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EVOLUTION NOT REVOLUTION

Chief Dental Officer answers the profession's concerns about the new oral health plan

MARGIE TAYLOR

ABID FAQIR

DEREK RICHARDS

NIALL MCGOLDRICK

ARVIND SHARMA

MONIK VASANT

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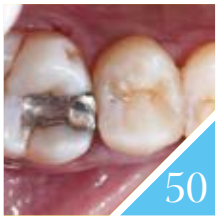

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Editorial

WITH BRUCE OXLEY, EDITOR →

NEW FACES AND NEW BEGINNINGS

It's the end of an era for our editor Bruce Oxley

It saddens me greatly to write that this will be my last ever issue of *Scottish Dental* magazine. By the time you read this article, I will have moved to pastures new after nearly a decade in the dental industry.

When I first took over, what was then Scottish Dentist, Aberdeen Dental School was still being built and the profession was still coming to terms with the new decontamination guidelines that were to cause so much disruption to practices across the country.

One thing that has stayed constant is the warmth of the Scottish dental profession. From GDPs in NHS practices, to specialists in referral centres and not to mention hospital doctors, tutors and deans of the dental schools, the profession in Scotland has proven itself to be a very friendly place. I came into this role a complete novice when it came to dentistry but I was made to feel very welcome and the help and support I was given over the years was fantastic.

A new editor has just been appointed and you will get to meet Sarah Allen, former director of communications at The Royal College of Surgeons, Edinburgh in the coming weeks and months, on these pages and out an about at events and conferences.

Speaking of which, the Scottish Dental Show is just a few short weeks away and it is shaping up to be the biggest and best yet. Our pre-registrations are still way up on last year, at the time of writing they were nearly 25 per cent higher than this time last year. The 2017 Show saw more than 2,200 through the doors, so 2018 promises to be even busier.

We have a great lecture and workshop programme again covering all the major topics as well as a few that you may not have come across before. All the information is at www.sdshow.co.uk and you can keep up to date with the latest news from the show and the magazine by following @ScottishDental on Twitter and by liking our Facebook page.

By the time you read this, the nominations deadline for the Scottish Dental Awards 2018 will have passed and the shortlist will have been announced. I'd like to take this opportunity to wish all those shortlisted for the 2018 Awards the very best of luck and I'm sure it will be a great night on the 27 April at the Glasgow Hilton.

One thing that has stayed constant is the warmth of the Scottish dental profession. From GDPs to specialists...

So, in my last issue of the magazine we have a feature on the new Oral Health Improvement Plan as Chief Dental Officer Margie Taylor moves to reassure the profession that nothing is, as yet, set in stone.

Over the coming weeks and months we will see if the initial fears from the profession start to come true or if this really is the chance to help shape the future of dentistry in Scotland for the better.

WE COULDN'T HAVE DONE IT WITHOUT...

1

MARGIE TAYLOR
(ON THE NEW ORAL HEALTH PLAN)
Margie Taylor is Scotland's Chief Dental Officer, a role she has inhabited since 2007. She received a CBE in the Queen's New Years Honours in 2016.

2

ABID FAQIR
(ON BECOMING ADI PRESIDENT)
Abid Faqir is the new President of the Association of Dental Implantology. He works at SCED and is co-owner of the Ecco Dental Group.

3

MONIK VASANT
(ON POSTERIOR RESTORATIONS)
Monik Vasant is the keyonte speaker at the Scottish Dental Show 2018. He is the director of Freshdental, with sites in London and Greater Manchester.

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ARVIND SHARMA
(ON ENDODONTIC IMAGIN)
Arvind Sharma works in practice limited to endodontics and takes referrals at New Life Teeth, Edinburgh and Philip Friel Advanced Dentistry.

HAVING HIS SAY →
Got a comment or question for Arthur? Email
arthurdent@sdmag.co.uk

LET'S GET TALKING

A new dentist takes on the Arthur Dent persona and starts off by challenging colleagues across Scotland to get in touch and start a debate

So, here begins a new era, at least for me, and perhaps for you? As I take on the mantle of Arthur Dent, I'd like to thank my predecessor for their many interesting and informed articles from the coalface of Scottish dentistry over the last few years.

I've been a dentist for a couple of decades or so and work in a fairly large, mostly NHS, mixed practice in Scotland. That's as much as I'm telling you. I don't have any great academic or research knowledge, but a whole host of practical experience as an associate and practice owner. I like to think I have a fairly balanced, forthright view on dentistry and that's why I've offered to write for this column.

I hope what I have to say is interesting and thoughtful. I may at times court controversy and I'm quite happy to admit if I'm wrong. To that end, I will ask questions and state opinions which are based on my experience and that of those I talk to. If you think I'm right or wrong, I'd like to hear about it and hope to spark some debate. I often think we, as a profession, don't say what we truly think as we are always concerned about competition in business and can have very differing views on the way forward. Perhaps with my anonymity and the anonymity (I promise) of anyone making a comment to me, we might spark an honest, open and benevolent conversation on these pages?

Anyway, enough about that. On with the meat. There's a new Oral Health Improvement Plan. I guess I have to talk about that. The problem is, like the consultation process, there isn't much meat on the bone. I don't think there's enough detail to get really worked up about either way.

I have heard a lot of rumour and innuendo among colleagues about how it's going to work but I think I'll wait for the detail. What does strike me as a general impression is prevention, quality improvement and targeting of care seem to be the focus. I don't think I can complain about this.

Evidence has a very prominent position.

ABOVE: As a profession we often don't say what we truly think. Let's have a debate

I do have concerns about that. I don't think dentistry has a good enough evidence base to rely on. Especially for basic treatment types and techniques. This may be the first controversial thing to say. I worry that academia is leading the profession and ordinary folks like me with anecdotal experience are ignored. In the absence of anything better, let's not ignore experience. Particularly for GDS, which is, after all, where the vast majority of care happens. (Remember this is opinion, not necessarily fact, but it's not just me.)

Things I do find a little funny (and I'm going to leave the iQUAD study and perio for another time here) are: 1 – increased levels of oversight/admin; 2 – enhanced accreditation and medical checks; and 3 – caries disappearing. These are things I could go on and on about but I'll try to keep it brief and pointed.

In NHS dentistry, practices have to deliver services dictated by regulations and policy based on a very simple earning stream. Why would you spend time, effort and money (particularly when funding is tight) on increased complexity of admin? For example, creating a dental director in each health board probably costing about £2m. What are they going to do? Practices will still have to do what they do with the same funding, or less, so why spend money on more layers?

Why do we need to get enhanced accreditation for doing stuff we already do – domiciliary care and oral surgery? Yet, we are going to be asked to do medical checks, which we are not trained for, to access 'extra' funding because nobody wants to be a GMP. This seems a bit strange. Not to mention, I'm quite busy doing dentistry.

On that note, do we really think caries and the health of the nation's mouths is that much better? I do agree it's better than 20 years ago but I still see a lot of caries. Every day. All day. Maybe I'm just unlucky.

I'd love to hear from some dentists in more private practices in those really nice areas. I suspect it's better, but I bet their patients still drink (new and improved) Irn-Bru. They just get white fillings done so the NHS doesn't know they get treatment. Or perhaps they are all caries free and I'm just blinkered?

Well, I'll end on that question. Please feel free to email. I promise I'll read it, learn from it and share it in SD Mag. Let's have a debate.

ORAL HEALTH PLAN ON PAGE 32

> We have never had so many older people that are frail but have their own teeth. It's uncharted territory
>
> MARGIE TAYLOR

SCOTTISH GOVERNMENT MUST TREAD CAREFULLY IN SHAKE-UP OF DENTAL SERVICES

BDA concern that changes to NHS care proposed in Oral Health Improvement Plan could undermine viability of practices

The British Dental Association (BDA) has urged ministers to proceed with caution following publication of the Scottish Government's Oral Health Improvement Plan (OHIP), which could lead to the biggest shake-up of NHS dental services in decades.

The BDA has expressed concern that changes to the range of care available on the NHS could undermine the viability of practices across Scotland.

It has accused the Scottish Government of spin, launching the OHIP off the back of statistics claiming 'record-breaking' numbers of registered patients.

