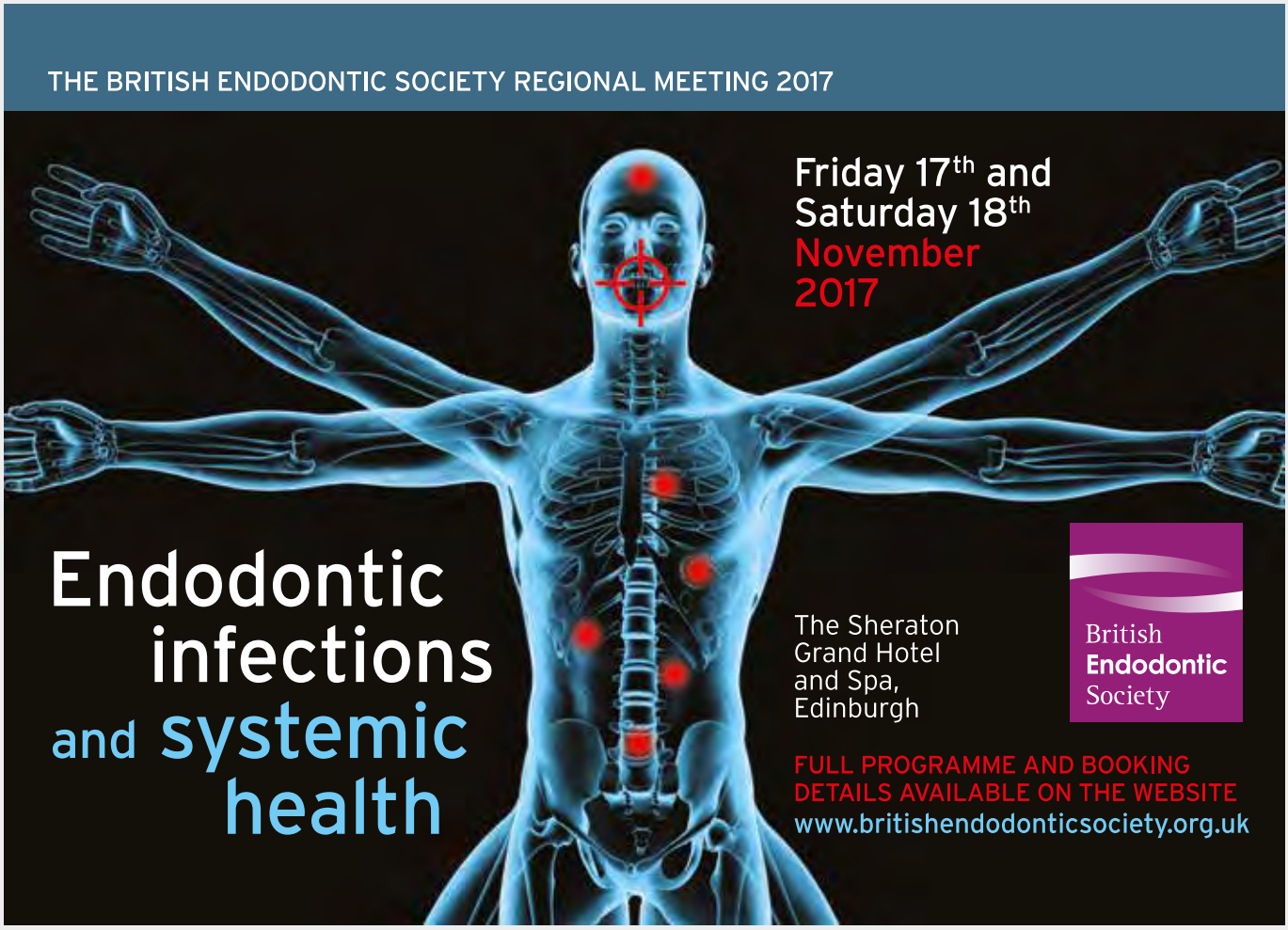
The conference continues on the Saturday with a quartet of Finnish speakers, covering such topics as systemic diseases and endodontology, and oral infections and cardiovascular diseases.

The final talk of the conference will come from Dr Riina Rautemaa-Richardson, Senior Lecturer in Infectious Diseases and Medical Education from the University of Manchester, who will speak on antibiotics in dental treatment.

The Society welcomes all members of the dental profession to attend its conferences. With two-thirds of its membership being GDPs the association aims for its programmes to have as wide an appeal as possible.

MORE INFORMATION

For more information and to book your tickets to the British Endodontic Society's Regional Meeting, visit www.britishendodonticsociety.org.uk



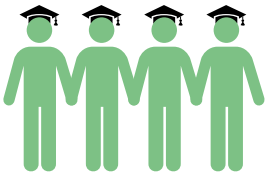
In depth

ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

A STAR IS BORN

THE YOUNGEST EVER WINNER OF THE DENTIST OF THE YEAR AWARD

See page 31



A FACULTY FOR THE WHOLE TEAM

AS THE NEWEST DENTAL FACULTY AT THE ROYAL COLLEGE OF SURGEONS OF EDINBURGH TURNS A YEAR OLD, DIRECTOR DR SARAH MANTON TALKS ABOUT ITS INCEPTION, ROLE AND PLANS FOR THE FUTURE

BRUCE OXLEY MIKE WILKINSON

Taking the helm of a new dental faculty, which also happens to be the first of its kind in the UK, is no short order, but Dr Sarah Manton seems to have taken it all in her stride.

The Faculty of Dental Trainers (FDT) at the RCSEd launched in September 2016 after it was recognised that there was currently no 'home' for dental trainers.

"These days you are very accountable to regulators and to the service, but first and foremost, you are accountable to patients for their safe care. Not only do trainees have to be trained so that they are competent at the tasks or treatments required, they also have to be consistent in how they perform them.

"So, if you have got to have clinicians who are trained to perform set competences, then why don't you have to have trainers who can demonstrate and prove that they are competent to train and are accountable, just as trainees are accountable?"

A survey of dental trainers, conducted by the RCSEd in March 2015, found that many felt there was a lack of recognition for their input into dental training or for rewarding training.

Sarah said: "Enough time needs to be built into individuals' job plans and work routines for there to be confidence that all the standards for training programmes are being met and that the public can be assured they are being treated by clinicians who are fit for purpose.

"We thought that if we created a faculty where like-minded people could come together, having had the evidence of their experience recognised and externally validated – particularly by their peers – this would help them develop their roles, achieve recognition in the workplace, help with their appraisal, help with their 360 degree peer review, help with validation processes, help support job applications, help gain training posts etc., and also give them somewhere to go for relevant and specific CPD for dental trainers."

Route to the RCSEd

Despite growing up in Guildford, Surrey, Sarah chose to head to Edinburgh to study, a city she was more than familiar with, having visited numerous times to stay with relatives over the years. After graduating in 1975, she undertook a PhD in breast pathology before taking up a post as a registrar at the dental school in Edinburgh. After that she moved to Bristol where she became a lecturer in oral medicine and periodontology as well as carrying out her senior registrar training – which at the time was the equivalent of StR training – in restorative dentistry.

> "IT IS FOR ANYONE WHO IS INVOLVED IN TRAINING IN DENTISTRY – WE FELT IT WAS IMPORTANT TO HAVE A FACULTY FOR THE WHOLE TEAM"
>
> DR SARAH MANTON, FACULTY OF DENTAL TRAINERS

Her next move involved a return to Scotland in 1994, this time to Dundee where she became a special care dentist in her new role as dental services manager for the community dental service. During this time she also undertook specialist practice in perio after gaining her place on the GDC's list. She is also on the specialist lists for restorative and special care dentistry.

Although she had taken her fellowship for the RCSEd in 1985, it wasn't until 1994 that she became more formally involved with the Royal College itself. She was a member of the Specialty Advisory Board for Additional Dental Specialities between 1998 and 2006, and became chair of the Specialty Advisory Board for Oral Medicine and Special Care Dentistry in 2007. She has been an elected member of the Dental Council since 2007 and is currently in her second term. It was during this term that she was nominated to become vice-dean of the council.

Although retired from her consultant post in Dundee, Sarah is still engaged in specialist practice in Cupar, in Fife, and Aberdeen. She is also the current chair

LEFT: Dr Sarah Manton, the first director of the Faculty of Dental Trainers, is keen to involve as wide a range of staff and skills as possible

of the BNF Dental Advisory Committee.

She came on board midway through the setting up of the FDT, initially as project lead and then, after a formal application and interview, was appointed as the new faculty's inaugural director. The FDT was officially launched in September last year and sits alongside its sister faculty in the college, the Faculty of Surgical Trainers (FST), which has been established for a number of years.

Inclusive

Sarah explained that one of the things that makes the FDT stand out is the fact that it is aimed at the entire dental team, which she believes is another first for the RCSEd.

She said: "It is for everybody who is involved with training in dentistry. They are going to be able to join the same faculty – we felt it was very important to have a faculty for the whole team. We recognise that everyone has a different role in the team and you are only as strong as your team members."

When setting up the faculty, Sarah explained that there were comprehensive discussions about who would be eligible to join and what constituted a dental trainer. She said: "In undergraduate training you might have some individuals who only spend a session a week doing training alongside others who are actually driving a curriculum and its development. Predominantly, the faculty rewards postgraduate training but, if you have a significant role in undergraduate training, then we are going to look at that as well.

"We are very keen that, for example, if you are a GDP in primary care, while you can't have the same training role within your sphere of practice as someone who is appointed as a lecturer or a senior lecturer in a teaching hospital, you may have a significant role because you might, for example, be a VT trainer, or be active in committee work involving training at various levels. You might have been appointed to do teaching at undergraduate level at a hospital because you are good at your job and you have excellent clinical skills.

"Equivalent seniority in the various different settings of dental training are going to be rewarded. So, if you are a DCP and you are training other DCPs, have a significant role in a national society, are involved with curricula change, or with developing postgraduate exams, all that type of activity counts."

Developing the strategy

The FDT has put together an over-arching strategy group that includes a number of individuals pulled from different groups within the profession who are all interested in driving and shaping the work and direction of the faculty. Alongside this, there will be several sub-groups looking at specific areas that the strategy group has deemed important or necessary.

Sarah said: "One of these will be our standards for dental trainers document. The surgeons have already addressed this and they have published their standards for surgical trainers. We want to see how we can develop these for our faculty.

"One of the main reasons for the FDT is patient safety. It is absolutely imperative that the public has confidence in dentistry and that the safety of patients is maintained so that they know that the people who come into the workplace have been trained to a consistent standard and can do the job that is required. And that those who have trained them are equally qualified to do the training. We owe that to the public; we owe that to regulators; we owe that to employers, and that is a big driver for the faculty."

Another area that the faculty is working on is non-technical skills courses for dentists and DCPs. Sarah said: "The emphasis in training so far has really been on demonstrating a particular skill, such as an injection. The trainer will look and see you give the injection and do a workplace based assessment on that. What the recognition of non-technical skills means is that there is more to just being able to do the task or having the knowledge to do the task.

"So, we are looking at things like your

CONTINUED OVERLEAF>

FROM PREVIOUS PAGE >

communication skills and decision making, your situational awareness, your team working, what you might do if things get a bit critical, and how you might lead that team. These are non-technical skills and we are looking to develop these for the whole dental team."

Sarah pointed out that, while the FST has a similar programme, it is different for the dental profession. "For the surgeons, in many ways it is more straightforward," said Sarah, "because they are in an operating theatre and they have an operating team, whereas for dentists there are various different environments. So, we have to look at all this and develop appropriate courses for dentists and DCPs."

Building the membership base

One of the main aims in the short term is to grow the faculty and raise awareness among the dental profession about its presence and its aims and objectives. The FDT recently welcomed its 100th successful applicant (see page 10). There are fellows, members and associates who have signed up and the faculty has also welcomed its first DCP fellows.

Sarah said: "You can join at any level, so if you are interested in teaching and training you can join as an associate at any stage. You could be two-years post qualification, for example, and you might be involved in some undergraduate supervision or be interested in taking on some training or teaching now or in the future.

"When you join as an associate, all you need is a letter of support from a peer or a clinical trainer to say that you are interested in training and what your activities have been. You can then work towards becoming a member or a fellow, when, if successful, you are also awarded post nominals. The information on how to join is on the RCSEd website and you can apply for entry at any level. To become a fellow, you need two references from your peers to support your application."

Sarah explained that they are driven by the ambition to make the membership as diverse as possible, and to develop a balance of voices and experience within the faculty. She said: "What we really want is for individuals to have shown and demonstrated by the evidence on their applications that they are seeking to be, or are, leaders in their field and that they are very active, but also want to get involved. We are not looking for people who may be demonstrably very senior, but whose working roles do not involve a strong commitment to teaching and training. We also want to welcome people who are at a starting point – an associate who wants to become a member, a member who wants to become a fellow."

Planning to succeed

Sarah acknowledges that, as the first dental training faculty in the UK, there is a certain amount of pressure on them to succeed, but she is determined that "we have got to make it work and we will make it work".

She continued: "It does help that the surgical trainers have already paved the way to a certain extent with their faculty and this is really useful."

And, she believes that the openness and opportunity that the FDT provides will prove to be attractive for dental professionals the length and breadth of the UK. She said: "We intend it to be open to anybody and hope that people want to take advantage of the opportunity.

"It's important to get some external validation and recognition because, in the workplace, very often you can't prove what you do. You might be putting a huge amount of effort into something and there is little encouragement or no tangible reward. Sometimes, there might be a lack of appreciation or a feeling that your efforts are taken for granted."

With a joint conference with the FST coming up in Birmingham in October (see Time to Train, right) and plans to release a range of resources on the FDT website, the next few months will be a busy time for the fledgling faculty. However, Sarah and her colleagues are determined to make their mark and make sure that the faculty is recognised and flourishes over the next few years and into the future.

She said: "At the end of the day, the basic need of the FDT is to protect patient safety. That is the key role of the dental team and of this dental faculty.

"So, we are working hard to make sure that we are the 'go to' faculty for resources on dental training and advice."

TIME TO TRAIN

The Faculty of Dental Trainers at the RCSEd is joining forces with its sister faculty the Faculty of Surgical Trainers for a one-day conference in Birmingham on 4 October. Sarah explained the reasoning behind the conference theme, 'Time to Train': "What we are addressing here is the issue of whether people get enough time to train. One of the problems that came up in our survey was that people might feel very competent in the clinical skills that they are teaching but they are not particularly confident or reassured that they are allowed the time to do the teaching or training and give trainess and students feedback.

"We'd like to see each trainer develop a personal trainer's portfolio, so that they can reflect on what they are doing and demonstrate their activities by including, for instance, examples of some of the assessments they have done with trainees. I think it is a problem that some authorities or employers expect to employ people who are fit for purpose, but they are not necessarily prepared to invest in the time required, or what is required to achieve that goal, and this includes the time that is required by experienced staff to undertake examining trainees at the end of their training programmes."

The reason the RCSEd event is being held in Birmingham is that most of the college's membership is actually based south of the border; so the Birmingham venue is accessible for delegates from all corners of the UK.

The programme for the FDT will feature a number of workshops, including one on developing non-technical skills courses.

She said: "We are going to ask the delegates to comment on our progress so that they have an input into our documents. We will also be asking them for an input into how they would like to see the faculty develop for them, what benefits they would like and how they would like to see the dental team integrated, rather than us telling them how it is going to be.

"We are very keen to hear from anybody who wants to help and be involved."

For more information, visit fdt.rcsed.ac.uk/2017-conference/

RECOGNISING ACHIEVEMENTS

EDINBURGH DENTIST WHO PICKED UP TOP AWARD AT THE SCOTTISH DENTAL AWARDS EXPLAINS WHY THE WIN WAS TINGED WITH A LITTLE SADNESS

When Edinburgh dentist Ciara Sutherland realised she had a number of missed calls from her practice manager on her day off, she feared the worst. Busy looking after her two-year-old son Conall at home, she immediately thought that there had been an emergency with one of her patients.

As it turned out, it was nothing of the sort and the news was much better than expected – she had been nominated for the Dentist of the Year award at the Scottish Dental Awards 2017. And, a few short weeks later her name was read out at the star-studded ceremony in Glasgow and she became the youngest winner of the award in the event's short history.

Ciara said: "When I saw I had three missed calls from my boss, my first thought was that something catastrophic had happened to one of my patients. Even when I'm at home, I'm always thinking of my patients, always hoping that their recent deep filling isn't sore, their aligner isn't irritating them or their root treatment isn't too tender. Maybe it's this constant concern, and perhaps sometimes excessive worry, is what won it for me. I think my patients know that I care so much."

After qualifying from Cork in 2008, Ciara and a few of her classmates decided against moving to London like so many of their predecessors and instead moved to Edinburgh in search of work. Ciara's first job was in Bathgate, West Lothian, and she fondly remembers the warm welcome the practice principal gave her. She said: "I'll never forget how welcoming and helpful my first boss was – a cheery highlander named Dr Don Macleod who was, incidentally, intent on finding me a Scottish laddie so that I would stick around!"

She joined City Health Clinic in the centre of Edinburgh in 2012 and lives in the Scottish capital with her husband Dave, a sheep farmer, and their young son. Ciara has a special interest in cosmetic dentistry including invisible adult braces, teeth whitening and advanced stain removal. She is also recognised for her ability to reassure the most nervous dental patients visiting her practice for complex treatments.

She explained that the element of her job that she most enjoys is the people, as simple as that. She said: "I have been at City Health Clinic almost six years and I feel I have a great relationship with my patients. I know them all really well. I actually look forward to having them back and hearing about how the wedding went, how the holiday was, what the grandchild was named etc!

"Clinically I am a big fan of minimally invasive dentistry and love the difference that just a little Align, Bleach and Bond can make."

As well as being a particular favourite of brides (and grooms) to be who are looking to improve their smile for their wedding day photography, Ciara is also undertaking training for cosmetic facial work. This will include wrinkle relaxation, prevention injections and fillers.

Shock and sadness

The Scottish Dental Awards 2017 were held at the Glasgow Hilton in May with 500 guests enjoying a star-studded dinner and ceremony. Hosted by comedian and radio personality Des Clarke, the event was in its sixth year and featured 16 awards from DCP Star and the Style Award up to Practice of the Year, Dentist of the Year and the prestigious Scottish Dental Lifetime Achievement Award.

Ciara, whose practice was also up for the Dental Team Award, explained that when her name was read out her initial surprise and delight proved to be bittersweet. She said: "When my name was read out I was in absolute shock. I really didn't expect it but was so thrilled. It was also tinged with some sadness. My dad passed away two years ago and, having supported me through it all, all the exams and study and challenges it made me sad

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TOP LEFT: Ciara and her colleagues from City Health Clinic in Edinburgh celebrate in style

LEFT: Ciara with her Dentist of the Year award

FROM PREVIOUS PAGE>

that he was not here to see the recognition. I know he would have been very proud."

However, despite these reflections, her friends, family and colleagues on both sides of the Irish Sea have been delighted at news of her award. She said: "My family in Ireland were thrilled and being in the local Cork newspaper was of course the pinnacle! My husband Dave, along with all my work colleagues, seemed so proud that night. City Health Clinic was shortlisted for the Dental Team Award and we really do have a great team spirit. We are all genuinely great friends at the clinic and I feel the patients pick up on that warm atmosphere.

"My patients were also so happy. It was so nice to hear them tell me they thought it was well deserved."

The judges revealed that Dr Sutherland was the "outstanding choice" for Dentist of the Year. Their comments included: "We were impressed with the amount of postgraduate training and further education Ciara had amassed in her career so far. While clearly a driven and ambitious individual, her nomination also managed to convey her ability to provide a calm and gentle environment for her patients."

A number of patient and colleague testimonials were submitted to the panel as part of Ciara's nomination and the judges all agreed that: "It is clear that Dr Sutherland is held in high esteem by patients and colleagues alike. Her professionalism, outstanding patient care and attention to detail are clear. She is has also built up a reputation for real warmth and depth of feeling in the way she helps patients through each stage of their treatment."