The BDA quotes actual attendance at NHS dentists has "reached a record low". It said the percentage of patients who saw a dentist within the previous two years has shown "a steady decline from around 98 per cent between September 2006 and March 2008, to 84.1 per cent in September 2010 and now 70.7 per cent in September 2017, the lowest reported rate".

David Cross, vice chair of the BDA's Scottish Council, said: "This programme represents the biggest change to NHS dentistry in the last 50 years, but it will be impossible to deliver without new investment.

"Yes, reform is needed, but ministers must tread carefully and avoid the unintended consequences that could easily destabilise the service.

"The Scottish Government is unwise to cover historically low attendance figures with claims of 'record-breaking' registration. The patients who need us most might be getting on the books, but they are not making it to the dentist's chair. Our nation's oral health challenges remain profound, and will not be solved by spin."

BDA Scotland has welcomed recognition within the document for a roll-out of Childsmile for all child groups, provision of funding for occupational health services, the implementation of consistent pathways for oral cancer across Scotland, addressing the care of the elderly in both care homes and in their own homes and the provision of local resolution rather than sending cases to the GDC initially.

A number of issues that were of concern to BDA Scotland have been removed by Scottish Government from the document. Orthodontic services will not be locally commissioned, and there will not be a minimum number of hours of clinical care required by NHS practitioners.

David added: "Many of our initiatives have been recognised within the strategy. We will continue working with Ministers and the Scottish Government to take forward sensible policies contained in the document and to deal with the opportunities and challenges facing the profession."

BDA SCOTLAND SEEK VIEWS ON OHIP

BDA Scotland is seeking the views of dentists on the Scottish Government's recently published Oral Health Improvement Plan (OHIP) through an anonymous online survey hosted on its website.

The survey is open to general dental practitioners and dentists working in the hospital dental services or in the public dental services in Scotland and will take approximately 20-30 minutes to complete. However, there is also a shorter version of the survey, which will take around five minutes to complete, covering some of main key points raised by the proposals.

David McColl, chairman of the Scottish Dental Practice Committee, said: "The release of the OHIP has caused concern among many practitioners; many of whom have taken parts of the aspirational plan and catastrophised some outcomes.

"There is little detail in the OHIP and we look forward to working with Scottish Government to develop the implementation of some of the themes alluded to in the plan.

"The profession needs reassurance that NHS dental practices will be viable under any changes and that regulation by Scottish Government, PSD, NSS and the GDC is fair, transparent and understood."

The information gathered from the survey will be used to inform on-going discussions that BDA Scotland has with the Scottish Government about proposed changes to dentistry in Scotland.

GDC LAUNCHES CONSULTATION ON MECHANISM FOR SETTING FEES

The General Dental Council (GDC) has launched a consultation on a new approach to setting fees.

The new proposed policy is based around three main principles:

- Fee levels should be determined primarily by the cost of regulating each registrant group
- The method of calculating fee levels should be clear
- Decisions on the allocation of costs should not lead to undesirable outcomes (e.g. in the form of unacceptably high or variable costs for some groups of registrants).

The consultation is about the mechanisms for setting fee levels rather than about the fee levels themselves.

Matthew Hill, GDC executive director, Strategy, said: "We've been listening to our stakeholders and have worked hard to develop a set of proposals which we think provides a greater level of transparency. We really want to hear the views of all our stakeholders, so I hope everyone will read the consultation and respond before the closing date."

The consultation is available at gdc-uk.org/about/what-we-do/consultations and is open until 15 May 2018.

IAN MILLS TO BE NEXT DEAN OF FGDP(UK)

FGDP announces Glasgow graduate and north Devon GDP as its new dean

Ian Mills has been elected as the next dean of the Faculty of General Dental Practice UK (FGDP(UK)).

Ian, who works in general dental practice in north Devon, previously held the post of Academic Clinical Fellow at Plymouth University Peninsula School of Dentistry, and is a Fellow of the Faculty. He is currently senior vice-dean of FGDP (UK) and will be inaugurated as dean on 15 June 2018, taking over from Dr Mick Horton.

Ian said: "It will be an enormous privilege to lead the UK's only professional body dedicated to general dental practice through a crucial period in its history. I thank my colleagues for the faith they have placed in me, and look forward to working with them in delivering GDP-focused education, guidance and representation over the next three years."

> "I THANK MY COLLEAGUES FOR THE FAITH THEY HAVE PLACED IN ME"
>
> IAN MILLS

He qualified as a dentist from Glasgow University in 1987 and spent the early part of his career working in maxillofacial surgery. In 1994 he moved to Devon and three years later set up Torrington Dental Practice, where he continues to work as a partner.

He is currently the Faculty's representative on the Care Quality Commission Dental Reference Group and has previously been an Assessor for FGDP(UK) Fellowship and chaired its Examinations Committee. He was previously an elected member of the British Dental Association's General Dental Practice Committee, a member of Devon LDC, and on the Professional Executive Committee of North Devon Primary Care Trust. He is a fellow of both the Higher Education Academy and the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow.

In addition to his clinical practice, Ian has worked at Peninsula Dental School

since it was established and has recently submitted his doctoral thesis to Plymouth University on 'The delivery of person-centred care in general dental practice.'

Dr Mick Horton, Dean of FGDP(UK), added: "Many congratulations to Ian on his well-deserved election as Dean. He is a highly experienced, respected and rounded practitioner, and I'm delighted the Faculty will be in such good hands."

DENTAL PROTECTION SUCCESSFUL IN CHALLENGING 'IRRATIONAL AND UNFAIR' PRACTITIONER SERVICES DECISION ON PAYMENTS

Judicial Review finds PSD misapplied regulations on recovery of overpayments

Dental Protection (DPL) has successfully challenged the actions of Practitioner Services (PSD) of NHS National Services Scotland in a Judicial Review over the recovery of alleged overpayments.

Following a review of a small number of clinical records, PSD alleged that, due to insufficient detail within the records, the claims a DPL member had submitted could not be supported. PSD therefore sought the recovery of the claims made.

Before seeking recovery, PSD permitted the dentist to review her own records and provide comments on the findings. After reviewing more than 5,000 claims, the dentist concluded that the detail in relation to some claims did not satisfy PSD's requirements. The dentist voluntarily offered to repay more than £10,000 but PSD chose to disregard the dentist's own review and informed her that they intended to recover more than £71,000. They then withheld payments by instalment from her monthly schedule.

DPL instructed solicitors to act for its member and a petition for Judicial Review of the actions of PSD was raised. The petition was granted in February and the actions of PSD were found to be "patently irrational and unfair" and the decision to act as it did was a "material error of law".

The court criticised the actions of PSD for disregarding without explanation the dentist's own extensive review and to instead proceed on the basis of an extrapolation exercise based on a very small number of records. The sum of £48,000 was recovered before the matter came to the attention of the Court.

Helen Kaney, head of dental services Scotland at Dental Protection, said: "In this case, Practitioner Services were found to have misapplied the regulations and acted unfairly and irrationally. It is important that payment verification processes are now reviewed to ensure they are fair and that, in future, Practitioners Services acts in accordance with the law when attempting to recover overpayments.

"Dental Protection would urge all dentists to ensure their records are sufficiently detailed in order to justify any claims made to Practitioner Services Division."

NOW TRENDING

73%

Almost three in four people support proposals to vaccinate boys from HPV, with the 95% of doctors and dentists putting their weight behind the national campaign*

* HPV Action (2017)

FRAUDULENT CLAIMS COST NHS £7.5M

The NHS is missing out on millions of pounds every year because too many patients mistakenly inform their dental practice that they are exempt from paying for their NHS dental treatment.

NHS Counter Fraud Services (CFS) reports that currently one in every six claims investigated are erroneous or fraudulent, at an estimated cost of £7.5 million per annum.

As a result, CFS is launching a prevention campaign in the spring which will use social media messaging and in-practice posters to promote honesty, and encourage patients to click on a link to the CFS website, so that they can check their exemption criteria. Other marketing materials, aimed at dental staff, will be sent to some practices, promoting the importance of informed and accurate claims to exemption.

The impact of the campaign will be measured in both the quantity and financial cost of exemption claims. This will help CFS establish the most effective approach to future campaigns. Practices in some health board areas will not receive posters or other marketing materials until later in the summer, to avoid impacting on the claim data collected for the period of the trial.

Fraud prevention manager Fraser Paterson said: "Stopping monies from being wrongly claimed has never been more important for the NHS. With the help of dental practice staff, we can show how a pre-treatment, prevention-focused initiative, delivered through a multi-stranded approach, can significantly influence patient behaviours and reduce fraud and error."

DENPRO TO CONTINUE AFTER PROCUREMENT SCHEME SUCCESS

DenPro, the NHS-run procurement scheme, is to continue following the success of its initial three-year period of operation.

The contract with current supply partner Dental Directory ends in May 2019.

Paul Cushley, dental director at NHS National Services Scotland, said: "The Chief Dental Officer's office has said there will be a second contract up for grabs next year.

"The spend through the portal has been greater this year than previously. We're committed to supporting dentists and have brought other goods and services to the table to augment the initial offer."

He emphasised that the new contract will reflect learning gained in the initial period and while price will be a major factor in determining potential commercial partners, it won't be the only criterion.

INSIDER ON PAGE 07

> I have heard a lot of rumour and innuendo among colleagues... but I think I'll wait for the detail
>
> ARTHUR DENT

E-DENTAL ROADSHOWS SUCCESS PAVES WAY FOR MORE EVENTS

A series of roadshows designed to introduce dentists to Scotland's new e-dental system has been deemed a success and provided useful learning for future events, according to Paul Cushley, NHS National Services Scotland (NSS) director of dentistry.

The roadshows, which were held in Inverness, Dundee, Edinburgh and Glasgow, were staged by Cushley's colleagues in the Practitioner Services Division of NSS. They included presentations covering e-dental, prior approvals and the pitfalls of the Statement of Dental Remuneration. The first two events were held during the Christmas/New Year period, which was also when e-dental was introduced.

Paul Cushley said: "We had over 440 people at the shows in total and we've already committed to holding more in the autumn. Most likely we'll visit Edinburgh and Glasgow again, and we are talking to the health boards in places such as Lanarkshire, Forth Valley, Ayrshire and Arran, and Dumfries and Galloway to see if they'd be happy to help so we can organise something in their part of the world."

Notably, the roadshows have been classed as verifiable for CPD and CPDA, which it's believed helped boost attendance numbers. "The success of the events was twofold," said Cushley. "We worked in partnership with dentists to manage the transition, and we put a human face on Practitioner Services. Our staff were able to meet our 'customer base' and those customers met the people who are there to advise and support them."

A number of issues were raised by practitioners during the events, from the addition and removal of splints from prior approvals to questions related to CHI numbers and glitches in the system.

Cushley believes lessons learned at these sessions will bring benefits when future roadshows are held. Meanwhile, an event designed for orthodontists is being held at the NSS premises in Gyle Square, Edinburgh on 16 April. "As well as covering e-ortho and e-dental, we will invite companies who provide patient management systems specifically for orthodontic practices," he said.

NEWCASTLE STUDENT JOE NAMED BEST UNDERGRADUATE DENTIST

Joe Reid (25), a student at the University of Newcastle, has been named the UK and Ireland's best undergraduate dentist following a dental clinical skills competition held in Edinburgh in March.

Run by the Royal College of Surgeons of Edinburgh and Dentsply Sirona, the competition, now in its fourth year, saw Joe and his fellow contestants undergo a demanding series of tests.

"I'm quite surprised to have won today, there are a lot of talented people here and it's not something I was expecting" he said.

"It was quite a novel experience competing in the Dental Skills Competition. You don't really compete with each other normally at dental school, and you don't see the quality of other people's work. I think the best part of the competition was spending time with people from other dental schools, as they're people you wouldn't normally meet."

More than 400 final-year students from 18 UK and Irish dental schools took part in the competition, which is designed to test a wide range of clinical skills.

Joe received an all-expenses paid, four-day trip to Dentsply Sirona's Restorative Forum in Konstanz, Germany in June 2019.

Second place went to 24-year-old UCLan student Rowan Glossop, with third place going to 28-year-old Ammar Zakirom the University of Liverpool.

GDC LAUNCHES CONSULTATION ON TRAINING CHANGES

The General Dental Council (GDC) has launched a consultation on proposed changes to the way it quality assures education and training leading to registration for dental professionals.

The regulator says it is seeking to use its resources more efficiently, supporting education and training providers to drive improvements in dental education.

The proposals seek to replace a 'one size fits all' approach, instead taking into account factors such as an assessment of a professional's scope of practice and an education provider's past performance.

Ross Scales, Acting Head of Education Policy and Quality Assurance, said: "We want to channel our resources effectively into those areas that will bring the greatest benefit, while working closely with training and education providers."

MANAGEMENT ON PAGE 63

A performance appraisal is not a chance to tell someone how badly they are performing

SUSIE ANDERSON-SHARKEY

BDA ASKS FOR DATA PROTECTION RETHINK

Government urged to drop plans requiring NHS providers to appoint data protection officers

The British Dental Association (BDA) has asked the UK Government to prevent implementation of EU data regulations heaping unnecessary burdens on dental practices.

Writing on behalf of 40,000 dentists, 11,500 community pharmacies, and 19,000 optometrists and dispensing opticians, the BDA joined with the Optical Confederation and Pharmaceutical Services Negotiating Committee (PSNC) to say the Data Protection Bill, as currently drafted, will mean significant extra costs for small providers.

The bill began its progress through the House of Commons on 5 March.

In a joint letter the groups have written to Minister for Digital and Culture Margot James asking her to drop plans that require all NHS providers to appoint a data protection officer (DPO). They say this goes beyond the General Data Protection Regulation (GDPR), which requires a body to appoint a statutory DPO if it is a public authority or processes certain data "on a large scale".

As it stands, small practices could be forced to hire additional staff or buy in additional services to fulfil this new requirement.

The BDA has estimated the set up and annual costs could add a further £2,000-3,000 to the existing £22,000 compliance bill for single-handed dentists – who make up one in five of the NHS workforce.

Compliance cost for dentists have skyrocketed by over 1,000 per cent in the last decade. DPO costs would easily exceed the costs of core overheads such as professional indemnity and registration.

BDA Chair Mick Armstrong said: "Failure to get these regulations right will further undermine the sustainability of high street health providers.

"Single-handed family practitioners serve millions of patients, and are already under huge financial pressure. Treating them like large corporates and slapping on another £2,000 bill serves no one, and goes well beyond the intentions of the GDPR.

"We urge ministers to urgently rethink their plans. Neither the NHS nor our patients should have to pay the price for badly drafted legislation."

BAD WEATHER POLICY ESSENTIAL, SAYS MDDUS

Recent disruption highlights need for flexibility on rights of staff unable to get to work

Massive disruption by the 'Beast from the East' has shown exactly why medical and dental practices should have a bad weather policy for staff, according to MDDUS.

Last month's severe conditions brought public transport to a halt, school closures and warnings from the police and government to avoid travel in some areas.

In Scotland, Transport Minister Humza Yousaf said it would be unacceptable for employers to dock wages of workers who were advised not to travel during the red weather warnings.

MDDUS employment law team received a flurry of calls from practice managers asking for advice on how to deal with staff no-shows during the disruptions.

MDDUS Employment Law Adviser Janice Sibbald said: "There is no legal obligation to pay staff if they cannot attend work due to the weather conditions. However, the practice may have contractual obligations or have custom and practice arrangements in place from previous years.

"The practice also needs to consider health and safety obligations, as each practice has a duty of care to its employees. Common sense should also be applied. Where there is a Met Office warning to avoid travel, then it is not reasonable to be encouraging employees to come to work.

"Few contracts will include a clause allowing the practice to deduct a day's pay if an employee cannot make it in and employees also have a statutory right protecting them against unlawful wage deductions.

"So, if the practice does not have the contractual right to deduct pay and the employee does not consent to the deduction, a complaint could be raised.

"Therefore, it is important for the practice to be flexible. How such matters are handled can often affect morale and productivity so it is advisable to introduce a bad weather policy that should be clearly communicated to all employees and applied consistently."

NOW TRENDING

52%

In the first six months, GDC case examiners closed more than half of the cases they considered, either giving a warning, advice or no further action*

* General Dental Council

GDC SEEKS NEW COUNCIL MEMBER FROM SCOTLAND

The General Dental Council (GDC) has opened applications for a senior dental professional to join the regulator's council.