Recognising achievements

While there are many dental professionals who don't put too much stock in industry awards, Ciara believes that they can play an important role in modern dentistry. She said: "I think sometimes we can all get bogged down with excessive worry and stress about our patients. It is so nice to take stock, take a deep breath and realise that you are appreciated. The awards are a fantastic way of recognising that all that hard work does pay off.

"Dentistry, like every job, has its challenges and there will be days that are really tough but it can all turn around so quickly when you see the gratitude and appreciation your patients express and there's nothing like that feelgood factor of helping people."

And, for all those dentists and teams pondering entering an awards competition, she said: "Go for it, there is nothing to be lost. It's a confidence boost that we all deserve and could all do with. If nothing else it's a great excuse for you and your team to get glammed up and enjoy a great night out together!"

Looking back on the whole event, Ciara is still delighted with her achievement and it has only made her more motivated at work. She also believes that her award is great proof that it is possible to have a family and a successful career in dentistry. She said: "I'm so thrilled. I love my job – and it's so great to hear that my patients actually look forward to their visits to the dentist.

"Whether I'm working with a bride-to-be to get her perfect smile, helping a nervous patient or planning more complicated treatments, I really like that I get to know everyone in the chair. I'm delighted to see that by simply being kind to your patients, you can gain recognition.

"It's also such a boost to get this award now, just a year after being back from maternity leave. It proves that being a mum of a toddler is totally compatible with progressing a career."

"IT'S A GREAT EXCUSE FOR YOU AND YOUR TEAM TO GET GLAMMED UP AND ENJOY A GREAT NIGHT OUT TOGETHER!"

CIARA SUTHERLAND, DENTIST OF THE YEAR 2017

PIONEERING DENTAL EDUCATION

A SHORT HISTORY OF THE ROYAL ODONTO-CHIRURGICAL SOCIETY OF SCOTLAND, 1867-2017

DR PAUL R GEISSLER SURGEONS' HALL MUSEUM

The Odonto-Chirurgical Society of Scotland, founded in 1867 is the oldest dental society in the United Kingdom, if not in the world, still actively functioning under its original title and upholding the original objectives. This year it celebrated its 150th anniversary.

Its roots are traceable to January 1865, when John Smith invited a few surgeons to meet in the Edinburgh Dental Dispensary, with the purpose of founding a society of persons practising ethical dentistry.

Smith was a man with foresight and concern for the welfare of his fellows. Born in 1825, son of a surgeon who practised dentistry, he qualified in surgery in 1847. On the death of his father in 1851 he carried on the dental practice at 12 Dundas Street, Edinburgh.

In the 1840s and 1850s the dental state of the population of the city was very poor. Concerned about this, in 1865 Smith had instituted a course of clinical instruction in dentistry at the Royal College of Surgeons of Edinburgh, the first person in Scotland to do so.

Then in 1860, along with his friends Francis B Imlach, Peter Orphoot and Robert Nasmyth, Smith founded the Edinburgh Dental Dispensary, later to become the Edinburgh Dental Hospital and School, to provide clinical instruction for student dentists and also to provide dental care for the poorer citizens of Edinburgh.

At the meeting in January 1865, those present were David Hepburn, Nasmyth, Orphoot, Andrew Swanson, Matthew Watt and John Wright. It was Smith who suggested the title 'Odonto-Chirurgical Society of Scotland' and submitted a code of rules which he had drafted.

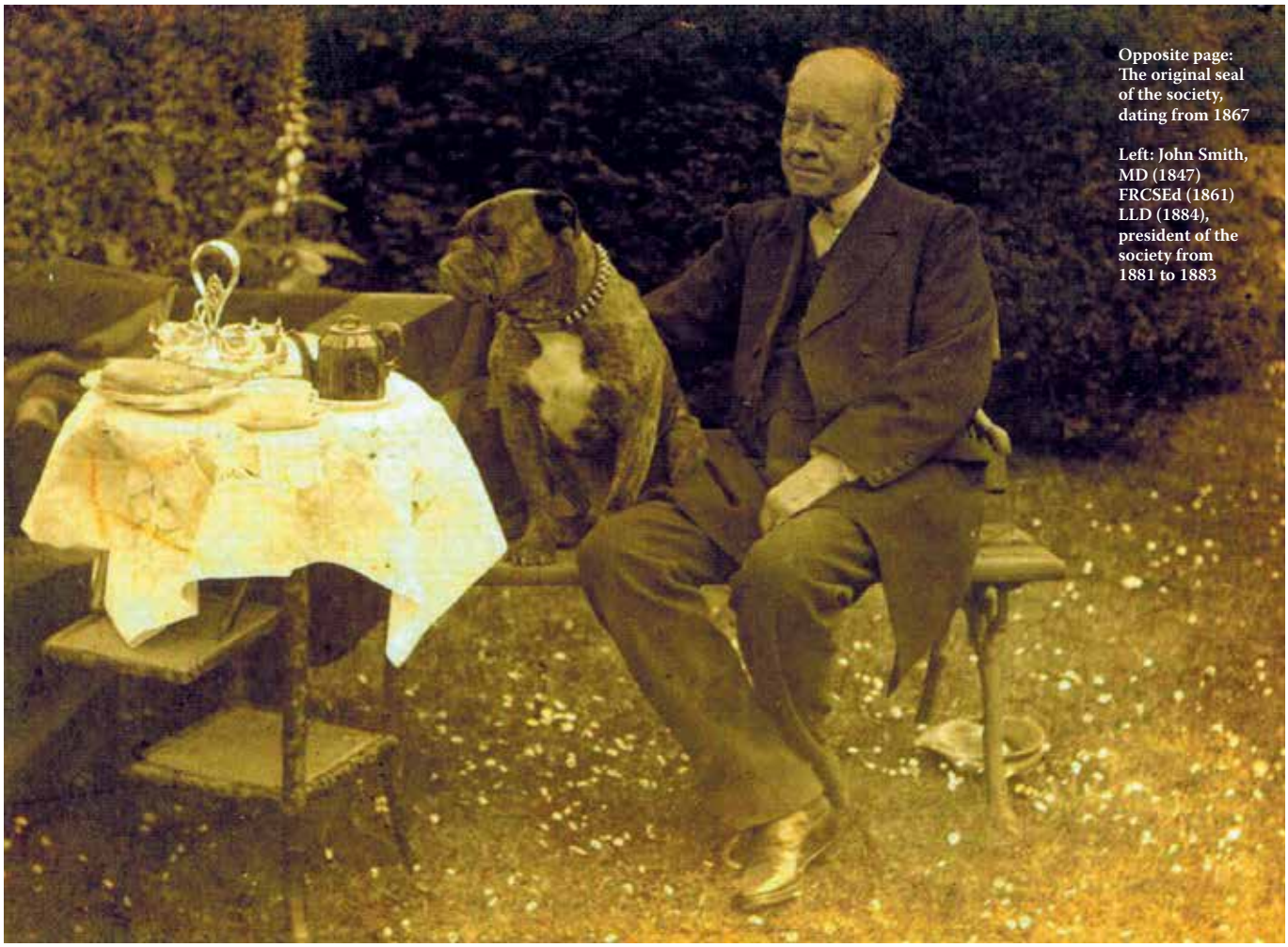
However, there were differences of opinion about whether membership should be restricted to those with a surgical qualification. This could not be resolved and, after two meetings, the idea was abandoned. Hepburn, however, was convinced of the ultimate success of the proposal.

> "DENTISTRY AT THAT PERIOD WAS UNSCIENTIFIC. THE MAJORITY OF THOSE WHO PRACTISED WERE CHARLATANS, MANY BEING ILLITERATE"
>
> DR PAUL R GEISSLER, SURGEONS' HALL MUSEUM

To understand the problems in founding such a society, one has to realise the state of dentistry at that time. To very few did it appeal as a profession. Dentistry at that period was unscientific and crude and training was, at best, by apprenticeship. The majority of those who practised dentistry were charlatans, many being illiterate.

Dentists in 1860s still adhered to the policy of total isolation. It was almost the exception for a practitioner to know a fellow practitioner. If he did, he was careful never to divulge anything connected with his own practice. All such knowledge was guarded as state secrets in a way that cannot be appreciated today.

The struggle for financial survival for some surgeon-dentists was extremely difficult. Some were forced by necessity to be slightly elastic with their ethics. It was this elasticity of ethics which enabled the charlatans to gain some elementary instruction in dentistry. These skills they then developed by trial and error. The claims which such persons made and the fees they charged were often outrageous. They concentrated almost exclusively on



Opposite page: The original seal of the society, dating from 1867

Left: John Smith, MD (1847) FRCSEd (1861) LLD (1884), president of the society from 1881 to 1883

the extraction of every tooth (sound and unsound) and the insertion of artificial dentures. These services were expensive, unhygienic and largely unsatisfactory. This state of affairs was totally inadequate.

For the man in the street in the 1860s, there was no way to recognise the ethical dentist from the unethical or even the charlatan. A revolution in the education and training of dentists and in the regulation of dentistry was needed. However, the first Dentists Act was not to be enacted until 1878 and the British Dental Association was not incorporated until 1880.

It required some notable person or persons to give the impetus. Smith had been one such person, Hepburn was another.

An initial breakthrough had occurred in England in 1860. The Royal College of Surgeons of England had introduced the Licentiate in Dental Surgery (LDS) diploma and the first graduation had occurred on 13 March of that year.

The practice of the surgeon-dentists having a dinner on 13 March, the anniversary of the introduction of the LDS diploma in 1860 had lapsed in London by 1867, but was continued in Scotland. Hepburn utilised the occasion by inviting the surgeon-dentists practising in Scotland to meet on the 13th, prior to the dinner of Licentiates in Dental Surgery in the Douglas Hotel, in Edinburgh's St Andrew Square.

On his suggestion it was decided to found the Odonto-Chirurgical Society of Scotland and to adopt the laws and constitution, with some alterations which Smith had drafted two years earlier and were identical in principle to those of the Odontological Society of Great Britain.

Law 111 of the Odonto-Chirurgical Society adopted at that meeting represented an enormous ethical advance. It stated: "No member shall; be permitted to advertise in the public journals his profession, his mode of practice, or his charges. They state not be permitted to expose specimens of their work for public inspection, nor to carry on their practice in connection with any other business, nor to hold any patent relating to dental practice, nor to conduct themselves in any way, which the Society may consider derogatory to the profession." Expulsion was the penalty for infringement.

The founding of the Odonto-Chirurgical Society proved a great stimulus to the ethical and scientific progress of the profession in Scotland, which up to then had been in chaos, particularly so at a time when there was no dental society nearer than London, so that to attend meetings entailed expensive and long journeys.

Nasmyth was elected first president, Hepburn the first treasurer and John Cunningham the first secretary. Interestingly, Smith did not become a member until somewhat later. He was president from 1881 to 1883 and was later to be president of the Royal College of Surgeons of Edinburgh from 1884 to 85, and the fourth president of the BDA in 1884.

Membership of the emerging society stood for some years at 13. However, in 1879, with the introduction of the LDS diplomas from both the Edinburgh and Glasgow Colleges, there was an increase in applications for membership as these persons with their approved training were considered to be ethical dentists and therefore eligible to join this august body.

Originally, meetings were held quarterly, alternately in Edinburgh and Glasgow, later restricted to three, two in

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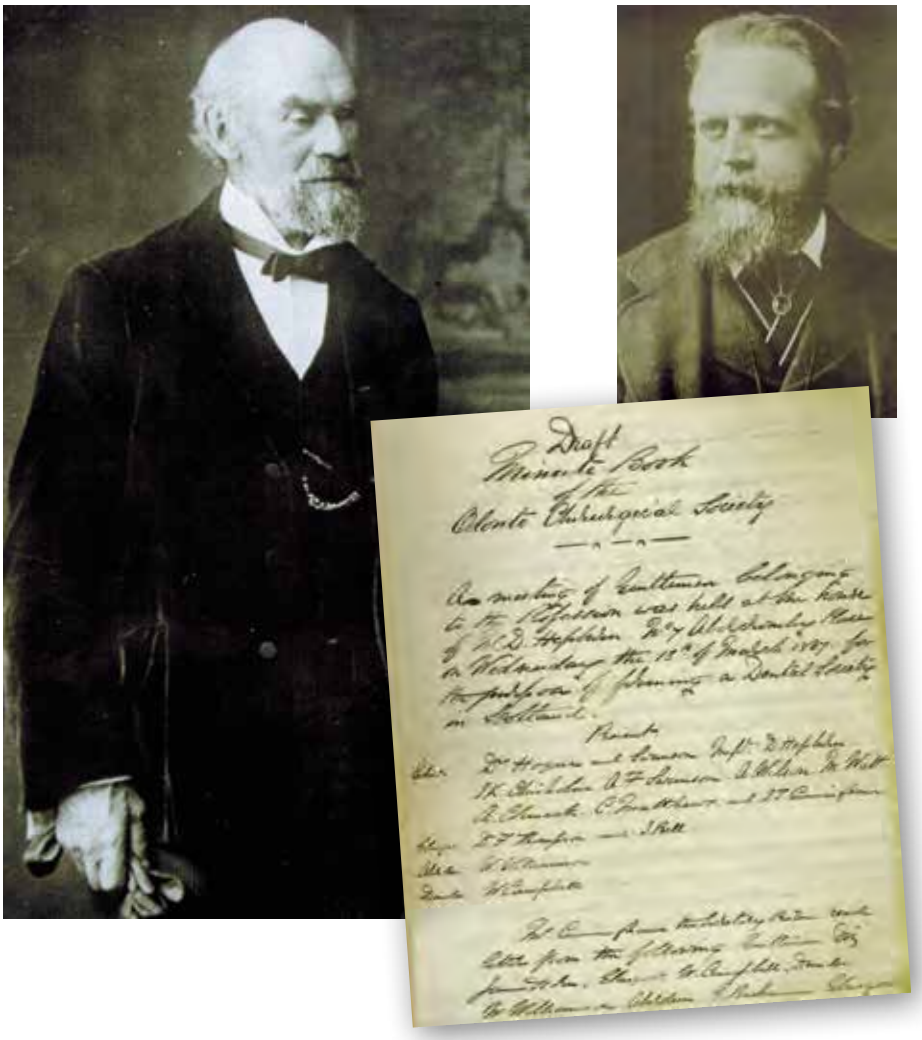

Far left: David Hepburn, LDSRCS Eng (1860), president 1877-1879

Left: William Bowman MacLeod, LDSRCSEd (1879) FRSE, president 1885-1887

Inset: Initial page of the original handwritten constitution of the society

FROM PREVIOUS PAGE >

Edinburgh and one in Glasgow. Since 1887, all the ordinary meetings have taken place in Edinburgh on the second Thursdays of November, December, January and February, with the Annual General Meeting in March, and the Annual Dinner on the Friday nearest 13 March.

From 1867 to 1869, the society met in Edinburgh in the home of the secretary David Hepburn at 5 Abercromby Place. From 1870 to 1879 the meetings were held in the rooms of the Obstetrical Society at 5 St Andrew Square. Thereafter it met in the Dental Hospital and School, first at 30 Chambers Street then 5 Lauriston Lane and, from 1894, 31 Chambers Street. It was only in 1949 that the society met in the Royal College of Surgeons.

The titles of some of the early papers delivered to the society should be mentioned. In March 1868, William Williamson of Aberdeen delivered the first paper to the society, entitled *Some of the Causes of Failure of Stoppings,* which created a very animated discussion in which all the gentlemen present took part. It should be realised that, at that time, tooth preparation could only be accomplished with hand rotated instruments, chisels or excavators. The foot drill did not appear on the market until 1871. Silicate cement and amalgam were used but the latter was very unstable.

Charles Fox of London read a paper on *Nitrous oxide, its preparation and use.* Among some of the subjects covered in the early years were *Filling teeth with Gold*, *Amalgam fillings* and William Bowman MacLeod reported on *Tooth wear in Bagpipe Players,* which induced a great deal of discussion. There was also an intriguing paper entitled *Oesophagotomy and Gastronomy for recovery of a Denture impacted in the Oesophagus*, but no report on the outcome for the patient.

The society has survived and prospered over the years. It has seen the developments of dentistry through greatly enhanced educational and scientific developments, and the coming of the National Health Service, each of which have benefited our patients. It has come through two world conflicts.

Our founding fathers strove to achieve high standards and, over the last 150 years, the society has strived to uphold these standards. This was recognised by the granting of a Royal Charter in 1967, it becoming the Royal Odonto-Chirurgical Society of Scotland. ◤

PROFESSIONAL STANDARDS

When the Odonto-Chirurgical Society of Scotland was founded in 1867, the committee were determined that members should adhere to the highest standards, in ethics and probity as evidenced in the constitution.

Some comments on the constitution as originally drafted:

OBLIGATIONS OF MEMBERS
"No member shall be permitted to advertise in public journals his profession, his mode of practice, or his charges. They shall not be permitted to expose specimens of their work for public inspection, nor to carry on their practice in connection with any other business, nor hold any patent relating to dental practice, nor to conduct themselves in any way which the society may consider derogatory to the profession as long as they continue as Members of the Society."
Constitution 1867, Page 4

ADVERTISING
"No member shall be permitted to advertise in public journals his profession, his mode of practice, or his charges."
Today this hardly applies.

BUSINESS ORGANISATION
"...nor to carry on their practice in connection with any other business."
This has fallen into abeyance.

HOLDING DENTAL PATENTS
Legally permitted but possibly unacceptable on ethical grounds.

CONDUCT
"...nor to conduct themselves in any way which the Society may consider derogatory to the profession as long as they continue Members of the Society."
This section still applies.

STANDARD OF DRESS
In 1988, the society was again concerned about the maintenance standards:
"It was agreed that members should be encouraged tactfully to maintain the standard of dress at a professional level."
Minute of 7 Jan 1988
Since that time clinical changes have occurred. Modern practice frequently involves changing from day wear into clinical garb. Thus the agreed comment of 1988 probably has little meaning today.

ABOUT THE AUTHOR
Dr Paul R Geissler is the honorary curator of the Menzies-Campbell Collection at the Surgeons' Hall Museum, Edinburgh, and the author of *The Royal Odonto-Chirurgical Society of Scotland 1867-2017, 150 Years of Progress*

UNDERSTANDING DENTISTS

THE FOUNDER OF A NEW SCOTTISH-BASED COMPLIANCE SERVICE SAYS THAT STANDING STILL IS THE FASTEST WAY OF MOVING BACKWARDS IN A RAPIDLY CHANGING WORLD

After 20 years in general practice, including more than 12 as a practice principal, I recently had the opportunity to take stock. I had been through a difficult few years and wanted to re-evaluate. During my musing I kept coming back to the same conclusion; I really wanted to use any knowledge and experience I had to help colleagues in any way I could. My task, then, was to set about how to go about refocusing my professional life.

I had been working as an expert witness for a number of years. My perception was (and still is) that many of the problems I saw my colleagues encountering could have been avoided. Given the stress that legal action or a GDC investigation can bring, I felt I was in a position to and, importantly, I wanted to help others. After all, there but for the grace of good luck and circumstance go all of us...

The first step I took was to apply and be appointed as a dental practice inspector (DPI) in Forth Valley. This gave me an insight into the stress and worry that practice inspections can bring. It also showed me that the vast majority of dentists are just out there, simply doing their best.

I still work in general practice and, therefore, I am very much in touch with the ongoing daily trials we all face. I fully understand dentistry is a tough profession and, in many ways, is getting harder.

While looking for ways in which I could help, I came into contact with English GDP Keith Hayes, who runs RightPath4, an online compliance service for dentists in England. He has worked with more than 650 practices south of the border and the list is growing. However, after looking more closely at his service, it quickly became apparent that much of our compliance requirements in Scotland are quite different to England.

In no time at all we were working together on how his service could be adapted and delivered for Scottish practices – something that has not been available before. And so, RP4 Scotland was born as a one-stop-shop to guide, advise and provide online advice on compliance, regulations and standards

The key was to make it simple to follow, and ensure that practices were safe in the knowledge that they were not just fully compliant but that we were able to help colleagues to excel rather than just survive.


Antony Visocchi

As a result, we developed the '3-Step BLUEPRINT', a simple but effective tool to assess your practice, provide a comprehensive compliance and governance system and then excel by going above and beyond the minimum. What's more, members will always be ahead of the curve as they will get updates sent to them as new legislation and guidelines are produced.

STEP 1 – ASSESS

Our Pre-Inspection Coach self-assessment tool has been carefully mapped to the CPI document to provide a true picture of your practice as it stands. A personalised Action Plan is then produced.

STEP 2 – COMPLY

A comprehensive Practice Governance Manual is then produced. This serves as a reference document for the smooth running of the practice and can be used as a guide for new staff induction, existing staff members, patients and governing bodies. This also ensures your practice has consistency across all clinical and non-clinical matters.

Then there is the RP4 Scotland Task Manager, which is a real winner. Once a task is completed, it is entered into the Task Manager. This helps keep track of all the practice requirements and prompts you when matters need to be updated, reviewed or renewed. Therefore, the mad, stressful months leading up to an inspection are a thing of the past. No more late nights trawling the internet or worry when the inspector calls. You will always be ready.

STEP 3 – EXCEL

This step takes you through clinical risk assessment and provides guidance. This gives you an insight into current expectations and requirements in order to keep your record keeping and clinical practices in line with the GDC standards. A variety of templates, patient advice sheets, meeting agenda and surveys are all available for you to easily incorporate into your daily practice.

Step 3 also offers audit packs, an employee manual, a medical emergency booklet and a personal development plan for you to customise to your practice. By joining RP4 Scotland and working on a PDP, you will already be ahead of the new GDC enhanced CPD requirements.

We also have some partners who we highly recommend to complete the package. Discounts are already available to members of DPAS and Practice Plan Direct. Recommendations are available for other services such as HR, fire safety assessment and CPD. TTC Medical Ltd provide medical emergency training and have agreed to be one of our partners. Steve Murray delivers what we believe to be a second-to-none training, which is at your practice, with your equipment and specifically tailored to dentists.

All this is delivered for only £59.95 per month. I know I am biased but I can't help feeling that, as a former practice owner, you can't afford not to join. We formally launched RP4 Scotland at the BDA Scottish Conference at the Crowne Plaza Hotel in Glasgow at the beginning of September and the response was fantastic.

ABOUT THE AUTHOR

Antony Visocchi BDS, MFDS RCS Ed, MJDF RCS Eng is a former practice owner and now an associate at Banchory Dental Practice.

He is a dental practice inspector for NHS Forth Valley, as well as being an independent dental expert witness, advising the GDC, dental indemnity providers and solicitors.

He is also a member of the panel of expert advisors for the NICE Centre for Guidelines.

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For Further Details Contact :

Antony M. Visocchi BDS, MFDS RCS Ed, MJDF RCS Eng

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Oral surgery (Mr Craig Wales)
Dental Sedation (Dr. Stuart McLaren)
Dental Hygiene (Jennifer White & Clare French)

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

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Philip Friel and his fellow dental professionals are registered with the General Dental Council (General Medical Council where appropriate). Philip's membership number is 77637. *Specialist orthodontist is Imran Shafi (GDC 79325).

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Clinical

SAFEGUARDING AND CHILD PROTECTION FOR THE DENTAL TEAM

SAFEGUARDING

Do you know what to do, or who to contact, if you or a member of your team raises concerns about a paediatric patient?

CHRISTINE PARK

I've been teaching in the area of child protection and dentistry for approximately eight years and completed a masters by research in 2013 on *Oral Disease in Vulnerable Children and the Dentist's Role in Child Protection* [1]. I'm now doing a PhD looking at what is involved in the decision by dental team members to refer suspected cases and how serious game methodology might support this context.

What is clear to me is that often decisions in this area are difficult and uncomfortable to make, so this article looks at what is expected of us as members of the dental team (whether we are dentists, dental nurses, therapists or technicians) and what this means from a practical point of view in our daily working lives.

The General Dental Council states that all members of the dental team "must raise any concerns you may have about the possible abuse or neglect of children" and "must know who to contact for further advice and how to refer concerns to an appropriate authority" [2]. They also state "you must find out about local procedures for the protection of children" and "you must follow these procedures if you suspect a child or vulnerable adult might be at risk because of abuse or neglect" [2].

These wide-ranging statements mainly cover child protection (defined as activities undertaken to protect specific children who are suffering, or are at risk of suffering significant harm) but also bring in elements of safeguarding (defined as measures taken to minimise the risk of harm to all children).

From a practical point of view, there is the need to identify what your concerns are. This could be anything from unexplained (or inadequately explained) injuries, concerns about dental neglect, concerns about general neglect, a general lack of engagement with dental services to witnessing a child being physically abused in your waiting room or surgery. It is the vast spectrum of these concerns which make it difficult to provide what so many people ask for – a step-by-step guide for any conceivable situation – because there are so many different situations that could present themselves.

Some health boards have produced flowcharts for dental teams to follow and there is also a summary flowchart available on the Child Protection and the Dental Team website which are very helpful [3]. For some of these situations, the dental team members that I have been privileged to speak to (during my research and teaching) find the decision of what to do next straightforward, but for other situations it is more difficult.

It has already been well documented that there remains a 26 per cent gap between the proportion of general dental practitioners who have suspected child abuse or neglect in one or more of their paediatric patients (37 per cent) and the proportion that have referred suspected cases (11 per cent) [4]. Quantitative methods have consistently shown that the gap between dentists who suspect and refer in Scotland is affected by lack of certainty of the diagnosis, fear of violence to the child, fear of consequences to the child from statutory agencies, lack of knowledge of referral procedures, fear of litigation, fear of violence to the general dental practitioner and concerns of impact on dental practices [4], [5].

So, let's explore four of the most common things I'm asked about and hopefully it will be helpful to all of the team.

1. The child with caries whose family don't engage with services

I'm asked about this situation a lot, probably because it is a common occurrence. We know caries is still common in children and statistics say 94 per cent of children in Scotland are registered with a general dental practitioner, with 85 per

Caries in children can be evidence of neglect at home

The initial focus should be on relief of pain accompanied by preventive care

cent having seen their dentist in at least the last two years [6]. Perhaps a dentist has referred a patient for extractions under general anaesthetic but the patient is never taken to the assessment appointment and the dentist gets a letter back from the public dental service or the hospital dental service discharging them back to their care because they've not managed to see them.

Or perhaps it is a family that come for their check-ups but don't bring the children back to have their treatment completed, or ones who repeatedly cancel, or don't book check-ups when they get their reminder letters and the dental teams only end up seeing them sporadically. Or it may be children who have required extractions under general anaesthesia for removal of all their primary teeth but then don't come back until they are aged seven or so and now have unrestorable caries in all their permanent molars.

These situations are difficult and all of them are examples of dental neglect, which is defined by the British Society of Paediatric Dentistry as "the persistent failure to meet a child's basic oral health needs, likely to result in the serious impairment of a child's oral or general health or development" [7]. Although dental caries is still common in children, signs such as failing to complete courses of dental treatment, failing to listen and act on preventive advice given by dental teams, children returning in pain repeatedly, children requiring repeated general anaesthetics due to dental issues or children who are repeatedly not brought to their dental appointments, are all concerning patterns of behaviour which are likely to result in the impairment of a child's oral or general health or development [7,8].

Untreated dental caries may be one of the first signs of child abuse or neglect [9]. Neglect should be considered if parents have access to, but persistently fail to obtain treatment for their child's tooth decay [10]. Research also suggests that abused/neglected children are more likely to have untreated decayed teeth, significantly more dental plaque and gingival inflammation than non-abused/non-neglected children [11-13].

Many practitioners whom I have spoken to then say: "Well if I have to refer every patient like that, I would be referring at least 60 per cent or more of my paediatric cohort!" This really depends on what practitioners mean by the term 'refer'. All of these situations do require some action to be taken, but not all will necessitate an immediate referral to social work. There is very sensible advice given for this type of scenario in *Child Protection and the Dental Team* (CPDT) which recommends a three-level response to concerns about dental neglect, namely preventive dental team management, preventive multi-agency management, child protection referral [3].

Preventive dental team management involves "raising concerns with parents, offering support, setting targets, keeping records and monitoring progress. The initial focus should be on relief of pain accompanied by preventive care. In order to overcome problems of poor attendance, dental treatment planning should be realistic and achievable and negotiated with the family" [3]. This is often all that is required and, in reality, is probably what most dental teams do on a day-to-day basis (although there is no evidence from research to prove this is the case).

Fully implementing a preventive dental team management strategy can have impacts on a practice and

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those impacts will have to be discussed as a team, for example deciding who will deal with contacting the family if agreed appointments are cancelled or missed. The CPDT website gives an example of how it might be put into practice [3]. The areas where research has suggested dental teams could improve upon are 'setting targets' and 'monitoring progress' [1,4]. If this level of response to the concerns is not working or there is a breakdown of communication or the child/family has more complex needs then preventive multi-agency management may be more appropriate.

Preventive multi-agency management involves liaising with other professionals who might be involved with the family. Examples of other professionals could include the health visitor (for pre-school children), the general medical practitioner, the child's social worker (if they already have one) or the child's named person. The aim of this liaison is "to see if concerns are shared and to clarify what further steps are needed" [3]. There is a sample letter to a health visitor freely available on the CPDT website which can be used to assist with multi-agency working for children under five years old [3].

A joint plan of action should be agreed (for example as a dental practice we will arrange appointments on these dates and the child's social worker will facilitate attendance, or the health visitor will arrange a home visit by a dental health support worker to facilitate registration and attendance at our dental practice). A date should be specified for review of the action plan so that it can be checked that progress is being made.

If there is any point in the processes above where things begin to deteriorate, or if it is felt at any time that the child is at risk of suffering significant harm (this can include things like a child being in pain for more than a couple of days due to toothache and this is happening on more than one occasion), then any member of the dental team can make a child protection referral. Some dental team members struggle to work out when things become significant. A good rule of thumb can be that if you wouldn't let children in your own circle of family or friends go through it, then it is probably significant.

Child protection referrals should be made according to the local procedures of where you work. In Scotland, a child protection referral is made either to the police or local children's social work team (referrals can also be made to the Children's Reporter but follow your local guidelines). If you do not already know your local contact numbers you can, currently, find them out by visiting www.withscotland.org/public-local-councils and typing in the postcode of the child you are concerned about. (Please note: This website address is likely to change in the future as WithScotland no longer exists, but many of their functions have been taken over by the new Centre for Child Wellbeing and Protection www.stir.ac.uk/ccwp/)

2. How do I make a child protection referral?

The majority of child protection referrals will involve a telephone call to your local social work office (Children and Families office ideally but in many areas in Scotland you will go through Social Care Direct) in the first instance explaining your concerns and stating you wish to make a child protection referral. Write down the names and job titles of everyone you speak to. The telephone referral should then be followed up in writing normally within 48 hours. This may involve completion of a shared referral form, or notification of concerns form (same form just different names), or similar, with one copy going into the child's dental notes, one copy sent to the social work office that you spoke to on the phone, and, depending on your local procedures, another copy may be sent to your local child protection unit (CPU) or similar (or you may just have to notify your CPU by email or phone).

3. Will the family know I've referred them?

The short answer to this is that they might. In most situations it is best practice to tell the family what your concerns are and why you are referring them to social services but there will, of course, be some situations where the family don't know, either because you can't get in contact with them or you may believe that you would put the child in more danger if the family were aware of the referral.

You can refer anonymously but, bear in mind that if the concerns you have are related to non-attendance with you or concerns about something dental, then even if you refer anonymously the family will, probably, be able to work out where the referral came from so it is a much better situation if you have informed them the referral is being made.

4. I'm worried about how the family will react

Many dental professionals assume telling a family you are going to contact social work will be bad news, but for some families it will be the first time anyone has actually offered them any help. As members of the dental team, we quite often have to break bad news to our patients (e.g. "I'm sorry I can't save the tooth, it needs to be extracted"). Being concerned is a natural human response but it is helpful to think through all the reactions that you would be worried about and how, as a team, your practice will manage them.

For example, if the family are angry and choose to de-register from your practice, you can't always prevent

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that from happening but you would want to pass that information on to the other agencies involved such as the social work office you referred to. I suggest being quite clear in your practice about what your professional responsibilities are and having posters or information up in waiting areas promoting that you take the safeguarding of children and vulnerable adults seriously.

Many dental team members have told me they are worried that as they live in a small town that word will spread, or their own children will be targeted at school or they will be threatened by the families involved. My advice is that if you are threatened, inform the police and relevant social work office involved. If your own children get picked on because of rumours, approach the school as you would do about any episode of bullying your child may experience and talk to your child about the nature of your job (e.g. "You know mummy/daddy is a dentist/dental nurse/practice manager and looks after people's teeth, but I also have a responsibility to make sure the children that I see at work are alright and are being looked after properly"). If your practice gets branded as "the ones who call social work", take this as a good thing as it means you are actively looking out for and promoting the welfare of your paediatric patients. There are many experts out there who can give advice on how to use it as a 'practice builder'.

Conclusion

Ultimately, it is not only our professional responsibility, but also an ethical responsibility to protect and safeguard those in society who can't do it for themselves. Doing nothing when you have a concern is never an option – you would probably continue to worry and you cannot predict what the impact on the child would be.

Unfortunately, I have had to look at statements from dental team members when something awful has happened to one of their paediatric patients, and so often there have been warning signs (e.g. multiple missed appointments, failure to complete treatment) but the dental teams did not record or raise any concerns. Clearly I have the benefit of hindsight and experience but my hope is that as more dental teams think about and practise looking out for the wellbeing of their paediatric patients, then perhaps I'll see fewer awful things happening. Or, if they are still happening, I'll see real evidence that the dental teams involved did everything they could to help the child.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- To discuss some common concerns with regards to safeguarding and child protection in general dental practice
- To inform readers about various web resources such as Child Protection and The Dental Team and the WithScotland website that can provide further useful information
- To encourage dental teams to think through how they will handle reactions from families.

LEARNING OUTCOMES:

- Readers will understand what the GDC expects of its registrants with regard to safeguarding of paediatric patients
- Readers will know what to do if they have concerns about a child with caries whose family don't engage with dental services
- Readers will know how to make a child protection referral.

HOW TO VERIFY YOUR CPD

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

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WHAT AM I LOOKING AT?

MOUTH CANCER

The trustees of Scottish cancer charity Let's Talk About Mouth Cancer give an overview of the signs, symptoms and best practice when it comes to diagnosing a potential mouth cancer

NIALL McGOLDRICK, EWAN MACKESSACK-LEITCH, STEPHANIE SAMMUT, ORNA NI CHOILEAIN, VICTOR LOPES

We are all too aware that mouth cancer is on the rise. More and more cases are being diagnosed every year with about 300,000 cases of lip and oral cancer reported globally [1]. In 2014, there were 7,680 cases of oral cancer in the UK [2] and, since 1970 there has been a 93 per cent increase in the number of cases [3]. Scotland remains a hot spot for oral cancer with higher incidence rates and lifetime risk compared to the rest of the UK.

Cancer Research UK predicts a further 33 per cent increase in oral cancer by 2035 [3]. Clearly, we need to act now to address this increasing problem. We, as a profession, have it within our power to do something; stand up, speak out and make some noise about mouth cancer. Our training and position in the community make us the ideal group of health care professionals to provide counsel to patients on risk reduction, screen for the disease and to empower patients with skills and knowledge to find the disease themselves at an early stage.

Risk factors

Traditionally, this has been a disease that affected older men. They have often smoked tobacco and drunk alcohol for many years. Now, that picture is beginning to change. Smoking and alcohol still remain important risk factors but more young people and women are developing this disease without traditional risk factors. Nine out of 10 cases of mouth cancer can be linked to a preventable cause [4]. Other risk factors include a diet low in fruit and vegetables, poor oral hygiene and the Human Papilloma Virus infection.

With global migration increasing it is likely we will see an increase in the use of smokeless tobacco, areca nut and betel quid in Scotland. There is also growing evidence of the adverse effect that shisha smoking has on health [5]. Therefore, we must think beyond the traditional risk factors.

A recent study revealed that the vast majority of patients developing head and neck cancer in Scotland are from the most deprived areas in our communities, therefore suggesting that this is a disease of inequality [6]. In fact, the deprivation gap for mouth cancer is the third highest amongst all cancers at 117 per cent [7]. Public health initiatives should take this into account when developing measures to address the burden of mouth cancer.

Prognosis

Dentists need to be vigilant when examining and screening our patients; we should have clear protocols and pathways in place for managing suspicious lesions and reviewing those lesions or mouths that simply 'don't look right'. Early detection is still recognised as the most important prognostic factor in mouth cancer [8]. Other prognostic factors include the aggressive nature of the tumour and the proliferation rate of the cells [9].

Currently, the mainstay treatment for mouth cancer is high morbidity surgery. As a result of such major surgery, patients' quality of life post surgery is vastly reduced. Treatment impacts on all aspects of life that we take for granted, such as enjoying meals, conversing freely and showing affection to loved ones. Although there have been great advances using free flap tissue repair to reconstruct surgical excision sites, this has had little to no impact on survival and prognosis, with only 53 per

Table 1

SIGNS AND SYMPTOMS (REF. SCOTTISH REFERRAL GUIDELINES AND NICE)
Persistent hoarseness that lasts for more than three weeks
Unexplained lump in the neck that lasts for more than three weeks
Unexplained oral ulceration that lasts for more than three weeks
A lump/swelling on the lip or the oral mucosa that lasts for more than three weeks
A red or white patch in the mouth that lasts for more than three weeks
Dysphagia or odynophagia (pain on swallowing) that lasts for more than three weeks
Persistent pain in the throat that lasts for more than three weeks.

cent of patients surviving to five years post diagnosis [10]. Those that receive an early diagnosis have an 80-90 per cent chance of survival at five years. While those that present late with advanced disease have a much lower survival or if there is spread to other body systems then treatment is likely to be palliative.

Mouth cancer referral guidance

Dental patients should be examined for signs of malignancy as a part of the routine oral examination at every visit. The Scottish Referral Guidelines for suspected oral cancer [11] identify a number of signs and symptoms which may represent malignancy (see Table 1.) The guidelines recommend that those patients who present with the identified signs and symptoms which last for more than three weeks should be referred urgently to a specialist service according to local referral protocols.

The National Institute for Health and Care Excellence [12] (NICE NG12) make similar recommendations and advise that patients who are referred urgently with suspected cancer should be given an appointment in the specialist service within two weeks of referral.

To improve early detection and thus survival, Scottish-based charity Let's Talk About Mouth Cancer (LTAMC) work directly with the public as well as with professional groups. We advocate a shorter timescale than three weeks, instead recommending that patients should be referred urgently when signs and/or symptoms which are suspicious of mouth cancer do not resolve after just two weeks. The aim of this initiative is to reduce diagnostic delay as much as possible.

Diagnostic delay

Patient delay and professional delay contribute to the total diagnostic delay.

Patient delay

This is defined as "the period between the patient first noticing symptoms and their first consultation with a health care professional concerning those symptoms" [13].

Approximately 30 per cent of patients diagnosed with mouth cancer will wait three months following the self discovery of signs and symptoms before attending a doctor or dentist [14], [15]. This may be because they attribute the symptoms to non-malignant, self-correcting conditions.