Last year the GDC published its plans for reforming dental regulation for patients and dental professionals.

GDC Chair, William Moyes, said: "This is an interesting time for the GDC as we continue to press ahead with the *Shifting the balance* reforms. I look forward to finding the right person to help us take forward this work."

Due to the Council's current composition, and the statutory requirement to have a mix of dental professional and lay members from across the four nations, this vacancy is for a dental professional who lives or works, wholly or mainly, in Scotland.

The closing date for applications is 5pm on Friday 13 April. For further information and to submit an application, visit www.gdc-uk.org/about/who-we-are/thecouncil

For alternative formats, please call 020 7167 6318.

SARAH ALLEN APPOINTED AS EDITOR

The new editor of Scottish Dental magazine is to be Sarah Allen, the former director of membership and communications at the Royal College of Surgeons of Edinburgh.

Sarah has a wide ranging knowledge of the dental sector in Scotland along with extensive experience of both publishing and communications having worked with a number of leading companies and agencies.

Connect chairman David Cameron, said: "I am delighted that Sarah has agreed to join our company at this exciting time in the development of our dental magazines in both Scotland and Ireland.

"She brings a wealth of experience and knowledge that will help to enhance and develop the content and services that we provide for our readers across the dental community."

DENTIST SCALES THE HEIGHTS IN MEMORY OF MENTOR

Zoe Paterson, a University of Dundee dentistry graduate, has climbed Kilimanjaro in memory of her university supervisor and colleague, Dr Garry Sime.

Zoe graduated with a degree in dentistry in 2014, and took on the task of tackling Africa's tallest peak in March, in memory of Dr Sime, who died due to a stroke in 2016.

Before taking on the 19,000 ft ascent, Zoe said: "I actually wanted to take on Everest, but seeing as I've never climbed a mountain before I figured the tallest in Africa might be more achievable.

"I'm climbing Kilimanjaro while fundraising for the Stroke Association, who provide crucial services for stroke survivors and their loved ones.

"Garry was a close friend and a kind soul. He was an incredible mentor and I hope by challenging myself and fundraising for I can raise some awareness of the types of stroke that can kill so quickly."

INTERVIEW ON PAGE 38

> The vital factor for patients is that it allows them to get a solution that's as close to their own teeth as possible
>
> ABID FAQIR

BEST FOOT FORWARD AS PHILIP HITS THE FLOOR FOR CHARITY

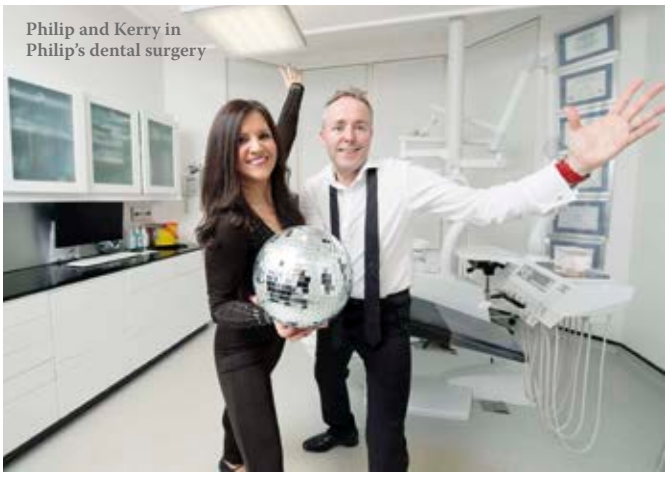
Glasgow dentist's ballroom dancing raises £24,000 for Prince and Princess of Wales Hospice

Implant dentist Philip Friel put on his best dancing shoes to compete in a 'Strictly Come Dancing'-style charity event the Glasgow Hilton in March and helped to raise £100,000 for The Prince and Princess of Wales Hospice.

Philip, clinic director at Philip Friel Advanced Dentistry, was one of seven 'non-dancer' contestants chosen by the hospice to take part in the event and to raise sponsorship.

He started his rumba training with professional dancing coach Kerry Montgomery in January after recovering from a leg injury sustained in a five-a-side football match, training up to three times a week in the run-up to event.

Philip admitted to being "just a tad nervous – but with good nerves" when he hit the dance floor but said: "Such a worthwhile cause made it easier for me to decide to potentially subject myself to much taunting and ridicule from friends and family when I turned out to perform.



Philip and Kerry in Philip's dental surgery

"Kerry was a great teacher and her focus and enthusiasm made sure I trained as hard as I could. "

Each contestant was challenged to raise £3,000 of sponsorship, but Philip's support nearly reached £24,000. He said: "The response from patients, friends, family and clinic associates was incredible and I'm so grateful for the support. It was a once-in-a-lifetime experience and learning to ballroom dance is another ticked off the bucket list!"

The 600-capacity sell-out event was hosted by Carol Smillie and David Farrell, and BBC Strictly show stars Oti Mabuse and Giovanni Pernice were special guests and judges who also performed a series of show dances for the audience.

Philip and Kerry impressed the judges enough to get through to the dance-off but in the end were pipped by Jean Bonner and Federico Ribeiro whose samba performance lifted the glitterball trophy.

One of Philip's dental hygienist colleagues, Clare French, won the prize draw for a dance with Giovanni – an experience she described as "super fun".

MSP SAYS SUPPORT FOR ABANDONING SINGLE UIST HUB IS 'OVERWHELMING'

Western Isles MSP Alasdair Allan has claimed that it's the 'overwhelming and seemingly unanimous view' of people in Uist that plans for a single dental hub should be abandoned.

The MSP has written to the chief executives of Comhairle nan Eilean Siar and NHS Western Isles urging them to take heed of that view.

The redesign of dental services has been discussed at the Western Isles Integrated Joint Board. An alternative three-site model has been proposed by Councillor Paul Steele. The chief executives of the comhairle and NHS Western Isles must make a joint decision on that amendment.

Dr Allan said: "Since these proposals were first put forward, I have made numerous representations on behalf of the communities in Uist.

"The unanimity of representations received by my office against this proposal has been unprecedented. The overwhelming and seemingly unanimous view of my constituents is that the single hub model would be a backwards step in terms of the delivery of dental care in the Uists. The public meetings held on this issue made that abundantly clear.

"I have therefore written to both chief executives urging them to listen to the communities and abandon the single dental hub model."

NEW CLINICAL DIRECTOR IN LANARKSHIRE

NHS Lanarkshire has appointed Anne Moore as the clinical director for Public Dental Service.

She was given the role permanently in January 2018 after undertaking the post in an 'acting' capacity.

Anne is involved in the care and treatment of special care patients in Lanarkshire.

Speaking of her appointment, she said: "I feel very proud and honoured to have been appointed as clinical director for a service which delivers such great care for the most vulnerable patients within Lanarkshire.

"My plans for the future are to further develop our service and strengthen our links with our social care partners, to ensure we continue to deliver the highest quality care for our patients and the population of Lanarkshire through our excellent prevention and clinical teams."

UPCOMING EVENTS

WE'VE GOT THIS COVERED

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

26-28 APRIL
IDA Annual Conference
Galway, Ireland
For details, visit www.dentist.ie

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

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

18-19 MAY
British Dental Conference and Dentistry Show
NEC, Birmingham
Log onto bda.org/conference for more information

17-21 JUNE
94th European Orthodontic Society Congress
EICC, Edinburgh
Find out more at www.eos2018.com

20-23 JUNE
EuroPerio9
Amsterdam
For more information, visit www.efp.org/europerio

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

5-8 SEPTEMBER
FDI World Dental Congress
Buenos Aires, Argentina
Visit www.fdiworlddental.org/events/fdi-world-dental-congress for more information

11-14 SEPTEMBER
British Society of Paediatric Dentistry Annual Scientific Meeting
Dundee
Visit www.bspdconference.org to find out more

27-29 SEPTEMBER
British Orthodontic Conference 2018
Queen Elizabeth II Conference Centre, London
Find out more at www.bos.org.uk

1 OCTOBER
The Infection Prevention Show
Scottish Event Campus, Glasgow
For more information, visit ips.uk.net/conference/infection-prevention-show

4-6 OCTOBER
BDIA Dental Showcase
ExCeL, London
For more information, visit www.dentalshowcase.com

23-24 NOVEMBER
BSDHT Oral Health Conference and Exhibition
Telford International Centre
Find out more at www.bsdht.org.uk/OHC2018

26-27 APRIL 2019
Scottish Dental Show 2019
Braehead Arena, Glasgow
Visit www.sdshow.co.uk for more information

2-4 MAY 2019
ADI Team Congress 2019
EICC, Edinburgh
To find out more, visit www.adi.org.uk

17-18 MAY 2019
British Dental Conference and Dentistry Show 2019
NEC, Birmingham
Log onto bda.org/conference for more information

Indepth

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ESSENTIAL EDITORIAL CONTENT FOR DENTAL PROFESSIONALS

IT'S SHOW TIME

ALL ABOARD FOR THE BIGGEST SCOTTISH DENTAL SHOW EVER!