A study by Scott et al (2008) [13] found that patients with better knowledge of signs and symptoms of mouth cancer are less likely to delay seeking advice. Knowledge about mouth cancer aids interpretation of symptoms and the decision to seek help. The same study also found that a low socio-economic background and deprivation are significantly higher in patients who delay seeking help. These patients also experience real or perceived limited ability to access healthcare. Some of the work of LTAMC aims to rectify some of these issues by educating the public about the signs and symptoms of mouth cancer, focusing on deprived and minority community groups.

Professional delay

It has been shown that lack of knowledge by general dental and medical practitioners about the signs, symptoms and risk factors of mouth cancer can also contribute to the delay in diagnosis. Patients will frequently present first to their doctor with mouth symptoms. A cross-sectional study in Dundee found that, compared to dentists, a significant number of doctors felt they had insufficient knowledge about the detection and prevention of mouth cancer [16]. Waiting lists and pressures in the health service may also contribute further to professional delay.

How to spot mouth cancer

As recommended in the guidelines, every patient attending for routine check-up should have a full head and neck soft tissue examination. A systematic approach should be routinely used to avoid missing any areas. A video of this can be seen on our website (www.ltamc.org/professional-resources).

Before any examination, a detailed history should be taken. For each area of concern, the patient should be asked about the length of time they have been aware of the lesion/symptoms and ascertain if there has been any pain, change in sensation or effect on function (speech, swallowing, eating). In many cases, however, early and even late tumours can be asymptomatic. It is also worth asking if a lesion has been present before and healed fully or partially. Of course, if the patient is unaware of the area, then questioning may be delayed until after detecting a suspicious lesion.

Extra-orally, the soft tissues should be checked for any asymmetry, swellings or lymphadenopathy; it is important to note any changes in texture and fixation. A hard, fixed lump in the neck is highly suggestive of tumour spread to the lymph nodes.

Intra-orally the oral mucosa has natural variation according to its anatomical site. It is important to be familiar with normal appearances as any changes need to be investigated. The Scottish Cancer Referral Guidelines [11] recommend referral for cancer arising from the oral mucosa when there are persistent unexplained lumps, ulceration, unexplained swellings, red or mixed red and white patches of the oral mucosa. Proper and clear description of any lesion is fundamental, both for the sake of good record keeping and also to allow any referral to be as fulsome and informative as possible.

To cover all aspects of a lesion, these characteristics should be recorded and described:

- Site – where the lesion is, note adjacent structures
- Size – can be measured in millimetres with probe/ruler or relative to local anatomy (e.g. extending from mesial 34 to distal 36)
- Colour – red, white or mixed (homogeneous/heterogeneous)
- Texture – hard or soft, fixed or mobile, smooth or rough, induration
- Border – well or poorly defined, raised or flat.

Based on all these findings, a decision must be made whether to monitor in practice, make a routine referral or to refer urgently. It is not necessary to arrive at a definitive diagnosis, rather a decision to refer for further investigation and appropriate treatment. The patient should be informed of the findings, possible diagnosis and also the reasoning for referral or monitoring in practice. The importance of attending arranged appointments must be stressed.

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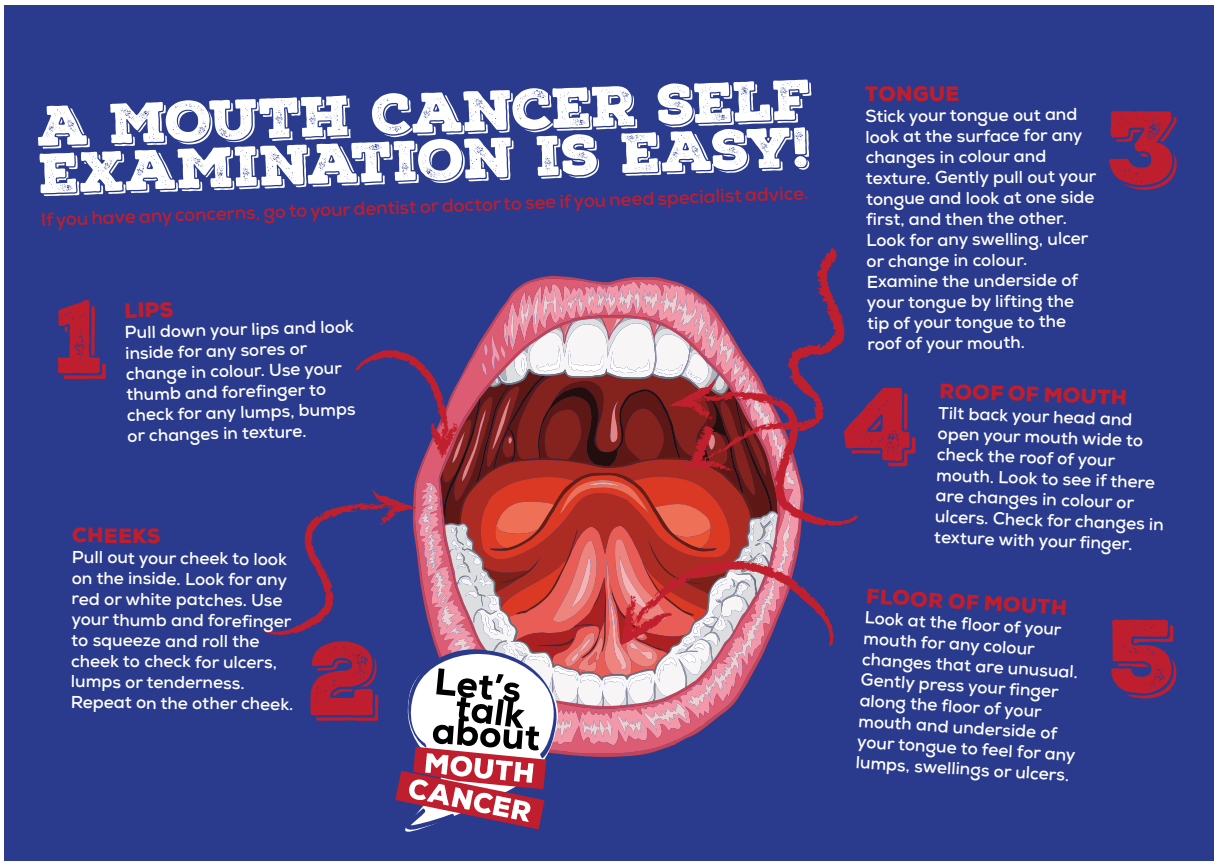

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Referrals quiz

Let's take a few examples and put this into practice. Look at each of the cases on page 49 and their brief history. Try describing each as you would for a referral and decide whether you would monitor in practice, make a routine referral or refer urgently. Have a guess at the diagnosis as well. Remember, the triaging surgeon ultimately decides from your referral whether to allocate as urgent or routine, so quality of information is key.

Many lesions are not clear cut and easy to decide on management. You are not alone – if in doubt, seek the opinion of a colleague or send in a referral. In this case, the description and history you submit is essential for the receiving surgeon to adequately assess the urgency for appointment. Be reassured that the majority of urgent referrals after investigation are not cancerous but it is only possible to know that after appropriate tests.

It is vital to follow up a patient where the decision to monitor a lesion within practice or a routine referral has been made. In the instance there are any changes to the area, reconsider if the original decision needs to be altered. Likewise, when managing a lesion in practice first (e.g. ease traumatic denture, smooth sharp edge on tooth, prescribe antifungals), this must be reviewed after two weeks to gauge response. If not healed, then reappraise the suspected cause, treatment provided and potentially send a referral. Also, if the patient misses an appointment or has not received one within the expected time frame, contact the department to ensure one is arranged.

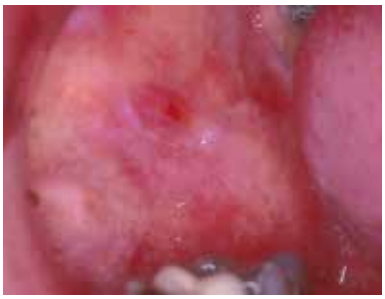
Empowering our patients

Recently, LTAMC has developed its strategy away from clinician-based screening in favour of patient empowerment – the focus has changed to teaching self examination for mouth cancer. Although a conventional oral examination by a clinician remains the most sensitive and specific method to detect mouth cancer cases [1 7], teaching mouth cancer self examination empowers patients to recognise pathology in their mouth and may increase awareness.

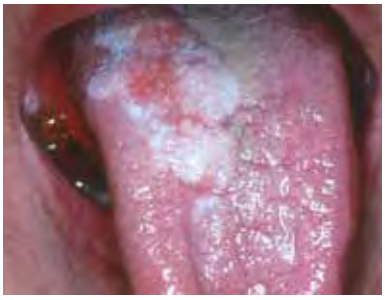
A Cochrane review published in 2013 found that mouth cancer self examination had similar sensitivity and specificity to breast self examination [1 7]. Teaching mouth cancer self examination can be used as a tool in general practice to increase awareness of mouth cancer. It can form part of a general discussion about the signs, symptoms and risk factors of mouth cancer. The thorough, logical mouth self examination process follows five simple steps and is demonstrated in the graphic above. The key messages are to check for: red or white patches; lumps in the mouth that grow; ulcers in the mouth that do not heal; and persistent soreness/discomfort.

The advice is to attend the dentist or general medical practitioner if any of these signs/symptoms do not resolve in two weeks and importantly, to alert the practitioner to a concern about mouth cancer. Patients should be encouraged that mouth self examination is easy, and only requires a light source and a mirror. The aim is simply to empower patients to recognise normal tissues, and to present early if something changes. The mantra "If in doubt, check it out" should be repeated often.

LTAMC has also produced an instructive video aimed at teaching the general public how to perform a mouth cancer self examination. It can be found at youtu.be/WQaujHXauso



CASE ONE



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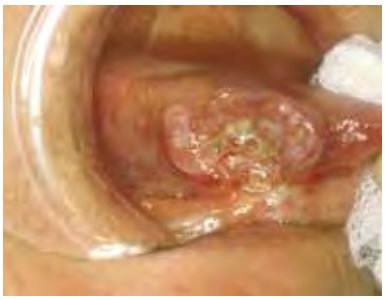

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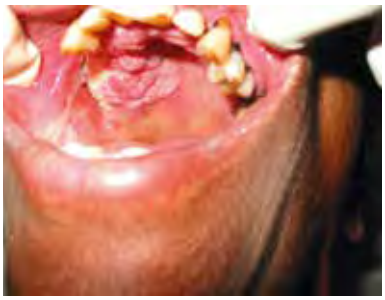
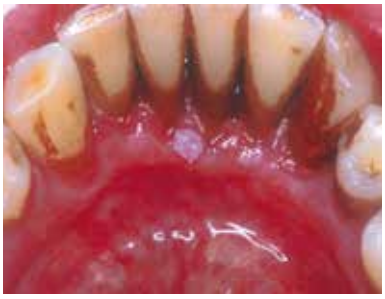
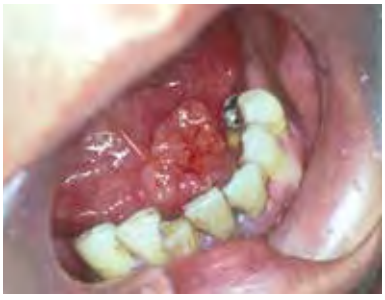


CASE FOUR



CASE FIVE



CASE SIX

Case one

Patient: Female, 34, with no symptoms, all feels soft.
Clinical description: Stellate reticular white lesion, right buccal mucosa, adjacent to amalgam restoration.

Case two

Patient: Male, 61, no pain, present for more than three weeks. Smoker. Soft on palpation.
Clinical description: Well defined but non-homogenous mixed white and red lesion on dorsum of tongue.

Case three

Patient: Female, 59, no pain but changed speech for one month.
Clinical description: Right lateral tongue raised rolled margins with necrotic centre, firm and fixed on palpation. Hard fixed lumps felt in right neck.

Case four

Patient: Male, 45, of Asian origin, painful large sore areas for more than three weeks, history of tobacco chewing.
Clinical description: Large area of exophytic-type (cauliflower-like growths) affecting maxillary alveolus.

Case five

Patient: Male, 46, non-painful lesion for one to two weeks.
Clinical description: Asymptomatic gingival 3mm in diameter, sessile papillomatous-like lesion.

Case six

Patient: Female, 55, painful mouth for more than three weeks.
Clinical description: Well defined 2cm lesion on floor of mouth with raised rolled margins with necrotic centre, firm and fixed on palpation. Associated left neck swelling.

CONTINUED OVERLEAF>

Answers:

Case one
Outcome: Monitor in practice.
Diagnosis: Lichenoid lesion/lichen planus.

Case two
Outcome: Urgent referral.
Diagnosis: Dysplastic lesion or early cancer.

Case three
Outcome: Urgent referral.
Diagnosis: Squamous cell carcinoma.

Case four
Outcome: Urgent referral.
Diagnosis: Squamous cell carcinoma.

Case five
Outcome: Routine referral.
Diagnosis: Human Papillomavirus related papilloma.

Case six
Outcome: Urgent referral.
Diagnosis: Squamous cell carcinoma.

FROM PREVIOUS PAGE>

The video has been viewed more than 4,500 times in the UK, USA, Japan, Vietnam and India, indicating a worldwide interest. As mentioned above, a recent study has shown that approximately 30 per cent of patients with mouth cancer delay seeking help following discovery of symptoms for more than three months [1 3]. As early diagnosis is a key factor for improving prognosis and survival, we as dentists must tackle the lack of recognition of symptoms among our patients.

Lack of insight into initial symptom interpretation and lack of knowledge of mouth cancer have been shown to be significant variables which contribute to patient delay in seeking help [1 3], and are issues that may be easily modified with targeted interventions by general dental practitioners.

Conclusions

Mouth cancer is increasing at an alarming rate and yet large sections of the public know little of the risk factors or signs and symptoms of the disease. Despite the fact that about half the population attend a dentist regularly for dental check-ups, many cases present at a late stage with a correspondingly poor prognosis. Survival has not improved substantially in the past 50 years and there is no treatment available that can transform the poor survival of someone with late stage disease to the much better survival of someone with early stage disease; the only thing that can do this is early diagnosis.

The work of LTAMC is firmly focused on teaching the public as well as professionals to diagnose mouth cancer early. We hope to break down health inequalities and empower as many people as possible to recognise the disease and its risk factors to improve survival. We call it our empowerment journey, so "Let's talk about mouth cancer!"

ABOUT THE AUTHORS

This article was co-authored by the five trustees of the Scottish charity Let's talk about mouth cancer (SC045100): Dr Niall McGoldrick BDS MFDS RCPS(Glasg), specialty registrar in dental public health.

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Dr Orna Ni Choileain BDS(Hons) MFDS RCSEd, medical student, Trinity College Dublin.

Prof Victor Lopes PhD FRCS, consultant maxillofacial surgeon.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES:

- Promote early detection of mouth cancer
- Provide a refresher on signs and symptoms
- Provide a refresher on guidance and best practice for referral
- Provide resource for empowering patients.

LEARNING OUTCOMES:

- Understand the epidemiology and risk factors for mouth cancer
- Understand the benefits and necessity for early diagnosis in mouth cancer
- Be able to recognise oral lesions at high risk of being mouth cancer
- Understand the work of the charity Let's Talk About Mouth Cancer in promoting mouth self-examination.

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

MORE INFO

Website: www.ltamc.org

Twitter: @couldbeUrmouth

Facebook: www.facebook.com/letstalkaboutmouthcancer

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DENTAL STAFF TRAINING FOR INHALATION SEDATION

TRAINING STANDARDS

The standards of training in relative analgesia in the UK is falling short and needs an overhaul to ensure patient and staff safety

JANET PICKLES

Over the last few years, there have been several articles written about the equipment used for inhalation sedation (IS), or relative analgesia as it is still occasionally referred to. However, there has been little about the training requirements and problems encountered where insufficient training may take place.

For some time, it has become increasingly evident that certain elements of training in inhalation sedation for all levels of dental professionals can be lacking, with some vital areas either being incompletely taught or missed out altogether.

This includes such topics as:

- Inability to identify and name the type of sedation equipment in use i.e. differing manufacturer/machine types
- Not able to identify or name the type of breathing delivery system in use or understand the varying components and how they interface – or even how to assemble it
- Ignorance of medical gas cylinders – handling, storage etc. This area often seems to be omitted from teaching
- Dental scavenging – a very misunderstood area and the most dangerous one to be ignorant about
- Damage caused by inappropriate cleaning methods.

The underlying basis for the above could well be twofold: syllabus content and the method of training employed. Training for undergraduate/postgraduate dentists varies significantly depending on where the training originates. Similarly, dental nurses are also subject to a great level of variation. The NEBDN syllabus, Training in Conscious Sedation for Dental Nurses [1], is designed to cover all methods of sedation, not just inhalational. However, it is now possible to train in just IS, although like dentists, they are subject to variable levels of training, some excellent, others much less so.

The syllabus employed by both sectors, while theoretically listing most of the functionality staff should display once trained, are extremely dependant on the actual teaching of such to ensure competency. As provision of this varies widely, staff have been displaying knowledge deficiency in even some of the most basic areas, leading to equipment usage problems.

This is as a direct result of the inequality of some training and causes inappropriate or misuse of sedation equipment and scavenging of exhaled gas, an unfortunate situation and one that should be remedied as quickly as possible. It is not perceived as a direct fault of the dental staff themselves, but more as a direct result of the training deficiencies.

It is not sufficient to revise the syllabus – the whole issue of training and how this is conducted, should also be subject to scrutiny.

Any training should include the following modules:

- Identification of all current IS equipment e.g. MDM, MXR etc. This section should also include a guide of how to identify older units that may now be obsolete or soon to be, due to age/condition
- Understand the variety of mounting options available for each type of flowmeter and how they would provide the medical gas supply, or interface with it
- Breathing systems and nasal masks. Staff need to know what type of breathing circuits are available for dental

CONTINUED OVERLEAF>

FIGURE 1
Badly corroded nitrous oxide regulator

FROM PREVIOUS PAGE>

sedation and which type of nasal mask can be used with each. They should also be taught regarding older types which technically are obsolete, but remain in use at some teaching establishments, i.e. the passive (not to be confused with another form of passive gas scavenging such as opening a door or window), or non-scavenging types of breathing system, which should not be used under any circumstances

- An understanding of exactly what comprises active dental scavenging as opposed to general anaesthetic scavenging. How the patient delivery circuit should be vented and the active draw (i.e. 40-45 L/min) provided
- Understand medical gases – differing delivery systems, medical gases, storage and handling
- How to employ an equipment pre-use checklist appropriate to the type of flowmeter and medical gas supply. This would also include preparation for use, including the scavenging equipment
- On completion of the IS session, appropriate cleaning of the sedation flowmeter and breathing system.

While most of the above would already appear to be included in inhalation sedation training syllabuses, there are a few vital omissions. The wide variety of how the syllabus is taught leads to many problems of actual use, particularly in the areas of scavenging and cleaning. Another major problem centres around fitting of E-sized medical cylinders to mobile four-cylinder stands and the storage of medical gas cylinders.

A further compounding problem is reference material. An example of this is HTM 02-01 [2], published in May 2006. It was already sparse in information pertaining to dental use with some small relevant areas to be found in Part A: Chapter 10 and Appendix L. The rest of this ageing document 'fits where it touches' when applied to much of the existing dental facilities. There would seem to be some movement by IHEEM and their Medical Gas Technical Platform who appear to be discussing the need for an ongoing process of review for HTM02-01, but who are also looking at the relevance of our current European and international legislation in the light of Brexit.

There does remain a distinct need for a document centred around the use of medical gases and scavenging of nitrous oxide within the dental sector, as many of the requirements for the hospital standard either do not 'fit' or cannot apply. An example of this is auto-change manifold systems or low-pressure alarms which are irrelevant in small dental surgeries.