See page 26

SCOTTISH DENTAL SHOW 2018

SCOTTISH DENTAL AWARDS 2018

ARE YOU READY FOR THE SHOW?

THE SEVENTH SCOTTISH DENTAL SHOW KICKS OFF IN JUST A FEW WEEKS. HAVE YOU PLANNED YOUR TIME AT THE EVENT YET?

There are just a few short weeks until the Scottish Dental Show 2018 returns to Braehead Arena in Glasgow. This year will mark the seventh year the show has been running and it has come a long way since that first event at Hampden Park way back in 2012.

That first Show saw just over 1,200 people through the door, while last year we welcomed more than 2,200 delegates. The event is now a firm fixture in the Scottish and UK dental calendar and it is no exaggeration to say that it is the biggest event of its kind in Scotland.

The 2018 Show will again see 140 exhibitors in the packed trade show, with some of the biggest names in the industry. Our sponsors include Leca Dental Laboratory (Diamond sponsor), DTS (Platinum), Dental Directory (Gold), Dentsply Sirona (Silver), Clyde Munro (Silver) as well as AWB Textiles, Barry Packaging and MDDUS (all Associate sponsors).

The show floor will also see a number of Dentsply Sirona live workshops and there are plans in place for Med fx to host facial aesthetics demonstrations on their stand as well.

The lecture programme will be launched by Monik Vasant on Friday morning. He will be presenting two one-hour lectures, the first will cover 'Composite artistry' and the second will cover digital dentistry and composites. As in previous years, the lectures and workshops will provide up to nine hours of vCPD for every delegate over the two days, with a choice of 13 CORE or GDC-recommended topics ranging from medical emergencies to infection control and from oral cancer to child protection.

The main workshop programme will see full-day programmes from the Scottish Centre for Excellence in Dentistry (SCED) and Philip Friel Advanced Dentistry. The SCED workshops will see Scot Muir and Kevin O'Farrell return with their hugely popular two-part implant workshops covering everything from treatment planning to restoration and prosthodontic planning.

There will also be sessions from Lorna Cox and Louise Warden providing 'Five top tips to managing periodontal disease effectively in general dental practice' as well as Colin Burns presenting a workshop on 'Dental implants for nurses'.

SCED are also bringing dental business coach Chris Barrow to the show for a session entitled 'Marketing in independent practice in 2018'. In this session, Chris will explain the difference between advertising and marketing and how best to get the best return on your investment.

All these sessions need to be booked in advance at www.sdshow.co.uk

OFFICIAL SHOW APP

The official smartphone app for the Scottish Dental Show 2018 is now available to download from the App Store and Google Play. As well as a full list of speakers, lectures, workshops and exhibitors, the app also offers information on exclusive hotel deals and all the latest exhibitor offers for delegates.

MORE INFO

Download the app from the App Store for your iOS device, or to download from Google Play for your Android device. Simply search for 'Scottish Dental'.


CLYDE MUNRO
DENTAL GROUP
SHOW
2017


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SPEAKER ROOM 2

FRIDAY 27 APRIL – LECTURES

	SPEAKERS	TALK TITLE	STREAM	ROOM
9:00 – 10:00	Monik Vasant	Composite artistry	Dentist | Team	1
	Lezley Ann Walker and Liz Webster	A-E assessment	Dentist | Team	2
9:30 – 10:30	Adam Morgan	Selling without selling – the one-hour guide to increasing treatment uptake	Business	3
	Clive Schmulian	Digital dentures	Dentist | Team | Technicians	4
	COFFEE BREAK			
10:45 – 11:45	Monik Vasant	Composites and digital dentistry	Dentist | Team	1
	Angela Harkins (The DDU)	Data protection and ionising radiation – making sense of the new regulations	Dentist | Team	2
	Craig Stirling (Davidson Chalmers)	Practice acquisitions and sales	Business	3
	John Wibberley	Aesthetics and dental technology	Technicians	4
	COFFEE BREAK			
12:15 – 13:15	David Offord and Ross Paterson	Advanced sedation techniques in dental implant surgery	Dentist | Team	1
	Aubrey Craig (MDDUS)	Roles, Responsibilities and Regulation	Dentist | Team	2
	Ashley Latter	How to remain profitable in an NHS world	Business	3
	Tariq Ali	The GDPs guide to dental implants	Dentist	4
	LUNCH			
14:00 – 15:00	Roy Hogg (Campbell Dallas)	Current Hot Topics	Business	3
	James Green (OTA)	Orthognathic model surgery and wafer preparation: The Great Ormond Street Hospital approach	Technicians	4
14:15 – 15:15	Elizabeth Connor	Radiation protection	Dentist | Team	1
	Arshad Ali	Immediate replacement of teeth – where are we now?	Dentist | Team	2
	COFFEE BREAK			
15:30 – 16:30	Martyn Bradshaw (PFM) and Michael Royden (Thorntons)	Selling a practice	Business	3
	Biju Krishnan (Cfast/SmileTRU)	Cosmetic tooth alignment – the missing piece in minimally invasive cosmetic dentistry	Dentist | Technicians	4
15:45 – 16:45	Jillian Eastmond	Head and neck cancer – an overview	Dentist | Team	1
	Kevin Lochhead and Pierluigi Coli	Peri-implantitis	Dentist | Team	2
	CLOSE			

SATURDAY 28 APRIL – LECTURES

	SPEAKERS	TALK TITLE	STREAM	ROOM
9:00 – 10:00	Christine Park	Child protection and safeguarding	Dentist | Team	1
	Brian Millar	All right on the bite (Splint therapies)	Dentist | Team	2
9:30 – 10:30	Adam Morgan	Selling without selling – the one-hour guide to increasing treatment uptake	Business	3
	Abid Faqir	Digital dentistry – guided surgery	Dentist	4
COFFEE BREAK				
10:45 – 11:45	Elizabeth Connor	Radiation protection	Dentist | Team	1
	George Cherukara	Tooth surface loss	Dentist | Team	2
	Martyn Bradshaw (PFM), Michael Royden (Thorntons) and Roy Hogg (Campbell Dallas)	Buying a practice	Business	3
	Sarah Manton	Current developments for the dental team from the Faculty of Dental Trainers at RCSEd	Dentist | Team	4
COFFEE BREAK				
12:15 – 13:15	Lucy Mitchell	Infection control and decontamination update	Dentist | Team	1
	Matthew Roper	Periodontal plastic surgery	Dentist	2
	Ashley Latter	How to sell private treatment ethically in a NHS world and have more patients saying yes willingly	Business	3
	Tariq Ali	The GDPs guide to dental implants	Dentist	4
LUNCH				
14:00 – 15:00	Louise Grant and Anna Coff (EQ Accountants)	Are you prepared for the NHS funding changes?	Business	3
	Flora Couper (Calcivis)	Calcivis imaging system	Dentist | Team	4
14:15 – 15:15	Roger Currie	Mouth cancer	Dentist | Team	1
	Helen Kaney	The highs and lows of helping the dental team at the GDC	Dentist | Team	2
CLOSE				

KEY:

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

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

WORKSHOPS

Places on the workshops must be booked in advance as spaces are limited to 10-20 delegates per session.
All workshops are free unless otherwise stated.
Details of how to book and information on each session is available online at www.sdshow.co.uk/workshops

The workshop area is in the arena atrium, which is accessed via the stairs between stands A6/A20 and D06/D20. The Dentsply Sirona Workshop Area is situated between stands D11/15 .