A further problem is the books referenced in many suggested reading lists, the content of which, in some cases is of dubious assistance. It is a sad reflection that in the UK there is no dedicated textbook for IS. However, paragraphs or sections can be found in several available publications. These include:

- *Sedation in Dentistry*. Girdler & Hill. Published 1998
- *Child Taming: How to manage children in Dental Practice.* Chadwick and Hosey. Published 2003
- *Advanced Dental Nursing.* 2nd Edition. Robert S. Ireland. Published 2010
- *Basic Guide to Dental Sedation Nursing.* Nicola Roger. Published 2011
- *Practical Conscious Sedation.* 1st Edition Craig & Skelly. Published 2004
- *Practical Conscious Sedation*. 2nd Edition Craig & Boyle. Published 2017.

The information and images contained in these books vary significantly in terms of useful, relevant or current information – some is inaccurate, including images of 'out of date' or redundant equipment – even in the more recent publications. Hence, the requirement for

Figure 2 (Left) MDM with cleaning damage

Figure 3 (Above) Obsolete passive system with re-used Dynomite hood

a textbook, not just a revised version, and dedicated to IS, the need of which is reinforced by the growing use of this equipment, especially in community dental settings. Certainly, any textbook employed for training purposes should be referenced for modern relevance to available equipment prior to being employed.

There is an excellent book published in the USA, entitled *Handbook of Nitrous Oxide and Oxygen Sedation* by Clark and Brunick, now in its fourth edition. First published in 1999, it has a refreshing approach to the subject of inhalation sedation equipment, having actively involved all three, of the then, main manufacturers: Porter, Matrx and Accutron. Now, of course, there are only two, with Porter having purchased the Matrx Nitrous Division in 2008. The only downside to this book is the very American nature of some of the content e.g. green colour coding for oxygen instead of UK white, as an example.

The lack of an inhalation sedation textbook, coupled with the varying and inadequate training is leading directly to the problems initially listed in this article. The author has attempted to highlight the problem with letters to various sources including the NEBDN and the English, Welsh, Scottish and Northern Irish CDOs. However, minimal response with little resultant action has been received to date.

While any authorised training establishment can 'teach' the NEBDN syllabus – sometimes in a distance learning format – depending on the ability of the trainee to access and use suitable inhalation sedation equipment, the provenance of which can be distinctly variable, then the problems and issues are going to continue. However, another sad fact is that some of the larger teaching facilities such as dental hospitals etc., are also not completely blameless. Some are known to have out-of-date or old equipment that they keep 'just for training' or are even using obsolete or incorrect scavenging equipment.

Conclusions

Any postgraduate and experienced dental staff member, who on receiving a basic training programme including the modules above, can then comment: "Why has nobody taught us that before?" has, unfortunately, not been correctly trained in the first place.

However, the fact remains that IS, when correctly taught and applied, is a safe and effective method for pain and anxiety control and can go a long way to reducing waiting lists for dental GA. It can also act as a practice builder and make the job of coping with paediatric, special needs and dentally phobic patients a lot easier.

The syllabus content for teaching of IS needs to undergo a thorough revision and, in addition, the methods of practical teaching should be thoroughly examined and those training establishments that are not prepared to invest in suitable training equipment but depend more on 'distance learning' modules should be removed from the lists of trainers.

While it is acceptable to teach subjects such as pharmacology and patient management, for example, in a distant learning format, the use and care of IS equipment is not one that can be taught without a comprehensive level of hands-on access.

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ABOUT THE AUTHOR
Janet Pickles is the chairwoman of RA Medical Services Ltd.

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GLASGOW DENTIST EXPLAINS HIS DECISION TO SELL UP TO OASIS AFTER NEARLY 30 YEARS AS A PRACTICE PRINCIPAL

Alan McClure qualified in 1990. After a year's vocational training in Kilmarnock, he started working as an associate dentist in Glasgow's Partick Dental Practice, where he still is today. He became the sole owner in 2001.

The practice really took off in 1997 after a move from a first-floor space to a former bank building on Glasgow's Dumbarton Road in the city's West End. A decade later, the team acquired an additional building 100m along the road. The two practices are now open six days a week, and the nine dentists and two hygienists look after about 20,000 patients.

Here, Alan, below, talks us through his career, his decision to sell the two practices and what he has learnt along the way.

"I really became a dentist by the flip of a coin – I had applied to study both law and dentistry, but the acceptance letter for dentistry at Glasgow University arrived first so I just said yes to that. I absolutely loved my time there and, after graduating in 1990, I completed a year's vocational training at a practice in Kilmarnock.

"Towards the end of my time in Kilmarnock I spotted an advert in the *Glasgow Herald* for an associate role at the Partick practice – I haven't looked back since. It's crazy to think that was nearly 30 years ago.

"Everything has changed since I qualified. Implants, Cerec (the digital technology used for things like dental restoration), and short-term orthodontics weren't really a 'thing' back then. As dentists, we generally just told our patients what they needed – now it's much more about a two-way conversation. My patients are interested and involved in their treatment and often research the different options available to them before an appointment. Sometimes they'll also ask for treatments that we don't yet offer – it's then a matter of seeing how feasible it is, but I'll always do my best to offer it to my patients by upskilling my staff through additional training and courses.

"Of course, when I first started out, there were a number of regulations that are no longer in place. For example, we weren't allowed to advertise, and dentists didn't have the high street presence they have today.

"I started looking into selling both practices in 2014. I had heard a few success stories on the grapevine and I was starting to get really bogged down with the increasing levels of paperwork that faces all of us as healthcare providers. I was spending less and less time doing what I really love – looking after my patients.

"I was really impressed by Oasis' reputation, and the fact that Bupa has since acquired the company has really been the icing on the cake. Both brands really resonate with me and my team – so the decision to sell was quite easy. Since we completed in April this year, the admin side has been completely taken off my hands and I get to spend four days in the chair seeing patients – so clinically, nothing has altered since the change of ownership.

"I also don't have to worry about accounting and banking any longer – which is a huge relief! I'm still in charge of a wonderful team – there are about 50 of us – but I now also have Bupa's focus and support with clinical governance, ensuring we continue to build on the best service and treatment for our patients. This has really given me peace of mind.

"While the integration into the Bupa brand is still in the early stages, I'm really looking forward to seeing what the coming months will bring."

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SPOTTING PROBLEMS BEFORE THEY ERUPT

CASE FILES

The following case study looks at the importance of ensuring treatment decisions are backed up by appropriate diagnostic investigations – and being prepared for the unexpected

AUBREY CRAIG

Noah is nine years old and attends the dental surgery with his mother for a regular check-up, having been a patient at the practice for the last four years. His dentist, Dr G, notes (for the first time in the records) that Noah still retains his upper baby central incisors (A/A), although the contralateral lower adult incisors have erupted. Examining further, she finds the unerupted adult upper incisors (1/1) are palpable buccally. In the notes she records: "Watch 1/1".

Six months later Noah is back at the surgery for another check-up and his mother expresses concern that he still hasn't lost his front baby teeth. Dr G examines the teeth again and finds they are "slightly mobile" and she advises there is no call to intervene just now but to keep monitoring the situation.

Nearly a year later Noah returns to the surgery still with "wobbly front teeth" and, at an appointment two weeks later, Dr G extracts A/A under local anaesthetic. Dr G tells Noah's mother that the boy's adult incisors should erupt soon.

Ten months later, Noah is back in the surgery for an emergency appointment with a toothache in a back molar. Dr G restores the carious tooth. She notes that 1/1 are still unerupted and arranges for a referral to the local dental hospital.

Noah is now aged 12 and attends the dental hospital. Radiographs reveal impacted central incisors caused by two upper supernumerary teeth (UL supernumerary/UR supernumerary) – one is palatal to unerupted UR1 and the other is in the UL1 position with that adult incisor significantly ectopic, lying horizontally close to the floor of the nose. A treatment plan is formulated to remove UR supernumerary to allow for eruption of UR1, and to surgically expose UL supernumerary and in time modify using a veneer.

A letter of claim is received two months later from solicitors acting on behalf of the patient claiming clinical negligence on the part of Dr G for failing to diagnose the presence of the supernumeraries so they could be removed allowing normal eruption of the adult incisors.

The delay has meant that UL1 has been pushed so far out of line by UL supernumerary that is now impossible to align this tooth. It is alleged that Noah now faces the prospect of having unnecessary surgery including future removal of UL supernumerary with replacement by a single tooth implant at around age 18.

Analysis and outcome

MDDUS commissions an expert report from an orthodontist who examines the patient records from the practice and the dental hospital. He is of the opinion that there were several missed opportunities by Dr G to take radiographs when it was clear there was delayed eruption of the adult upper incisors (normally between ages six to eight years).

Guidelines from The Royal College of Surgeons of England call for intervention in cases when eruption of the contralateral teeth occurred six months previously or there is deviation from the normal sequence of eruption (e.g. lateral incisors erupt prior to central). The expert believes both these conditions applied at the time of Noah's first consultation with Dr G regarding his upper front teeth.

Radiographs taken at this time would have revealed the supernumerary teeth and allowed for extraction (along with the deciduous teeth) with a reasonable chance that the adult incisors would have come down normally into position.

Given the unsupportive expert opinion it was decided in consultation with the member to settle the case for a sum commensurate to the cost of future remedial treatment.

ABOUT THE AUTHOR
Aubrey Craig is head of dental division at MDDUS. For more information, go to www.mddus.com

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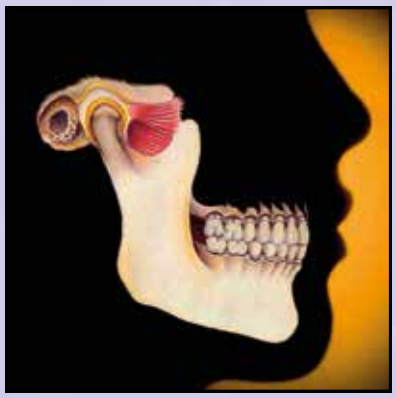

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    - (a) Orthodontics including the A.L.F. appliance
    - (b) Re-treatment of T.M.D. previous orthodontic cases
    - (c) Reconstruction and Adult Twin Block Therapy
    - (d) Equilibration
* Long term retention

The course was hard work but extremely practical. Skip has a way of compartmentalizing things which make it easier to understand. Anyone interested in T.M.D. who wants a comprehensive oversight of how to diagnose and treat these often difficult patients will find the course more than helpful. I really enjoyed it. What a great way to spend a weekend!

. . . . . **Philip J E Lang** L.D.S. R.C.S. (Eng), M.G.D.S, R.C.S.(Eng).

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Management

PRACTICAL INFORMATION FOR PRACTICE MANAGEMENT PROFESSIONALS

THANK YOU

WHY IT CAN PAY TO SHOW YOUR APPRECIATION

See page 61

REWARDING STAFF

HOW DO YOU SHOW YOUR STAFF THAT YOU APPRECIATE THEIR EFFORTS? SUSIE ANDERSON-SHARKEY OUTLINES A FEW DIFFERENT STRATEGIES TO ENSURE YOUR STAFF ARE AS HAPPY AS YOUR PATIENTS

SUSIE ANDERSON-SHARKEY

Much has been written on the sometimes thorny subject of rewarding staff – so, here's my insider's tips on the subject, which I hope you will find rewarding in lots of little ways.

Rewards come in all different shapes and sizes and there is a time and a place for all of them. First off, we have to be clear about who or what we are rewarding. Is it the person? Is it their performance? Their loyalty? Are we rewarding one person or a whole group? You see, I told you it could be a minefield. There are often as many questions as there are answers.

Hopefully, long gone are the days when employers had the mind-set that paying staff a monthly salary was all that was needed for an employee to feel valued. A happy staff equates to happy patients. I can't overstate how important it is on every level to have a happy team. There are various ways and means of achieving this. One very important 'reward' is simply telling an individual or team that they have done a great job. Don't leave it until the end-of-year review, but keep telling them, keep encouraging them with positive communication and feedback and they will want to push themselves to perform even better. People respond well to a kind word and your staff are no exception to this. Positive verbal feedback and recognition are a great morale booster.

Take a photo of your staff, post it on Facebook, Twitter, the practice website, and tell people how much you appreciate their help. This only takes a few minutes and is a small but positive way of rewarding staff.

We recently ran a Staff Appreciation Day, where every employee was rewarded with an extra day off (at a time that suited the practice) and this was gratefully received by everyone.

Some rewards work better than others. We once ran a reward scheme where, if we reached a certain monetary target in a month, again each staff member would get a day off. However, this was difficult to administer and we only trialled it for a short time.

A gift voucher for an employee's favourite shop is a great way of rewarding individuals. Find out where they like to shop, buy a voucher and present it to them on their birthday, anniversary, special event or for just being an exceptional employee.

Some other innovative ways to reward an employee could be:

- Buying them a year's subscription to their favourite magazine
- Pay their gym membership for a year
- Buy a gift voucher for a local beauty salon so that staff can be treated to a facial, or have their nails done. We have done this and it has proved really popular
- Buy a year's subscription for flowers to be sent once a month to the employee

> "THINK OUTSIDE THE BOX... IT'S IMPORTANT TO FIND OUT WHAT WORKS FOR YOUR BUSINESS AND YOUR STAFF"

- Food – who doesn't like to be treated to a meal out? Take your staff out for a meal or have a pizza lunch from time to time where you all sit down at the same time and just enjoy the social experience
- Pay to have an employee's car valeted
- Give staff members the day off on their birthday or the anniversary of the day they joined
- Give your staff a half day or full day off for Christmas shopping.

And then, of course, there is money. You will see many websites full of ideas about how to reward staff without giving them money. But in reality, I've never come across anyone who doesn't appreciate a little bit extra from time to time.

Many years ago, I worked as a nurse in an orthodontic practice. I was going on holiday and just as I was leaving, the boss said to me "Have a great time", and quietly put £20 taken from his own pocket into my hand. I have never forgotten that simple act of kindness and appreciation – it meant so much to me.

Christmas especially is a great time to thank your staff with a small monetary gift. It is, after all, a time of year when everyone wishes they had a little extra cash.

And so the list goes on. Think outside the box, there are many different ways of rewarding staff. It's important to find what works for your business and your staff but be assured that your employees will really appreciate being rewarded either in word, deed or cash and you, as 'the boss', will in return find a happy, contented team – who are more than willing to go the extra mile.

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*PFM Dental have registered "Priority Buyers" who will pay the agency fee in addition to their offer on behalf of our clients. All payments are sent to our client's solicitor and fees are charged as normal

NHS PENSION VERSUS PERSONAL PENSION

UNIQUELY, SELF-EMPLOYED DENTISTS CAN BE MEMBERS OF THE NHS PENSION SCHEME. JON DRYSDALE LOOKS AT THE PROS AND CONS

JON DRYSDALE

Associates starting their first self-employed NHS job remain members of the NHS pension scheme despite giving up their employed status. Being self-employed and benefiting from an employer's pension scheme is unique to dentists and General Medical Practitioners. No other professions offer this perk to the self-employed. However, the NHS pension is not what it used to be and many members seek to supplement their pension with additional retirement savings.

Pay more, retire later

What you get out of an NHS pension will depend on when you qualified. Dentists qualifying before 2008 looked forward to a retirement age of 60, contributions rates as low as 6 per cent of NHS income and automatic entitlement to a tax-free lump sum worth three times the pension. However, the global financial crisis of 2008 and subsequent Government imposed 'austerity' has changed public sector pension schemes for good.

Any dentist qualifying after 2015 will have their NHS pension age linked to the state pension age. For most this will be age 68. The state pension age may increase further. No longer is automatic tax-free cash available. To take a tax-free lump sum from your NHS pension at retirement you will be required to give up some of your pension on a ratio of 1:12. For example, a lump sum of £60,000 will cost £5,000 of pension.

Contribution rates have increased steadily in recent years and tiered contribution rates now apply. This could mean contributions are as high as 14.5 per cent – more than double the flat rate of 6 per cent that once existed. Most dentists fall into tier 4 or above, with minimum contribution levels of 9.3 per cent. Contribution rates are only set until March 2019 and could rise further (see below).

Tier	Full-time pensionable pay used to determine contribution rate	Contribution rate (before tax relief) (gross) 1 Apr '15 to 31 Mar '19
1	Up to £15,431.99	5.0 per cent
2	£15,432.00 to £21,477.99	5.6 per cent
3	£21, 478.00 to £26,823.99	7.1 per cent
4	£26,824.00 to £47,845.99	9.3 per cent
5	£47,846.00 to £70,630.99	12.5 per cent
6	£70,631.00 to £111,376.99	13.5 per cent
7	£111,377.00 and over	14.5 per cent

Assuming you don't wish to work to age 68 or later, it is important to build up an alternative source of retirement income. For many, the simplest and most flexible arrangement is a personal pension. There are fundamental differences between the NHS pension and personal pensions. An NHS pension is an arrangement between you and the NHS. A personal pension is a savings pot.

An NHS pension example

The NHS pension is based on a proportion (1.85 per cent) of your NHS earnings. If you have £60,000 of NHS income, you will accrue £1,110 of pension at state retirement age in one year alone. Assuming a 37-year career to age 60 and the unlikely event of unchanging NHS income, this might be a pension of £41,070pa at state retirement age (37 x 1.85 per cent x £60,000). The pension is taxable and payable for life.

Personal pension rules

1. For higher rate tax payers, there is no more tax efficient saving than making pension contributions. In the following example, a contribution of £250 has cost only £150.

You pay	£200
The government adds	£50
What goes into your pension pot	£250
You reclaim this amount if you are a higher rate tax payer (income more than £45,000pa)	£50

2. You can't access your pension pot until age 55.

3. At age 55 or later you can take up to 25 per cent out without any tax liability. Any amount beyond 25 per cent will incur income tax.

4. There is no time limit on drawing your pension.

5. In the event of your death before age 75, the pension is released as cash to your dependants without tax liability. After age 75 you can pass the pension onto your dependents (it remains as a pension).

6. Contributions are limited to £40,000pa and can be stopped and started as you wish.

Think long term

Short-term investment volatility should not concern you early on in your career as the pension will remain invested for many years. The returns of risk-based investments over the longer term have always outpaced cash and inflation by a significant margin. Nevertheless, seek advice on how your pension is invested and review it regularly.

Projecting a contribution of £200 per month over 30 years reveals a final savings pot of £234,000. This assumes investment growth of 7 per cent and increased contributions in line with inflation. While this may not build a pension pot large enough to provide a 'plan B' for retirement, it is a good start to complementing your NHS pension income.

ABOUT THE AUTHOR
Jon Drysdale is an independent financial adviser for chartered financial planners, PFM Dental, which has offices in Edinburgh and York. Go to www.pfmdental.co.uk

BUILDING FROM THE GROUND UP

GLASGOW GRADUATE KATRINA MEIKLE DESCRIBES HER DECISION TO OPEN UP A SQUAT PRACTICE AND THE HELP SHE RECEIVED ALONG THE WAY

When she decided to open her own dental practice after five years as an associate, Katrina Meikle's first port of call was to contact a trusted adviser.

A colleague, who had been through the process before, recommended she spoke to Trisha Munro of Strictly Confidental and they duly met in November last year. Katrina said: "Trisha had been recommended to a friend by her accountant, and I felt that contacting her to arrange a meeting would be a good starting point with regard to my own practice – I wouldn't have known where to start otherwise!"

Katrina graduated from Glasgow in 2011 and completed her VT year in Kirkintilloch before spending a year in Stewarton, Ayrshire and two in Croftfoot, Glasgow. In April 2015, she started working in Airdrie, North Lanarkshire. She gained her MFDS from the Royal College of Physicians and Surgeons of Glasgow in 2015 and spent a year as a VT trainer at her previous practice. She has also undertaken further training in IV sedation, which she has used to great success with very anxious patients.

Despite being relatively young, Katrina had been trusted with increased responsibilities in her previous practice and, by mid 2016, she had decided that her long-term future lay in starting her own practice. She met with Trisha to discuss options and asked her opinion on starting a squat practice. She said: "The practice I was currently working in was a squat, and a friend had recently started two sessions a week at a squat. While there are obvious downsides – namely the lack of patient list initially – I felt that squats do come with numerous benefits and was keen to pursue this line of enquiry."