SCED workshops – Atrium 1
Friday:
- 09.30-10.30 – *Scot Muir and Kevin O'Farrell, Implants Part One*
- 10.45-11.45 – *Scot Muir and Kevin O'Farrell, Implants Part Two*
- 12.15-13.15 – *Louise Warden and Lorna Cox, Five top tips to managing periodontal disease effectively in general dental practice*
- 14.15-15.15 – *Chris Barrow, Marketing in independent practice in 2018*

Saturday:
- 09.30-10.30 – *Louise Warden and Lorna Cox, Five top tips to managing periodontal disease effectively in general dental practice*
- 10.45-11.45 – *Scot Muir and Kevin O'Farrell, Implants Part One*
- 12.15-13.15 – *Scot Muir and Kevin O'Farrell, Implants Part Two*
- 14.15-15.15 – *Colin Burns, Dental implants for nurses*

Philip Friel Advanced Dentistry – Friday and Saturday all day workshop programme– Atrium 3
Details and timings of these sessions will be available on www.sdshow.co.uk

Atrium 2 workshops
Friday:
- 10.45-11.45 – *Lezley Ann Walker and Liz Webster, Medical emergencies*
- 12.15-13.15 – *Lezley Ann Walker and Liz Webster, Medical emergencies*
- 14.15-15.15 – *Rebecca Whiteoak (Dental Directory), Enhanced CPD and completing your PDP*

Saturday:
- 09.30-10.30 – *Jillian Eastmond (NEBDN), Radiography and radiation protection (IRMER update)*
- 10.45-11.45 – *Brian Millar, Quick and clever composite*
- 12.15-13.15 – *Brian Millar, Quick and clever composite*
- 14.15-15.15 – *Jillian Eastmond (NEBDN), Smoking cessation – Level 1*

Dentsply Sirona workshops – Stands D11-15
Visit www.sdshow.co.uk for more information and to book onto these courses.

MORE INFO
For more information and to book onto any of these workshops, visit www.sdshow.co.uk/workshops

EVOLUTIONARY TALK

SCOTLAND'S CHIEF DENTAL OFFICER DISCUSSES THE AMBITIOUS PLAN FOR THE FUTURE OF THE COUNTRY'S ORAL HEALTH AND THE CHALLENGES OF MEETING THE NEEDS OF AN AGEING POPULATION

TIM POWER MIKE WILKINSON

Following the publication of the new Oral Health Improvement Plan (OHIP) in January, the press headlines have highlighted some of the more ambitious aims of the new policy, such as dentists going out into the community to offer services, the reduction in regular check-ups and the end of scale and polish.

This has raised some alarm in the dental community but Margie Taylor, Scotland's Chief Dental Officer, says this is just scaremongering. *Scottish Dental* magazine spoke to Margie who boldly stated the new plan is going to "change dentistry for the next generation" but she wants to make it clear the new plan is based on "evolution and not revolution" She insists the OHIP is a starting point for conversations with the profession who will have a say on how it develops.

Margie explained: "We want to do this properly and we want to do it by taking full cognisance of the views of the profession – so we are all ears."

So what does OHIP mean for the future of Scottish dentistry? Margie believes that it means a great deal for the future of people's oral health in Scotland, as well as the future of dentistry. She explained: "We are very fortunate in knowing what causes disease and also knowing what prevents it, so it seems rational and realistic to implement what we know works – and this plan helps to do exactly that.

"Dental practitioners have been working very hard over the years to improve oral health, but what we need to do is to make sure the system allows them to work on that further.

"We also have to tackle the problem of our ageing population. We have never had so many older people who are frail but have their own teeth. It's uncharted territory but we need to have the capacity to provide dentists to go into people's homes or care homes and be experienced enough to deal with somebody who is suffering from dementia, who may be suffering from toothache but unable to describe it.

> "WE HAVE NEVER HAD SO MANY OLDER PEOPLE THAT ARE NOW FRAIL BUT HAVE THEIR OWN TEETH. IT'S UNCHARTED TERRITORY"
>
> MARGIE TAYLOR

"It's a completely different challenge when you are trying to do that type of treatment without the usual equipment in your surgery and in different surroundings.

"But we have to be realistic about our expectations. One of the things in this plan is to accept and recognise that people who have not done domiciliary care for a long time may not feel comfortable about doing it now. The Public Dental Service (PDS) are clearly the ones who have got the most expertise but with the increase in the ageing population they are not going to be able to treat everyone – and there is no reason why they should really, as GDPs are experienced enough to contribute to that service."

Under Part 4 of the plan – Meeting the needs of an Ageing Population – Action 11 calls for the Scottish Government to introduce arrangements to enable "accredited" GDPs to provide care in care homes. There is great

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"THE IMPORTANT THING IS THAT PEOPLE ARE ACCESSING THE DENTIST WHEN THEY WANT TO AND NEED TO"

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interest in how this accreditation scheme will be set up, but Margie said it is still early days and the establishment of the scheme will require further consultation with dentists.

She said: "Our intention is to discuss the accreditation details with the profession. The people that have got the expertise at the moment are the PDS and it could well be that they would be in a position to help train GDPs, but we are still to discuss that with both those groups.

"As I've said, we are going for evolution and not revolution, because one of the very important issues that we have to recognise is the financial sustainability of general dental practices. Shona Robison, the Cabinet Secretary for Health and Sport, has reinforced that message and she also wants to make sure that practitioners have the confidence that we recognise their financial sustainability is an important issue."

As regards the numbers of GDPs that would be required to be "accredited" to serve people in care homes, this is still under discussion.

When asked about financial incentives to 'persuade' GDPs to provide domiciliary visits, Margie believes there is a genuine will to help but dentists may need support with the right equipment for home visits.

She said: "I don't think I will convince every dentist to do home visits but we will be discussing with them what the incentives need to be – and one of the issues is having the right equipment to go into a home or care home."

Financial sustainability is high on a lot of dentists' concerns when it comes to a wholesale change in the system of remuneration, such as the SDR and grants, and particularly, with "perceived" declining attendances, measures in the new plan to extend the period between check-ups to two years, and, potentially, drop scale and polish procedures.

While there has been concern about the declining numbers attending dentists, Margie argues that registration numbers are just as important as attendance rates, which are currently around 70 per cent of the population.

She said: "The vast majority of the dentists I know are in the business of dentistry to improve the oral health of their patients, so I'm sure they consider that as a priority. But, equally, they have to maintain the sustainability of the practice and we, of course, want them to do that as well.

"If you've got registration going up, and participation as defined as the people who have been to the practice in the last two years, the people who are newly registered will not have had a chance to be there in the last two years – so participation is always going to look like its coming down if the registration is going up at a particular rate.

"The important thing is that people are accessing the dentist when they want to and need to. In order to address that there needs to be plenty of dentists – and we have got that right now.

"Clearly, we want people to go back regularly to see their dentist but there is a limit to how much the government can encourage people to do that – to an extent we are relying on the practitioners to encourage their own patients back to the practice. And the figures show that the actual number attending is higher than it used to be."

When it comes to the SDR and grants, Margie admits that the current system is too complicated and needs to be simplified, but wants to allay dentists' fears if they think everything is going to change on 1 July.

"At the moment there are more than 400 things you can do to someone's mouth! This is extraordinary and it seems a few too many to manage.

"There's a lot of discussion to be had with the profession and one of the reasons we have not had wholesale change of the SDR is because of the impact it might have had on practices.

"We said in the consultation that grants are confusing but it's not our intention to reduce the quantum. Our intention is to make it easier to apply for them and make it more straightforward – similarly with the SDR.

"We want to make changes at a pace that not only brings about a health improvement but also maintains the financial viability of the practices – this is at the forefront of our minds."

Margie said that one of the common misconceptions about the SDR is that every single item is based on the cost of providing

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the procedure, plus a profit margin for the dentist. She explained: "The SDR is based on what the average practitioner covers during an average amount of treatment and to give them a reasonable living at the end of the day. There are some elements that do not cost anything to provide in terms of sundries, for instance oral health advice, but there are other things that are more expensive and the SDR is designed to balance these out.

"But if you go down the route of describing absolutely everything and what the profit is in relation to that item then you will get great disparities. What we aim to do is to give practitioners a reasonable living but it's not based on absolute profit margins for every single item."