As it happened, Trisha had a squat practice on her books and invited Katrina to have a look around the building in Cardonald. She said: "I was really impressed when I saw it. It had been finished to a very high standard and I could see how attractive it would be to new patients. It is in a densely populated area and I felt that there was good potential for patient list growth."

Katrina Meikle

After weighing up the pros and cons, including seeking the advice from family and friends, she decided to put in an offer, which was accepted just before Christmas 2016. And Katrina explained that as well as the initial meeting and introduction to the practice itself, Trisha's input didn't end there. She recommended a financial adviser, accountants and solicitors as well as introducing her to trusted suppliers who have helped her equip the practice and get it ready for the practice inspection.

She said: "As well as all of these introduction and recommendations, she has been on hand as often as I need her to answer questions, guide me in the right direction with regard to the timing of each stage of the process and also provide friendly support. Had I done all of this without Trisha, I believe the whole process would have taken a lot longer and there would have far more challenges to overcome. She made it as easy as it was ever going to be."

While the initial purchase was cheaper, owing to the practice's status as a squat, Katrina admitted that the financial outlay since then have been quite high. Allied to the fact that the banks are less inclined to invest as much in a practice with no goodwill and no existing patient list, Katrina insists she went in with her eyes wide open and aware of all the associated risks, but that she trusted her plan was robust and she was in the best place to succeed.

She said: "I plan to work single-handedly initially while the patient list grows, and will recruit for an associate when it is busy enough. In years to come, I would consider applying to be a VT trainer again, or perhaps recruiting a therapist. I believe excellent patient care is of the utmost importance, and I strive to deliver this. I want to build Cardonald Smiles into a practice where each patient knows that they will be well looked after and staff will do their very best for them."

Sales

Valuations

Purchase

Recruitment

Strictly Confidental has been operating for over 16 years within the Dental Profession in Scotland.

We can source and supply all relevant information regarding sales, valuations and acquisitions of Dental Practices and we can also assist with recruitment.

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An alternative option for retirement planning

LIFETIME ISA SCHEME OPENS NEW TAX EFFICIENT SAVINGS ROUTE TO HELP YOU PLAN FOR A MORE SECURE FUTURE

ROB TURNBULL

For most young dentists, the new Lifetime ISA (LISA) will be seen as a way to help purchase their first home, however, it can also provide several tax planning benefits if used towards your retirement.

Since April this year, anyone between the ages of 18 and 40 can open a Cash Lifetime ISA or Stocks & Shares Lifetime ISA and save up to £4,000 per tax year (which forms part of your total ISA limit, currently this is £20,000). The Government will then provide a bonus of 25 per cent on these contributions, meaning a maximum £1,000 bonus every year. The Government has stated that this can be done every year until you reach age 50.

To keep this bonus when withdrawing the money in your LISA, it has to be used for the deposit on your first home (up to the value of £450,000), or taken after you reach the age of 60.

Focusing on the retirement planning aspect of the LISA, there are some useful advantages compared with traditional private pensions, the most relevant one being the potential effect of the Lifetime Allowance (LTA) on your private pension savings.

The LTA for pensions is currently £1 million, meaning your NHS pension alone could breach this limit, especially with the recent increase in the NHS pension retirement age from 60/65 to state retirement age. Even if you managed to stop your NHS pension before breaching the LTA, the value of any private pension savings would be added to your overall pension total. If this exceeded the LTA then you would have to pay the Lifetime Allowance Charge (up to 55 per cent) on the amount above £1 million.

As the LISA does not count towards your pension total, it will not be included in any LTA calculations, meaning you will not have to worry about losing a large percentage if your NHS pension comes close to the LTA.

Most dentists are still looking to retire around the age of 60. The Lifetime ISA can help that ambition by providing additional retirement income without the need to access your NHS pension earlier than your state retirement age.

There are many other factors that should be considered when planning for your retirement, an independent financial adviser can provide the expertise in helping you to make the right decisions.

ABOUT THE AUTHOR
Rob Turnbull is a dental specialist independent financial adviser at Skyridge Financial Planning. To contact him, email rob@skyridgefinancial.co.uk or call 07771 606 125.

Skyridge Financial Planning LLP is an appointed representative of TenetConnect Services Limited, which is authorised and regulated by the Financial Conduct Authority.

Should I stay or should I go?

HOW, AND WHEN, TO ACHIEVE THE OPTIMAL EXIT STRATEGY FROM YOUR PRACTICE AND GET THE BEST VALUE OUT OF THE SALE

IAN MAIN

It was the immortal question posed by the rock band The Clash in their 1981 hit song, but it is increasingly a question facing Scottish dental professionals and we are often asked when would be the optimal time to sell their practice.

Recent concerns have emerged over NHS remuneration changes which may follow on from the Oral Health Plan consultation. This, allied to the threat posed by the Brexit negotiations and the future supply of dental professionals from the EU (estimates show that 17 per cent of currently registered dentists in the UK are from the EU), are causing some concern in the profession about the future demand that will exist when the time comes to exit.

We have witnessed a consistent rise in goodwill prices in Scotland over the last 10 years, and this continues unabated. The emergence of the 'corporate' consolidator, fuelled by venture capital, has impacted this pricing and, despite the dominant corporate consolidator stopping all purchases recently, there remains a number of acquisition hungry corporate entities and the ambitious associates out there looking to make the move from associate to principal is equally plentiful. The economics of practice sales still tips the scales in favour of sellers as the demand for acquisitions outstrips supply.

This said, there is always an optimal time to exit. We continue to advise a watching brief on the market, alongside a full assessment of your own personal finances, to determine when best to begin marketing your practice. To achieve best value for the years of hard work and endeavour you have put into building your business, we recommend you 'groom the practice' for sale and work towards a three to five-year pre-sale period of high performance, while making sure your house is in order. before placing the 'for sale' sign in the window.

We'd love to advise you on the likely value/marketability of your practice and identify the areas you might want to focus upon to achieve best price when you do exit. Get in touch if you'd like to discuss further.

MORE INFO
To contact Ian, call 0131 248 2570 or email ian@starkmaindental.co.uk

Know your employment status

RECENT CHANGES TO HMRC RULES COULD HAVE IMPLICATIONS FOR DENTAL PRACTICE STAFF

LOUISE GRANT

It has become the industry norm that dental professionals, whether it be an associate, hygienist or therapist are treated as self employed for tax purposes, and rarely as an employee. You may ask yourself why this is the case and whether, in light of recent legal rulings, this employment status will continue to be accepted by HM Revenue & Customs (HMRC).

You may be aware of the Uber ruling which decided the employment status of the drivers should move from being treated as self-employed to employed. The self-employed drivers of Uber were not entitled to, for example, employer pension contributions or holiday entitlement. And, Uber saved on Employers Class 1 National Insurance.

On a similar topic, new rules under what's known as IR35, were introduced from April 2017. These rules were aimed at locum medical professionals taking up work in the public sector, for example, an NHS Trust using a private limited company. Rather than change their status to being employed by the NHS Trust, HMRC changed their status to 'off payroll workers'. What this means is that they are taxed through the payroll system, but are not entitled to the legal employee benefits like pension contributions or holiday entitlement.

With these changes in mind, you might expect to see a shift in the employment status of dental professionals away from being treated as self-employed. However, this is unlikely for dental associates where standard forms of agreements have been approved by the British Dental Association and the Dental Practitioners Association. HMRC state in their guidance: "Where these agreements are used and the terms are followed, the income of the associate dentist is assessable under trading income rules and not as employment income."

It is very important that you seek advice about your current workforce arrangements to determine whether their status continues to be accurate following recent changes.

EQ Healthcare would love to hear from you if you have any concerns.

MORE INFO

To find out more, please contact Louise Grant by calling 01382 312 100 or emailing louise.grant@eqaccountants.co.uk

Cloud accounting – the tax benefits

MAKING THE SWITCH TO A CLOUD-BASED PLATFORM HAS THE POTENTIAL TO PROVIDE REAL-TIME INSIGHT AND SAVINGS

STUART PETRIE

Tax. A small word with often much bigger implications. Especially in this ever-changing landscape, it is vital to have visibility and up-to-date financial information to avoid any unforeseen tax liabilities and allow for essential tax planning opportunities.

Through our partnerships with cloud-based accounting firms, these user friendly systems allow practices to have more clarity of their financial position and the ability to monitor their business' profitability and cash flow in real time.

This information allows for enhanced decision-making, particularly as the software's functionality lets you and your accountant access the 'live' information. With this ability, greater collaboration can be achieved to provide regular and timely tax advice.

This advice can be extremely wide-ranging. However one example of the tax, and financial, benefits of using cloud accounting software could include determining real time profits and the best time to purchase a new piece of equipment, in order to make the most tax efficient Capital Allowance claims to reduce taxable profits and, in turn, tax liabilities.

In addition to the tax benefits of using cloud accounting, time will also be saved as a result of the platform's multi-user access settings and simple inputting procedures. This will allow practice owners and managers more time to spend running the business, as opposed to dealing with the often laborious accounting function.

Although the timeline for HMRC's flagship Making Tax Digital (MTD) has been delayed until at least April 2020, now is still the time for practice owners to be considering their present accounting system. Moving to a cloud-based platform will provide many benefits, especially for tax. With our assistance we aim to make the word 'tax' have a smaller implication for you and your practice.

MORE INFO
Stuart Petrie is tax senior manager at Anderson Anderson and Brown LLP

Ensuring a professional process

WHEN IT COMES TO SELLING YOUR DENTAL PRACTICE, WHY IS REGULATION AND RICS ACCREDITATION IMPORTANT?

PAUL GRAHAM

Sometimes it suits practice owners to sell off-market, but in today's modern market the only way to ensure that the best price and terms are achieved is by undertaking a professional process and approaching a variety of parties, ideally through a specialist broker.

All dentists understand the importance of medical regulations, and in a similar way the property industry is also regulated. The Royal Institution of Chartered Surveyors (RICS) is the leading global professional body that promotes and enforces the highest international standards in the valuation, management and development of land, real estate, construction and infrastructure.

So what does this mean for you when it comes to appointing a property advisor in the event of you requiring a valuation or if you are contemplating the sale of your business? To put it simply, you wouldn't expect one of your patients to visit an unregulated dentist, and in the same way, why would you put a valuation, and/or the sale of the business you have spent years, even decades building up, into the hands of a valuer who is not RICS registered, or an agent who is not employed by or part of a RICS regulated firm?

Christie & Co is the only RICS regulated specialist dental agent in the UK. This means that we are committed to offering the highest professional standards. For example, when it comes to a practice sale, we do not operate with a list of 'premium' purchasers paying fees to us. We work solely for you, the seller, meaning there is no conflict of interests, but also ensuring that no potential purchasers are ruled out; resulting in a greater number of people being informed of the opportunity and a higher price being achieved via competitive bidding.

In the last 12 months, our specialist brokerage team has agreed deals on 47 dental practices across the country with a combined value of over £45 million. In addition, our team of RICS accredited valuers has valued 228 individual dental practices worth over £260 million.

MORE INFO
To discuss how Christie & Co might help you achieve your future plans in Scotland, contact Paul Graham, associate director at Christie & Co on 0131 524 3416.

BEGIN YOUR TRAINING JOURNEY

AESTHETIC MEDICINE IS A GROWTH INDUSTRY AND A NEW TRAINING FACILITY IN GLASGOW HAS RECENTLY OPENED UP TO OFFER TOP QUALITY TRAINING FOR DENTAL PROFESSIONALS

As a dentist, there is no better time than now to train for a career in aesthetic medicine. Aesthetic medicine is one of the most rapidly growing industry sectors, with a recent surge of providers in Scotland. Facial aesthetics both enhances and complements the private dental care you offer your patients.

Aesthetic practice is a specialty within medicine. As such it requires the same dedication and study as any other specialty. The choice of training provider requires careful selection to maximise the educational value of your time and investment, and likelihood of success in this exciting, rapidly developing field of medicine.

Simon and Emma

Dentists have a significant advantage when studying and practicing facial rejuvenation, having spent five years studying facial medicine including anatomy, skeletal relations and tooth support at undergraduate level. Dentists will have gained postgraduate education relevant to the study of aesthetic medicine and will have clinically gained consultation, diagnostic and treatment planning skills to support the practice of aesthetic medicine.

Senescent ageing of all tissues leads to characteristic signs of ageing both intra and extra-orally. Tooth wear, crowding, loss and yellowing of teeth are commonly managed dental complaints. Complementary extra-oral anti-ageing treatments include wrinkle relaxing toxin injections for wrinkles, and dermal fillers for volume replacement and tissue resuspension. Mild class II and class III skeletal relations and anterior tooth malocclusions may also be camouflaged using strategically placed perioral fillers and toxin.

In Scotland, from 1 April 2017, registration of premises from which aesthetic injectables are performed became compulsory under government regulation. Registered dental practices are exempt from this additional registration. Exception from HIS regulation reduces the financial and time burden on dental practitioners looking to start offering aesthetic treatments from their surgery. The study of aesthetic medicine is also accepted as continued professional development by the GDC.

Clinetix Aesthetic Training Ltd was established by Drs Emma Ravichandran BDS MFDS and Simon Ravichandran MB, ChB, MRCS in 2010. Emma and Simon are recognised as national and international teachers, lecturers and demonstrators. With more than 15 years NHS practice and 12 years' aesthetic practice each, they offer a wealth of expertise, experience and ability to teach new aesthetic skills in a comprehensive and comfortable fashion.

In 2017, the Aesthetic Training Academy (ATA) was opened in Mitchell Lane, Glasgow. The ATA is a purpose-built, HIS-approved facility for training in aesthetic medicine in the heart of Glasgow's city centre. The clinic is delighted to have been listed as a finalist in the category of best independent training provider for the UK Aesthetic awards 2017. The ATA offers bespoke, small group teaching, from getting started courses through to advanced master classes, all with a perfect balance of theory and hands-on practical experience.

MORE INFORMATION

For more information on upcoming training events at ATA, please visit www.ataglasgow.co.uk

The ATA in Glasgow

AESTHETIC TRAINING ACADEMY

GLASGOW

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Best Independent Training Provider

2017 UK Aesthetic Awards

Oct 30th	Lip Augmentation using a Cannula 10.00 - 13.30 *£500*
Oct 30th	Treating Axillary Hyperhidrosis with Botulinum Toxin 14.00 - 17.00
Oct 31st	Tear Troughs 10.00 - 13.30
Oct 31st	Temple Augmentation 14.00 - 17.30
Nov 13th & 14th	Getting Started in Aesthetic Medicine (12 cpd points) 10.00 - 16.30 *£1500*
Nov 27th	Advanced Injectables 10.00 - 16.30 *£995*
Nov 28th	Upper Face Masterclass 10.00 - 16.30 *£995*
Dec 11th & 12th	Getting Started in Aesthetic Medicine (12 cpd) 10.00 - 16.30 *£1500*

Aesthetic Training Academy, 6th Floor,
14 Mitchell Lane, Glasgow, G1 3NU.
01698852093
enquiries@ataglasgow.co.uk
www.ataglasgow.co.uk

VISAGE

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Based in our modern and luxurious clinic in central Glasgow,we would like to welcome Mr Aman Ulhaq. Having graduated with a BDS (Hons) in 2004, Aman was appointed as a Consultant in Orthodontics at the EDI and Honorary Senior Lecturer for the University of Edinburgh in 2016.

Aman will be offering the following treatments at Visage:

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EXPERIENCED AESTHETIC TREATMENTS

UDDINGSTON-BASED CLINIC OFFERS BESPOKE TREATMENTS, TRAINING, AND EXCELLENT CARE

Your Face Aesthetics Clinic is a discreet medical aesthetic practice situated above Uddingston Dental Care. Headed up by Dr Heather Muir BDS (Glas) MSc (UCLan), it offers a range of treatments, from wrinkle relaxing injections, chemical peels, and dermal fillers, to rollers, body contouring, skin tightening and treatment for excessive sweating and stress-induced incontinence.

As well as nearly 20 years' experience as a dentist, Heather has more than 14 years' experience as a medical aesthetic practitioner and trainer. She is joined at Your Face Aesthetics by medical aesthetic practitioner Dr Jonathan Doran BDS (Glas), therapist and practice coordinator Michelle Archibald and therapist Amy Louise Gorman. The team aim to provide

Heather Muir

bespoke treatments and excellentand professional care to all their patients.

Heather also has several years' experience teaching facial aesthetic procedures with Medics Direct and Med-Fx and a common question after teaching was where attendees could take their own patients and students for further teaching and guidance. As a result, she is now pleased to offer mentoring support to those who have attended courses but require further training or advice on treatment techniques, treatment planning or simply to help practitioners gain confidence. This can carried out on a one-to-one basis or in small group sessions. Practitioners can also arrange to take their clients to the Uddingston clinic or arrange a session with Heather at their own clinic.

MORE INFORMATION
To find out more, call 01698 815 658 or visit www.uddingston-dentalcare.co.uk/facial-aesthetics

DENTOFACIAL ORTHOPAEDICS & ORTHODONTICS

DR JW 'SKIP' TRUITT EXPLAINS HOW HIS CONTINUING EDUCATION PROGRAMMES CAN HELP YOU CREATE BEAUTIFUL SMILES, HEALTHY TEMPORAL-MANDIBULAR JOINTS AND AN OCCLUSION THAT WILL LAST A LIFETIME

Understanding maxillofacial orthopaedics has become the foundation for modern orthodontics. More than 85 per cent of all patients have some type of maxillary deficiency. This deficiency may express itself as a transverse problem, it can be seen in an anterior – posterior direction, resulting in a short maxilla; and it can be seen in a retrognathic position of the maxilla relative to the anterior cranial base. These deficiencies can also occur in any combination.

When the maxilla is under developed in any of these three planes, there is a negative effect on the patient's facial growth and dentition. For example, a transverse deficiency (narrow arch) not only creates dental crowding, but also traps the mandible, preventing normal forward and downward growth. Some types of maxillary entrapment can always be seen in the skeletal class II patient.

The symptoms may include pain within the joint, tinnitus, vertigo, difficulty in opening and closing the mouth, and a wide variety of head and neck pain.

In addition to affecting the growth of the patient, maxillary entrapment upon the mandible can force the mandibular condyles distally within the glenoid fossa. This distal position of the condyle relative to the meniscus is the primary cause of temporal-mandibular dysfunction.

The maxilla also has a direct effect on the function of the respiratory system. When the maxilla is narrow, the palatal vault will be high. This, in turn, causes the nasal passage to be constricted both transversely and vertically. The patient is forced to mouth breathe creating a severe vertical growth pattern with the face.

"TREATMENT OF A STRUCTURUAL NATURE IS OFTEN FAR EASIER THAN YOU MAY THINK"

DR JW 'SKIP' TRUITT

Other respiratory effects include chronic inflammation of the tonsil and adenoid tissue and middle ear infections due to reflux within the Eustachian tube. Many children who have had grommets placed in their ears on a regular basis to drain fluids, return to normal function by simply developing the size of the maxilla.

The most obvious clinical effect of an under-development of the maxilla is the change that occurs in the facial profile. The severe skeletal class II patient that presents as a 'chinless wonder' can easily be corrected after the maxilla is properly developed.

Certainly the orthodontic component of any malocclusion must be addressed with fixed appliance therapy. This phase of the treatment usually follows the completion of the maxillo-facial orthopaedic therapy. Most fixed orthodontic treatments are now 12 months or less.

A large majority of the patients can be treated on a non-extraction basis.

Treatment of a structural nature is often far easier than you may think, as you will discover should you decide to invest in your future and attend a forthcoming introductory course (see right), the first in a series of six which are designed to take you from the very basics, right through to the most complex of cases.