While oral health advice does not consume sundries it does take up a valuable part of dentist's or hygienist's time and some practitioners have asked whether they will be recompensed for this as prevention is the main theme of the new plan.

Margie said: "If you are tackling periodontal disease you are expected to give the patient oral hygiene advice but if we are moving the whole system towards prevention – and we are saying that that is very important – what we need to do is work out with the profession how we achieve that.

"One of reasons why the allowances came in was to try to get the practitioners off the capitation treadmill – it's a fine balance and we will be speaking to them about what that balance should be."

In the section, 'Focus on Prevention', the document states that people with good oral hygiene could be left for up to two years between appointments – a cause of concern regarding the detection of oral cancers from some dentists.

Margie said: "I can understand that thought, and, although the guideline from NICE said up to two years, I think it's a big leap to say to people who have been coming in every six months for the last decade to say to them that we want you to come every two years.

> "DENTISTS ARE VERY GOOD ABOUT THINKING IN DETAIL - AND WE WANT TO HEAR WHAT THEY ARE CONCERNED ABOUT AS WE ARE SETTING UP WORKING GROUPS TO ADDRESS THE ACTIONS IN THE PLAN. THIS IS HOW WE ARE GOING TO CHANGE DENTISTRY FOR THE NEXT GENERATION"
>
> MARGIE TAYLOR

"But quite a lot of people go annually at the moment, so that should not be too much of an issue, especially if they have a history of good oral hygiene and have not have had any problems. The high-risk ones, for instance older, smoking, drinking males, you would probably want to see them more regularly."

One of the more controversial elements of the new plan is its downgrading of scale and polishing as an effective measure against the prevention of gum disease… and a valuable income stream for dentists.

She said: "I think there has been a bit of scaremongering going on about this because if you read the document it's pretty conservative about scale and polish, but people have interpreted the evidence and have concluded that we are getting rid of them.

"What the evidence has shown for your patient who is a regular attender, and is looking after their mouth is that the simple scale and polish is not of any more benefit than actually giving oral hygiene advice. But, of course, there are a lot of people that can't or won't look after their mouths or have not attended the dentist for a long time – so it is too big a leap to say we don't need scale and polish any more."

During the discussion, Margie reiterates her "evolution not revolution" mantra and the need for further consultation with the profession. She said: "We consulted widely before the plan was developed, both with the practitioners and the public, and as I've discussed here there is more consultation to do with GDPs.

"Dentists are very good about thinking in detail – and we want to hear what they are concerned about as we are setting up the working groups to address the 41 different actions identified in the plan.

"This is how we are going to change dentistry for the next generation in order to improve oral health and reduce inequalities."

MARGIE TAYLOR – RECOLLECTIONS OVER 10 YEARS

Margie Taylor took up post as Chief Dental Officer (CDO) for Scotland in May 2007 and looking back over 10 years at the helm of the profession she regards her tenure as an "enormous privilege".

She explained: "My role is to improve the health of the population so to have that as one of my main aims is just perfect as far as I'm concerned."

She said that the biggest change over her tenure has been the improvement in oral health: "When I started nearly 40 years ago, I spent a lot of time taking teeth out of children and I realised that there must be a better way of dealing with this. Prevention seemed to me to be the obvious way forward so when I hear from practitioners and others that dental health is improving – and we see this in the statistics – that's the biggest change for me.

"I'm not saying that because I want to take credit for it because the CDO does not achieve anything unless there are a whole lot of other people contributing to the cause."

She's also impressed with the commitment and resilience of the dental community to meet challenges, such as the introduction of decontamination facilities.

She said: "I'm enormously proud of the profession and how they reacted to this under extremely difficult circumstances. This was an enormous change for them but the profession responded incredibly well."

While access to dentists has improved over the past decade, Margie is concerned about the affect Brexit will have on dental provision, particularly in more rural and isolated areas.

She said: "When I came into post there was an access problem – we did not really have enough dentists at the time, so we've taken the steps to fix that. But now I think Brexit will cause issues as nearly half the dentists in some of the rural areas of Scotland are from the EU. So, with Scotland not becoming as attractive to dentists compared to their home EU countries, this is going to mean our workforce planning is not going to be as straightforward.

"But while being Chief Dental Officer is not always plain sailing, even on a bad day you just remember it is just a privilege to be in the job."

IMPLANTING EDUCATION INTO PRACTICE

AS THE RECENTLY-ELECTED PRESIDENT OF THE ASSOCIATION OF DENTAL IMPLANTOLOGY (ADI), ABID FAQIR IS DETERMINED TO DO ALL HE CAN TO SUPPORT THE ONGOING DEVELOPMENT OF THE ASSOCIATION, WORKING ALONGSIDE HIS FELLOW COMMITTEE MEMBERS

STEWART MCROBERT

Abid Faqir is the fourth Scots (or Scottish-based) president in ADI history, and, as he settles into his two-year term of office, he has a clear set of goals.

"The ADI aims to promote education for implant dentistry, promote implant dentistry to the public, improve the options available to patients, and let them know what to expect from the discipline. My plan is to continue concentrating on these areas.

"Among other things, that means continuing to develop ADI's patient-focused website 'Considering dental implants', as well as the organisation's own site. That's a valuable space that gives dentist members, and those who want to join up, information about implant dentistry events and guidelines and protocols.

"Both that and our Facebook page for members also helps people create a network of like-minded individuals where the can share thoughts and ideas.

"My aim is to try to improve and develop those platforms as well as enhance member benefits, increase membership numbers and continue to collaborate with industry, course providers and other bodies important to implant dentistry. It's particularly important to meet and discuss current issues with the GDC and the defence unions."

The ADI hosts a range of events throughout the year. One notable occasion is the ADI Focus Meeting at the ICC in Birmingham on 17 November, which will have five top speakers coming from across the world to discuss new ideas in implant dentistry.

"We are always looking at keeping ourselves ahead of the game," said Abid.

"ANY DENTISTS WHO WANT TO GET INVOLVED IN IMPLANT DENTISTRY, WHETHER THEY ARE NOVICES OR OLD HANDS, SHOULD BECOME ADI MEMBERS"

ABID FAQIR

MASTERS OF DESTINY

Abid provides implant dentistry at the Scottish Centre for Dental Excellence, based in Govan, Glasgow and is co-owner of Ecco dental group, a privately-owned mini corporate with practices throughout Scotland.

His own history with implant dentistry goes back to his completion of a Masters in Primary Care in 2003 – he'd qualified in dentistry in 1999 and has achieved Membership of the RCSEd.

"During the Primary Care programme I got the chance to place my first implant, although the first occasion in practice didn't come until the end of 2004. From the start, I enjoyed the surgical aspect of it and implant dentistry became something I was keen to learn more about."

It became his main focus in 2006 when he undertook an extensive overseas course and spent a lot of time learning as much as possible, finding out about the limits and possibilities of implant dentistry.

That experience taught him about the need for a structured pathway for learning – something he'd recommend for anyone keen to find out more about the topic. "The way to start is to take a short course so that you get some understanding of what implant dentistry is. Thereafter, you should look for something that's a bit more long-term and intense and allows you to place implants. As part of such a course, it's good to have someone watching over you who can mentor you long-term."

REGIONAL REPRESENTATIVE

A member of ADI for more than 10 years, Abid got involved at committee level approximately five years ago when he became regional representative for Scotland. Following on from that, he was elected as treasurer for two years and then voted in as president-elect for another 24 months.

"Paul Stone was the first Scottish, or Scottish-based president in 2003, followed by Stephen Jacobs, then Philip Friel. Our numbers are going to go up again – after my term of office is up, the current president elect, Eimear O'Connell of Edinburgh, will follow on.

"I'm lucky to know every past president extremely well, both professionally and

LEFT: Abid Faqir with outgoing ADI president Craig Parker

personally. From speaking to them about cases to travelling with them on courses they have been closely involved in my career."

Abid sought the counsel of those former-president colleagues when he was considering running for the post, and all were extremely encouraging. "Initially, I was worried about the time commitments and especially did not want to miss out on time with my children. I knew a lot of travel to London would be involved, but it's something I wanted and needed to do – I want to give back to the profession in any way I can."