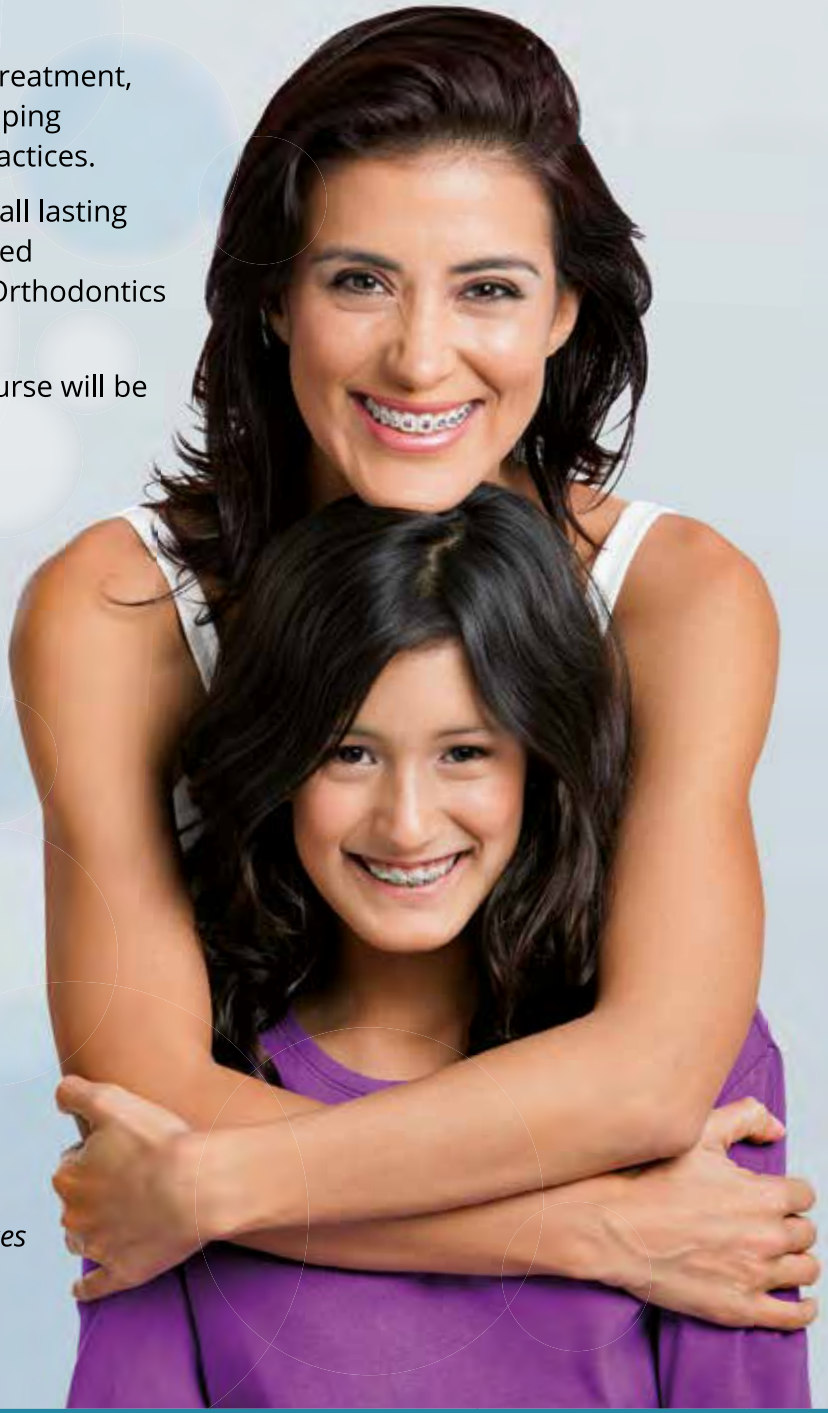
Our objectives should be to create beautiful smiles, pleasing facial aesthetics, healthy temporal-mandibular joints and an occlusion that will last a lifetime.

ORTHO & YOU

This superb course has led to thousands of general dental practitioners developing a thriving Orthodontic side to their practice

Presented by the world's foremost Ortho lecturer

Dr. J.W. 'Skip' Truitt DDS BS



You will learn the benefits of early interceptive treatment, how to correctly diagnose and then treat developing malocclusions that you see every day in your practices.

This is the first course in a series of six courses, all lasting three days. The remaining courses will cover Fixed Appliance Therapy, Cephalometrics, Advanced Orthodontics Techniques and T.M.J. Therapy

We guarantee that your only regret after the course will be that you did not attend sooner!

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MOVING WITH THE TIMES

BEARSDEN DENTIST STEPHEN JACOBS HAS BEEN AT THE FOREFRONT OF IMPLANTS ADVANCEMENTS FOR MORE THAN 25 YEARS, PIONEERING AND EMBRACING NEW TECHNIQUES AND TECHNOLOGY THE WHOLE TIME

Stephen is widely regarded as one of the foremost implant surgeons in the country. Qualifying from Birmingham University in 1985, he went into general practice in London, before moving to Glasgow in 1990.

Stephen's training in dental implantology was carried out in the USA and Europe. He has continually travelled the world to work closely with, and learn from, various mentors, bringing these world leaders in the field back to his practice for further training. Fast forward to 2017, and Stephen is now an an educator and mentor to many dentists, enabling them to progress their careers in implantology.

Stephen lectures extensively on all aspects of dental implantology throughout North America, Asia, Europe and the UK. His lecture diary this year is very busy, with multiple trips planned to the USA and Europe, and Japan for the second time to lecture on behalf of the Academy of Osseointegration (AO)

> "IMPLANTS REMAIN MY PASSION... ALL THIS IS DESIGNED TO ALLOW OUR PATIENTS TO BENEFIT FROM EVEN BETTER OUTCOMES"
>
> STEPHEN JACOBS, DENTAL FX

Stephen started his implant referral practice, Dental fx, in Bearsden, Glasgow, in 2006 and from himself, one nurse and a practice manager, he now leads a team of 13, including three clinicians and three hygienists, where all aspects of implant and reconstructive dentistry are carried out.

He is a key opinion leader and an ambassador for Dentsply Sirona Implants and, along with 39 other clinicians worldwide, played a role in the development of the Astra Tech EV Implant System. He is also a key opinion leader for Osstell, the device that measures implant stability, this being one of his current hot topics and one that he is lecturing on, among many other subjects.

Stephen is a past president of the Association of Dental Implantology (ADI) and a committee member of the American Academy of Osseointegration, where he is the UK Ambassador for AO. He is a founding board member of PEERS UK, and is the past scientific chairman of the ADI. He is committee chair for the AO Global Program Development, where he oversees all the non-American activities of the academy around the world. Last year Stephen was awarded Fellowship of the AO, becoming only the second clinician from the UK to be bestowed this prestigious honour, and one of fewer than 100 in total worldwide to be be honoured by the elite organisation.

He is on the editorial board of three journals and runs a variety of courses at his practice, including a comprehensive year-long course for those starting out in the field of implantology, sinus grafting and restorative programmes and is experienced with many implant systems.

When asked about his overall philosophy and current focus in dental implantology, Stephen said: "For more than 25 years, my life's work has been working with implants, where I have seen many aspects change, creating great advances and improvements. Many others have come full circle, new ideas not proving very successful and old ideas re-surfacing. It is so important to stay current, engage with fellow implant clinicians, attend conferences and meetings (non-commercially biased) and regularly read a range of peer reviewed journals.

"Implants remain my passion and things continually change and progress, but we have to be in a position to assess whether change actually will enhance treatment outcomes, or whether they are just for 'change's sake'. The digital revolution for example, is engulfing dentistry in general, and impacting on our field also, where the digital workflow now begins at the consultation stage with three-dimensional imaging and planning, leading to computer assisted implant placement and the use of CAD/CAM for the production of the restoration.

"I have been using CBCT imaging for more than 10 years, but with the recent advent of intra-oral optical scanning, a whole new dimension has been added, allowing more precision with all aspects of implant treatment. Of course, we must not forget that all this is designed to allow our patients to benefit from even better outcomes, providing them with long-term, predictable success. This remains my goal and underpins my philosophy."

dental fx
implants and cosmetic dentistry

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.

Gareth Calvert accepts referrals for all aspects of periodontal and restorative dentistry.

Contact: referrals@dentalfx.co.uk

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Patients can also be referred to the practice via the website **www.dentalfx.co.uk**

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Dentale's week-long introduction to implantology course is suitable for all GDC-registered dentists with little to no previous experience of implantology. The course will take you through the entire implant procedure; from start to finish you will learn all there is to know about implant placement. Beginning with the background and planning stages of implant surgery, including dental anatomy, implant design, surgical theory and the practical use of the implant kit, the course will also cover suturing and post-operative care using pig heads, placement techniques and treatment planning skills including prosthetic components. In addition, you will also get to experience live surgeries, learn about bone augmentation and finally, place an implant yourself on a patient.

Following this, Dentale offers a 10-day advanced surgical course which expands on the knowledge and skills gained from the week-long course. Working as a sequence, Dentale offers these courses in conjunction with one another to provide effective training that covers all aspects of implantology. The 10-day advanced surgical course builds on the week-long course, allowing delegates to master treatment from diagnosis all the way through placement to restoration on provided patients.

Many of our past delegates have gone on to become highly successful implant dentists. Former Dentale delegate Vineeth Balachandran qualified in 2003 from RG University, India, and has since developed a keen interest in cosmetic and implant dentistry. Vineeth is a vocational trainer for NHS Education for Scotland, where he is involved in training new BDS graduates in general dental practice.

Vineeth, who is director of practices in Edinburgh (www.sevenhillsdental.co.uk) and Livingston (www.banktondental.co.uk), said: "Having placed straightforward implants for two years, I was looking for a course that would take me up the pathway into advanced treatments and came across Dentale's 10-day advanced course. The course was well organised with a very skilled tutor and a set of well experienced implant nurses.

"It was held in Bristol, where there were four surgeries. There were also four candidates, which meant that each of us got a surgery to ourselves and an abundance of patient work. I placed around 16 implants over the duration of the course, six of which I did from start to finish. There was one-to-one supervision throughout and cases ranged from single implants to full arch cases, bone augmentation as well as had the opportunity to view some lateral sinus lifts. This course was also my pathway towards the diploma from RCSEd which I went on to successfully complete in 2013.


Dr Vineeth Balachandran

"The portfolio, which I received at the end of the course, helped a lot in preparing for the exams and is also a very good record of the qualification. I can confidently say that this Dentale course was a definite building block in my journey from simple implant treatments to the complex work that I undertake now."

MORE INFORMATION

For Scottish-based dentists, the Dentale Clinic in Bristol is ideal as cheap low cost flights are available from Glasgow to Bristol. Book a week-long course in 2017/18 before 30 September and we will cover the cost of your flights. T&Cs apply.

WORKING IN CONJUNCTION WITH REFERRING COLLEAGUES

WITH MORE THAN 50 YEARS OF EXPERIENCE IN CLINICAL DENTISTRY, FERGUS AND GLOVER PROVIDE A RANGE OF IMPLANT AND COSMETIC DENTISTRY

Jacqueline Fergus and George Glover have a combined practice experience of more than 50 years having graduated in 1993 from the University of Edinburgh and Glasgow Dental Schools respectively.

Having worked in general practice since graduating, they have both gone on to be among the first to achieve the MSc in Implant Dentistry postgraduate qualification from Warwick University in 2006. They are also both currently working towards a second MSc in Restorative Dentistry.

With more than 17 years of dental implant experience, having both been associate clinical tutors and regional mentors for the Warwick and GIFT Programme, both lecturing across the UK and internationally. Their focus now is exclusively on practising dentistry.

With a special interest in dental implants and cosmetic dentistry, referrals are welcomed for complex and simple cases. Their aim is to work in conjunction with the referring clinician, either as joint cases or, if the clinician prefers, they can look after their patient for the whole treatment and return them to the referring clinician at the end of treatment.

For dental implant cases that would benefit from visualising the case in 3D, they were one of the first practices in Scotland to invest in the i-Cat CBCT scanner and

welcome referrals for this service in their Aberdeen practice.

In addition, their team of hygienists can accept referrals for non surgical treatment of periodontal diseases for practices that do not have their own hygienist but feel their patients would benefit from this service.

MORE INFORMATION

To find out more, call the Aberdeen practice on 01224 644 876 or the Glasgow practice on 0141 548 6548. Alternatively, visit www.fergusandglover.co.uk

START YOUR DIGITAL JOURNEY

GLASGOW SMILE CLINIC'S JAMEEL GARDEE AND HAROON SHER PROVIDE COMPREHENSIVE ADVANCED DENTISTRY UTILISING A WIDE RANGE OF DIGITAL TECHNOLOGIES

Dentistry has changed significantly in recent years. Now, technology that has already been used for a number of years in non-dental industries, such as super accurate 3D scanning, milling and 3D printing, are finally finding their place in the dental clinic.

Leading this uptake have been world renowned clinicians like Christian Coachman, the developer of the Digital Smile Design (DSD) concept, and companies such as Sirona and 3shape.

At the Glasgow Smile Clinic, we are fortunate to have one of the few DSD masters and instructors, Dr Jameel Gardee, who has trained extensively with Coachman, Paulo Kano and other leading dentists in Europe and the USA.

Dr Haroon Sher, Jameel's business partner and fellow digital dentistry enthusiast has undergone extensive postgraduate training in implantology, orthodontics and advanced restorative dentistry. Together, they provide comprehensive advanced dentistry, often working closely with referring dentists to guide them on their own digital dentistry journey.

The Glasgow Smile Clinic has two Trios intraoral scanners, a Cone Beam CT scanner (CBCT), and 3D printer, which allows us to design, plan and complete patient treatment procedures in-house, guided by DSD technology. We accept referrals for advanced restorative cases and also implant and adult orthodontic cases.

All implant patients are 3D scanned and have CBCT imaging carried out. Planning of the implants is done digitally as well, on software such as Implant Studio or Nemotec. The surgical guides are formed on the 3D printer to allow the best and most accurate placement of the implant. In most cases, thanks to the DSD technology, we can produce full arch temporary restorations without having to take a conventional impression.

When it comes to restorative dentistry, DSD is used at the outset to ideally plan the end result before treatment commences. By allowing the patient to see the end result before work begins, this also serves as a marketing and case acceptance tool. Using digitally-generated motivational mock-ups helps the Smile Clinic team to provide the kind of emotional dentistry experience that patients absolutely love.

Both Jameel and Haroon present and teach digital dentistry, both in the UK and abroad. This year, Jameel has presented at the Dentistry Show in Birmingham – at the BACD lecture theatre, and also, with his DSD UK partners, Elaine Halley and Adam Morgan, at the DSD UK certification course in Manchester. He also presented, for Henry Schein and Dentinal Tubules, at the Digital Dentistry Show in London. Later this year, he will present and at the BDIA in Birmingham.

Referring dentists can be involved in their patients' journey and treatment. Many of those who refer like to attend to be mentored along their own digital dentistry learning path. Sitting in on treatments is a great way to learn about the latest guided implant methods and digital restorative principles and ideas.

GlasgowSmileClinic

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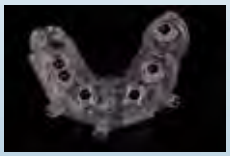
Based in the city centre of Glasgow we are conveniently located to accept referrals for advanced restorative and implant dentistry cases.






Full digital treatment utilising digital smile design, Intra oral scanning, CBCT and 3D Printing.

Referring dentists welcome to attend and become familiarised with the full digital workflow we offer.

Dr Jameel Gardee is a Digital smile design master and instructor and a post graduate of Boston university USA.

Dr Haroon Sher Post graduate Implantology and orthodontics (adult).

Phone referrals : 0141 204 4080
https://www.glasgowsmileclinic.com/referral

Info@glasgowsmileclinic.com

DSD INSTRUCTOR

A WELCOME ADDITION TO THE TEAM AT SCED

The team at Glasgow's Scottish Centre for Excellence in Dentistry (SCED) are delighted to welcome their newest member of staff, Lorna Cox.

Lorna has extensive clinical experience in adult and paediatric dentistry as well as an enhanced knowledge and expertise in the management of patients with complex periodontal needs. She is experienced in carrying out open flap curettage in patients with persistent periodontal pocketing, and, when required, uses regenerative techniques such as Emdogain.

SCED offers a full referral service for hygiene treatments that includes; charting of periodontal disease, peri-implantitis treatment, airflow treatments, as well as detailed oral hygiene instruction bespoke to each patient

Lorna is taking online referrals via the website, www.scottishdentistry.com You can also email the referral to enquiry@scottishdentistry.com or call the Centre on 0141 427 4530.

TRAINING OPPORTUNITIES AT THE CENTRE

To enhance the service supplied to referring dentists the Centre runs a variety of courses and seminars throughout the year. Update evening seminars, held at the Centre, at 335 Govan Road, Glasgow G51 2SE, usually run 6.30pm-8.30pm and are free to attendees. The Centre also runs longer courses, including the Esthetic Alliance Program (EAP) and the on-line SmileTube learning platform.

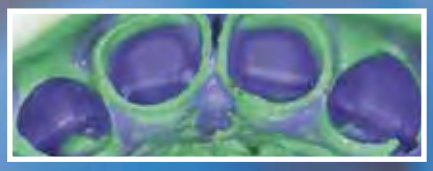
The EAP course, run in conjunction with Nobel Biocare, takes place over two Saturday mornings. The next dates are 7 October and 28 October, followed by an evening dinner on 1 November. This course will help dentists to restore implants. The £495 cost of the course includes a Nobel Biocare restorative kit.

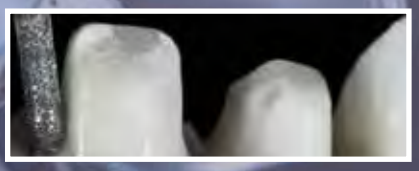
The next two update seminars are; GBT: The Game Changer, by Jo Pinder and Barry McLelland (Optident), on 24 October, and Update on Endodontics, by Mark Leng, on 30 November. All courses can be booked on secretary@scottishdentistry.com

If you would like to talk to a member of the referral team, or have a tour of the Centre, please call 0141 427 4530.

THE PREP COURSE

JASON SMITHSON





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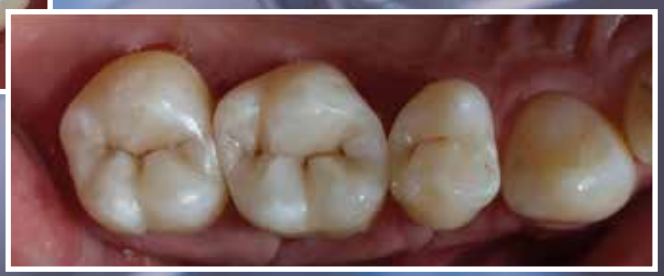

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Winner of Best Dental Team Award
(Scottish Dental Awards 2017)

Winner of Health & Wellbeing
(Life With Style Awards 2017)

Winner of Most Improved Practice
(Dentistry Scotland Awards 2016)

The Orthodontic Clinic is a specialist practice in Aberdeen, originally established in 2006, but bought over and redesigned by Directors Dr Lisa Currie (Clinical Director) and Ivin Tan (Managing Director) in 2014. The ground floor suite of an office building was completely renovated to create a modern clinic with the installation of 4 dental surgeries, separate LDU room, xray room, dental laboratory, office and dedicated staff room.

Since the new ownership, the clinic has been elevated to a new standard that we are extremely proud of. In 2016, we entered the Dentistry Scotland Awards and won the category "Most Improved Practice 2016". We were also nominated as finalists for the category of "Best Team" both in the Dentistry Scotland Awards 2016 and in the Dentistry Awards UK 2016 (Scotland). This year, we won the "Dental Team Award" at the Scottish Dental Awards 2017 and were winners of the "Life with Style Awards 2017" (Health and Wellbeing category) in Aberdeen and the North-East.

These accolades are a huge achievement for us and it feels wonderful to be recognised and rewarded in this way by our peers.

Clinical Director/ Consultant Orthodontist, Dr Lisa Currie, has many years of hospital and practice experience in the specialty. She gained her BDS with Honours at Dundee Dental School in 1996. After various hospital posts and vocational training, she completed her specialist training (MOrth RCSEd), with an MSc from the University of Edinburgh for her research in sleep apnoea. Lisa then worked as a Fixed Term Training Appointment (FTTA) at Birmingham Dental Hospital/ University of North Staffordshire Hospital. Following this, she gained her Fellowship in Orthodontics (FDS Orth RCSEd) and accreditation as a Consultant Orthodontist.

She was Consultant Orthodontist at Borders General Hospital/ Edinburgh Dental Institute from 2006-2010. She has received an honorary appointment as Senior Clinical Lecturer at the University of Aberdeen (Aberdeen Dental School). Lisa has lectured extensively and been involved in training and examining at all levels, including of general dentists, undergraduate and postgraduate dental students, as well as dental care professionals and still continues to do so with great enthusiasm.

Managing Director, Ivin Tan, has owned several design and printing companies, based in South-East Asia and her training has been in Art and Design. Her business acumen has been key in our clinic's growth and her design background is reflected in the modern interior and style of the clinic.

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We are the only specialist practice in Aberdeen to have a full time specialist orthodontist that has undergone further higher training to qualify as a Consultant Orthodontist. We believe that this and the renowned clinical expertise of our team make us the recognised clinic choice in Aberdeen for referral.

The integration of Orthodontic Therapists is one of the most important ways that we provide a holistic care for our patients.

We truly believe in our team - they are our best asset and by investing in them and being dedicated to continuous professional development, we give our best to our staff and likewise, our patients.

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The company has grown impressively over the last few years and is now seen as the 'go to' dental recruitment agency for Scottish practices and Scottish dental professionals. However, director April East insists that their aim is not simply to "get people in any job, it's to get the right person in right job every single time".

April and her team meet every candidate face-to-face, matching their specific skills and experience to specific jobs and practices, making sure that they are the best fit possible. They carry out all the necessary checks and paperwork so that the candidates are fit for purpose and ready to start when and wherever they are needed.

With 20-years' experience, the team now know the dental industry inside out, they also have in-depth knowledge of dental recruitment, HR and personnel management. April said: "We have specialised dental recruitment experience, not just dental experience and we feel that distinction is important. To give the very best service, you need to know dental recruitment, you need to know HR and, most importantly, you need to know people."

April explained that they take the time to get to know the candidates and employers as much as possible to understand their specific needs and wants, as well as the various pressures practices are under. Even if you have a special interest or a specific area of experience you want to make the most of, the team at PS NewJob are best placed to find you the perfect job in the perfect practice.

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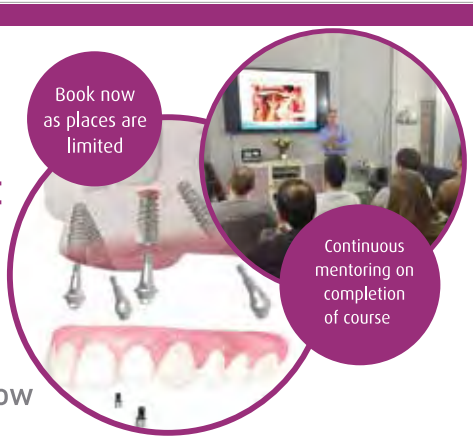

Highly experienced clinical trainer:

Dr Greig McLean
MFDS RCPS (Glasg). 2002, BDS (Glasg). 2001, MB ChB (Glasg) Clinical Director, Doctor & Dentist (GDC No 79630)

Greig is a highly experienced dentist and medical doctor with a special interest in implantology, cosmetic and surgical dentistry. He also practices the treatment of anxious and phobic dental patients. Dr McLean has been placing implants since 2005 and teaches all aspects of surgery and restoration. Dr McLean is a member of the International Team for Implantology (ITI), the Association for Dental Implantology UK (ADI) and the British Academy of Cosmetic Dentistry (BACD).

Course topic include

- Morse Taper principles
- Surgical and prosthetic components
- Immediate loading and considerations
- Immediate provisionalisation
- Complications for full arch cases
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- Final stage restoration and hygiene considerations

Course Features

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- See & observe live surgery
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A PERFECTLY PROFESSIONAL MARRIAGE

DUNDEE GRADUATES START THEIR PRACTICE OWNING JOURNEY AND LIFE TOGETHER AS HUSBAND AND WIFE AT THE SAME TIME

BRUCE OXLEY

For Hannah Jackman and Michael Foster, the decision to open their own dental practice was borne out of a desire to take control of their own destinies.

Both were working as associates in Fife and Angus and, while they were happy with the clinical side of their jobs, they were growing frustrated at the lack of control they had in other aspects of their professional lives.

Hannah explained that owning her own practice was never something she saw herself doing until she met Mike at Dundee University. The couple graduated two years apart (Mike in 2009 and Hannah in 2011) and got married in the summer of 2015. However, in the weeks leading up to the happy day, they made another big decision.

Hannah explained: "We were sitting watching TV one night and we just said: 'Shall we just go for it?' That was pretty much what happened. We decided that we were fed up thinking about going it alone, we just needed to get on with it and go ahead and do it."

They were keen to open a practice in Dundee itself and started thinking about locations. The consensus from friends and colleagues was that they would be best sticking to areas south of the Kingsway, one of the main trunk roads that skirts the north of the city and inspiration for the practice's name – KW Dental. It was with this in mind that Hannah noticed a rather nondescript building on a property website that she had initially disregarded before realising it might just be exactly what they were looking for.

She said: "At first I scrolled past it because, from the pictures, it looked a bit of a mess. Then I realised where it was and I realised it was a great location."

They visited the building, the offices of a former offshore technology business, and within a couple of weeks they had decided it was the place for their new practice. So

CONTINUED OVERLEAF>

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FROM PREVIOUS PAGE>

it was that, just a couple of weeks before they tied the knot personally, they bought the building and committed themselves professionally as well.

However, while they managed to purchase the building without too much hassle in June 2015, it took the best part of a year before any work could start due to delays in getting the change of use and planning paperwork sorted. So, in May 2016, work began turning the run-down office building into a modern dental practice.

One of the first things that Hannah and Mike did was to remove the hedge from the front of the property as it was essentially obscuring the view of the building from people walking and driving past. They then put up a banner on the railings advertising that a new practice was opening soon to take advantage of the busy pedestrian and road traffic that passed by the location on a daily basis.

Hannah explained that, while the building was stripped back to the shell, there was one structural wall running the length of the property that limited their options in terms of layout. The original plans from the architects featured two large surgeries in the space that Hannah and Mike decided were too large and they opted to make better use of the space and change to three smaller, but perfectly suitable surgeries instead.

As they and the architect had no previous experience designing or fitting out a dental practice, Hannah and Mike enlisted the help of a number of dental suppliers and companies to help them realise their vision. A-dec supplied the chairs – a purple A-dec 400 and a blue A-dec 300 – with the suction motors supplied by Dürr Dental. They both advised on the plumbing and installation requirements and worked with the contractors to ensure everything was ready for the equipment to be put into place.

The IT infrastructure – R4 software and hardware – was supplied and installed by Carestream who advised on its installation and what was required, again before the equipment arrived so that everything was ready. Also, The Dental Directory provided invaluable help and support in terms of the instruments, materials and sundries that would be required when the practice opened its doors, helping Hannah kit out her surgery in the first instance as Mike wasn't due to join the practice for another few months.

She said: "Mike didn't actually start working here until April 2017 (the practice opened on 18 October 2016). I was working on my own for the first six months.

"I actually took some time off and did some locum work while the work was going on as we felt we needed someone to come

WE WERE FED UP MOANING ABOUT WORK AND THOUGHT, WE JUST NEEDED TO GET ON WITH IT AND DO IT

up and be on site and make sure everything was okay. There was a lot of stuff to do with regards to the practice inspection and so on, so I dedicated a couple of months just to getting it all done. So, while we lost some money as I wasn't working full time during this, I think it was a good decision as I could focus on that and we could get it all done properly."

Hannah explained that one of the main aims for the look and feel of the practice was for it to be easy to maintain as well as being bright and welcoming. She said: "The actual building itself was quite old, so we wanted it to look as modern as possible inside. We

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wanted it to be easy to clean as well, because there were only a couple of members of staff to begin with, we just wanted it to be really simple and easy to maintain.

"Patients have commented on how relaxing they find the practice and we have had quite a few nice comments, which is great."

To drum up interest and to advertise their services the couple printed 5,000 flyers that they distributed around Dundee on their days off, including at wedding fairs and other events, and Hannah even designed and launched the website herself, all in the aim of saving cost where they could. She said: "I think it all helped – there was a long time where we couldn't exactly book people in as we didn't know when it was actually opening but we got people to pre-register and on the day we opened we had several hundred people to call and book in.

"Once people started emailing in that was quite reassuring, but I don't think we have had a day since we have opened when we haven't registered a new patient. We both now have about 2,500 patients at the practice, which is pretty much what I had when I was an associate."

The couple admit that the experience, while stressful, has certainly been worth it.

"It is your practice so we now stress about doing things properly and making sure that the patients are happy," said Hannah.

"It has definitely a positive experience. It has been stressful, but I would have been surprised if it hadn't been to be honest. I wouldn't ever change anything, I am so glad that we did it.

"I'm sure all the hard work and stress will be worth it in the long run."

DENTAL SKY IS DEDICATED TO PROVIDING GREAT PRICES AND GREAT SERVICE

Dental Sky are a little different to other dealers. Firstly, they like to keep things simple and don't believe in confusing promotions, or reams of small print. They will never knowingly be undersold and believe in price clarity and simple offers so you know exactly what you're getting and at what price.

Secondly, they offer a broad range of sundries and are delighted to have recently been selected as the sole distributor for The Wand, a computer Assisted Anesthesia System, capable of providing virtually pain-free dentistry.

Thirdly, they're constantly looking at ways to improve the customer experience. Their website, for example, has been completed overhauled making it even easier to navigate. Furthermore, all customers ordering online automatically receive a 2 per cent discount; a further 2 per cent discount is given for upfront payments. There are even several payment options, i.e. American Express card (if you're collecting Airmiles), Paypal or you can even use your Amazon account!

See Dental Sky on Stand 054 and 058 at the BDIA Dental Showcase in Birmingham, 19-21 October.

Made for lovers of detail:
The VistaScan Mini View.

The VistaScan Mini View: improved image quality, more comfort. Scan all intraoral formats in seconds with the highest resolution using the compact image plate scanner VistaScan Mini View. Monitor the results directly on the large touch display. A fully-integrated WiFi function ensures full flexibility.
More at www.duerrdental.com

DÜRR DENTAL
THE BEST, BY DESIGN

SIT DOWN WITH THE EXPERTS

For more than 50 years, A-dec has focused on providing dental professionals with innovative and reliable solutions for better practice. One of the most trusted names in dentistry, A-dec is responsible for creating some of the most highly acclaimed dental chairs on the market.

The team will be attending the BDIA Dental Showcase in October 2017, exhibiting on stand K20. Delegates will have this fantastic opportunity to speak face-to-face with the A-dec experts, to learn more about the world-class technology they have to offer.

This includes the all-new A-dec 300 LED light, a powerful but economical lighting solution, and the new A-dec 200 chair, a competitively priced entry-level system that has been manufactured to the highest standards.

Be sure to visit A-dec on stand K20 at the BDIA Dental Showcase.

For more details, visit www.a-dec.co.uk or call 0800 233 285.

INTERACT WITH CARESTREAM DENTAL AT SHOWCASE

Dedicated to making your life easier, Carestream Dental provides an array of cutting-edge technologies and equipment to suit the needs of every practice.

To discover the latest from the company, meet the team and get involved, visit stands J58 and K60 at the BDIA this October.

For everyone looking to better understand the practice workflow with Carestream Dental technologies and to find out how its potential can be optimised, a dedicated virtual reality experience will be available.

You can also get hands-on with the CS 3600 intraoral scanner by trying it for yourself on-stand.

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

WORLDWIDE LAUNCH FOR CALCIVIS

UK dental technology innovators, CALCIVIS have chosen the BDIA Dental Showcase 2017 for the worldwide launch of its revolutionary new CALCIVIS imaging system.

The unique system visualises early enamel demineralisation through the use of a bioluminescent (light-emitting) dental biologic and chair-side 'demin-map' that engages patient commitment at the time when simple preventive approaches are the most effective.

The first 100 Committed UK Practices will receive a VIP starter kit and induction training, representing a saving in excess of 40 per cent. Make sure your practice is one of the first to benefit by visit the CALCIVIS team on booth G21.

To register for the VIP offer, visit www.CALCIVIS.com

LEADING EDGE IMAGING EQUIPMENT

Dürr Dental will be exhibiting a range of its equipment on Stand D30 at the BDIA Dental Showcase (19-21 October, NEC Birmingham). The Dürr Dental brand is synonymous with leading edge imaging equipment and its panoramic device is so easy to use you won't need a second take, as the first one will be perfect.

Unlike other devices, this unit does not rely on experience or expertise, in fact both are almost negligible. You'll also get a chance to experiment with a totally new piece of imaging equipment.

Visitors might also be interested in the latest networking systems that can be used with your compressor and suction system. Linking the compressor, for example, to the digital network yields numerous benefits: current status, faults or messages, such as for filter changes, are immediately displayed on screen.

STUNNING TREATMENT CENTRES

Belmont invites you to take a seat on one of its stunning treatment centres on Stzand H20 at the BDIA Dental Showcase (19-21 October, NEC Birmingham).

Their flagship Cleo II features a unique folding leg rest, which has a much smaller footprint than a conventional chair and is also far more familiar in design to patients, and less intimidating.

For those requiring the flexibility of an ambidextrous unit, there's either the tbCompass or the Voyager III. With Belmont treatment centres you also have 48 colours to choose from so you can co-ordinate perfectly with the rest of your interior!

With your patient perfectly positioned, you need an operating light that will provide a flooded area of illumination, with minimum heat transfer and white light, which most closely matches daylight. The 900 LED light from Belmont does just that.

MAKING HEADLINES AT SHOWCASE

Oral-B is once again the Headline Sponsor at this year's Dental Showcase.

Much interest is expected in the company's flagship power toothbrush, Oral-B Genius. By combining motion sensor technology located in the brush, and video recognition using a smartphone's camera, all areas of the users mouth can be tracked so that they know exactly where they've brushed and where they've missed!

Patients receive instant feedback on the brushing of each zone of the mouth via the Oral-B App 4.1, including guidance on pressure applied and brushing duration.

The mechanical benefits of Oral-B's power toothbrushes compliment the chemical efficacy afforded by their toothpaste. The new Oral-B Gum & Enamel Repair Toothpaste will help patients address the increasing prevalence of gum or enamel issues.

Visit Oral-B on Stand L2 and K10 at the BDIA Dental Showcase, 19-21 October in Birmingham.

DIGITAL IMPRESSIONS HAVE NEVER BEEN SO EASY

The brand new intraoral scanner Planmeca Emerald is a small, lightweight, and exceedingly fast scanner with superior accuracy. It is the perfect tool for smooth and efficient chairside workflow.

Scanning is extremely fast and easy, making the experience comfortable for the patient and clinician alike. The accuracy of the impressions meets the most demanding needs with a fully integrated colour scanning option.

This simple plug-and-play solution makes it easy to share between operatories with it's fully open-STL format. The scanner is compatible with Planmeca Romexis and Planmeca PlanCAD Easy software suites, for constant access to real-time scanning data.

Call free phone 0800 5200 330, email marketing@planmeca.com or visit www.planmeca.com

PRESERVING VALUE AND YOUR UNIT'S LIFE

The inventors of the modern-day suction system Dürr Dental has this advice to preserve the life of your dental unit:

1) Aspirate at least one glass of water through the spittoon and the suction hose after every patient to remove blood, saliva and dentine residue.

2) Use cold water to mix disinfectant as hot water inactivates many disinfectant components, creates foam and causes coagulation when combined with blood.

3) For hard water, use MD555 cleaner at least once a week.

4) Use only foam-free products intended for the job, never use household cleaning agents.

5) Never mix products as this can neutralise the disinfectants.

6) Do not use the suction unit to vacuum drawers!

7) Ensure regular maintenance.

For more info, call 01536 526 740.

A-HEAD OF THE REST

Minimising the amount of dental equipment in a surgery makes sense financially as well as logistically. The VistaCam iX HD, from Dürr Dental, does just that, since it has an interchangeable head so that you can use it for intraoral, extraoral and macro images (using the 'Cam' head) as well as to detect carious lesions and display plaque (courtesy of the 'Proof' head) in addition to early detection of proximal caries (using the 'Proxi' head). The concept is simple, the technology unrivalled, the possibilities endless.

Videos can also be recorded in HD resolution with twin LED's illuminating the oral cavity. For patient communication – seeing really is believing.

The VistaCam iX HD offers unrivalled functionality in a single device with multiple applications, a tool that perfectly complements daily practice.

UPGRADE YOUR DENTISTRY WITH COLTENE

The quality of your dentistry is dependent on the products you use. For more than 50 years, COLTENE has been developing world-class materials that help dental professionals improve their clinical outcomes.

Exhibiting at the BDIA Dental Showcase on stand L20, the COLTENE team will be giving delegates more information about the wide range of products they have to offer. This includes the full range of internationally renowned restorative materials, as well as the latest endodontic products that COLTENE has developed in cooperation with dentists.

COLTENE will also be showcasing the new Biosonic UC150 Ultrasonic Cleaning system, which features a 5.7 litre tank capacity and a low noise level of 63dB.

www.coltene.com, email info.uk@coltene.com or call 01444 235 486

LONG-LASTING CROWNS MADE EASY

DMG's new LuxaCrown enables simple, quick and cost-effective chairside fabrication of long-lasting crowns. The result is an incredibly precision-fit, aesthetic and long-lasting restoration which can be worn for up to five years. In addition to excellent flexural strength, it also possesses outstanding fracture toughness which ensures long-term stability of semi-permanent restorations.

LuxaCrown can be used to protect the remaining tooth as well as to restore the anatomical form and the masticatory function. With LuxaCrown, dentists can offer their patients a long-lasting semi-permanent solution with excellent results – and a cost-effective, attractive alternative to laboratory fabricated crowns.

Call DMG on 01656 789 401, email paulw@dmg-dental.co.uk or visit www.dmg-dental.com

'IT HAS BEEN BRILLIANT'

The SmileTube.tv Ultimate Implant Year Course offers a blended learning structure that combines online theory modules with hands-on training days, to ensure delegates have competence and confidence with dental implants.

Current delegate Dr Cole McConnell said: "It has been brilliant. I have been so impressed with the course content and the depth of the lecturers' knowledge.

"I really like that I can go back to a lecture if I missed something, and the hands-on elements have been invaluable to my understanding.

"Using products from Nobel Biocare has also been beneficial as I have experience with some of the best materials available on the market."

Visit www.smiletube.tv or email Janine@SmileTube.tv

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LuxaCrown: The easiest way to long-lasting crowns.

From now on, restoring is child's play: With the new LuxaCrown you can make long-lasting crowns easily, quickly and cost-efficiently – directly at the chairside. The easy to make composite crown fits precisely, is highly aesthetic and shows a remarkable longevity. A LuxaCrown restoration could last for up to 5 years.* With this unique semi-permanent solution, you can offer your patients longevity with excellent results as a cost-efficient alternative to lab processed crowns.

Discover the new possibilities for you and your patients. With LuxaCrown from DMG.
www.dmg-dental.com

DMG

*In vitro study of LuxaCrown; N. Albrecht, S. Duy, Germany, FEB 2016