His time as president-elect provided good preparation. He was involved in helping the then president – Craig Parker – to promote initiatives and events and, where necessary, helping to make sure long-running projects proceeded as intended.

PERSONAL EXPERIENCE

As well as valuing the benefits the ADI provides for his fellow professionals, Abid's determination to see the organisation continue to flourish stems from personal experience. "The ADI has been very important for me because, as a UK-based association, it's helped shape my career.

"Young dentists and those who are new to implant dentistry need direction and to be in touch with people who have either been through, or are going through, a similar career path. There's no better way to do that than be part of an organisation like ADI. I'd say that any dentists who want to get involved in implant dentistry, whether they are novices or old hands, should become members of ADI."

Implant dentistry is not considered a speciality by the GDC – it's a sub topic of a number of other specialisms. Abid believes it will always remain the preserve of general practice.

"This is a personal opinion, but I don't think it will ever be made a speciality. The majority of implant dentistry is fairly straightforward and can be done in general practice by well-trained and experienced dentists. Nevertheless, it's a very important part of dentistry. The vital factor for patients is that it allows them to get a solution that's as close to their own teeth as possible and they can continue to function without resorting to dentures."

Looking forward, his hopes are based around the continuing development of ADI and those practices he is involved with, as well as delivering good, reliable care to his patients.

"On a personal level, I'd like to spend more time with my kids and help them develop their future. Who knows, in time if they decide on dentistry as a career it would be nice to give them any help I could."

ADI COMES TO EDINBURGH

A significant amount of Abid's time as president will be spent in helping to ensure the success of the 2019 ADI congress, which will take place at the EICC in Edinburgh. The congress is always a special occasion and Abid is delighted it's being held in Scotland during his presidency. "We chose Edinburgh because we wanted a location that would be appealing to delegates."

ABOUT THE ADI

The Association of Dental Implantology (ADI) is a registered charity dedicated to providing the dental profession with implant education and the public with a greater understanding of the benefits of dental implants. Its roots were established in 1986 when a small group of dentists set up the London Study Club as a means of providing general dental practitioners with access to advances in implantology. The ADI was incorporated and charitable status as an educational body granted in May 1988. It has more than 2,000 active members across the UK.

THE LATEST IN RESEARCH AND PRACTICE DEVELOPMENT

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EVIDENCE-BASED DENTISTRY IN PRACTICE

RESEARCH

Niall McGoldrick and Derek Richards present the first part in a series of articles looking at how dental professionals can identify, use and maximise evidence-based dental research in their everyday practice

This article is the first in a series that aims to introduce the modern-day dental practitioner to evidence-based dentistry (EBD). After reading this series, you will be clearer about how to keep abreast of the ever-growing evidence base and the latest guidance. You will know where to look for evidence and learn how to maximise time spent searching for evidence to inform your practice.

In our day-to-day lives we have become accustomed to using search engines such a Bing or Google to help answer simple questions, but, when it comes to our clinical work and professional life, we need to take a more formal approach in our search. There are a number of web-based scientific databases that catalogue evidence. The databases can be thought of as massive online libraries, but like any library, if you don't know your way around it or the cataloguing system used, then you are likely to get lost and spend hours searching for what you need. Therefore, having an awareness of the different scientific databases available and understanding how to use them is a good starting point.

An example of a well-known database, and one you may have already used, is PubMed. Simply typing the word 'dental' into the search box on PubMed results in more than half a million hits – 516,870 to be precise. These 516,000 hits are spread over 25,844 pages, which makes for a lot of reading. Clearly, we need a more focused approach. So, what then if we pick a subject within dentistry such as fluoride varnish? This search still returns 1,293 hits spread over 65 pages.

There is some skill required to negotiate databases and identify evidence. A busy practitioner needs access to high-quality evidence quickly and easily

The point we are demonstrating here is that there is a wealth of information and publications that we can make use of, but there is some skill required to negotiate databases and identify quality evidence. A busy practitioner needs access to high-quality evidence quickly and easily.

Evidence-based dentistry

The American Dental Association describe EBD as "an approach to oral healthcare that requires the judicious integration of systematic assessments of clinically relevant scientific evidence, relating to the patient's oral and medical condition and history, with the dentist's clinical expertise and the patient's treatment needs and preferences."[1]

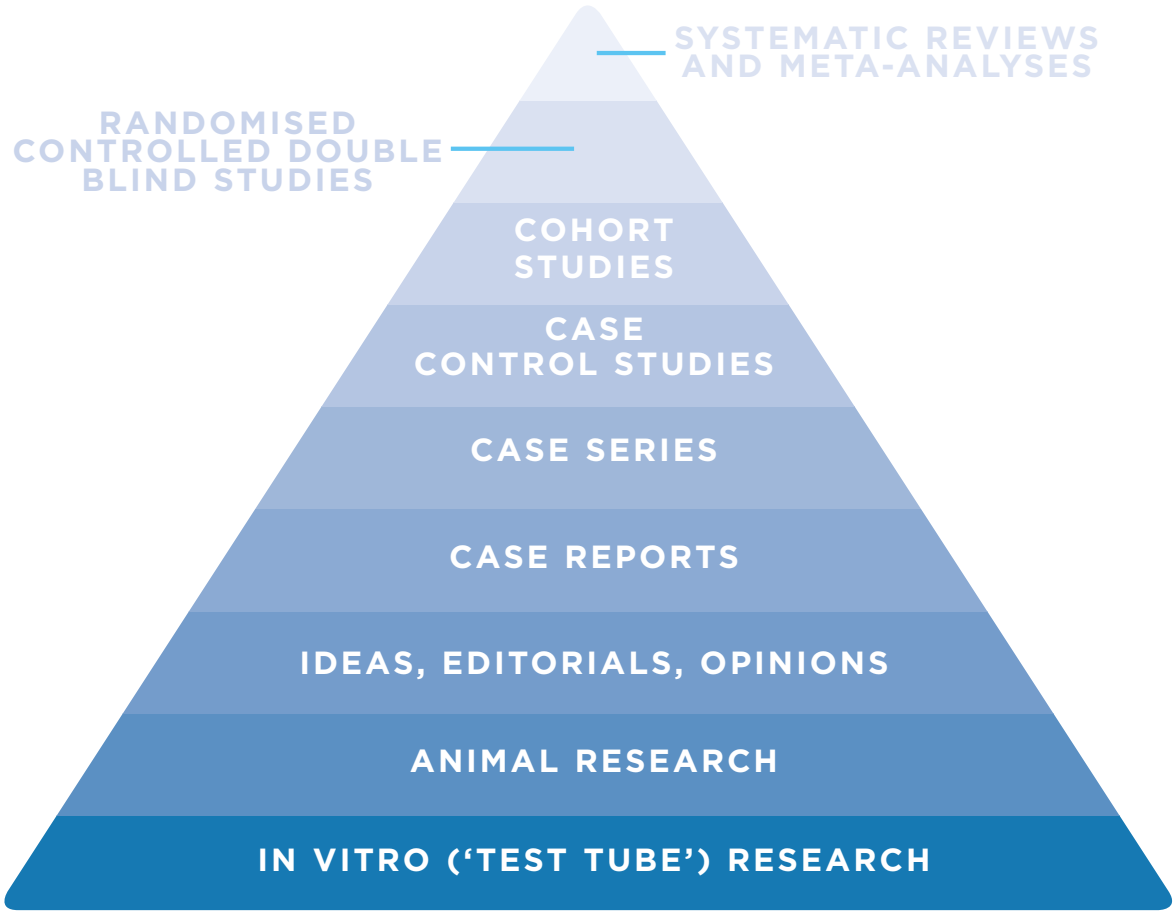
As dentists we want to do our best for each and every patient we treat, and this is at the heart of EBD. Most dentists will be confident in their clinical skills and will listen to patients but not all will be confident in the strength of evidence behind how and what they practice. The evidence should be a constant go to for a modern day dentist.

Developing an evidence-based approach can be thought of in five stages:

- 1. Asking the right question
- 2. Searching for the best available evidence
- 3. Critically appraising the evidence
- 4. Applying the evidence
- 5. Evaluating the outcome.

In your life outside of the surgery, you will already be using this approach, whether you realise it or not. Take buying a new car, for example. Let's say it is a used car; you may not want to rely solely on the sales person's word that

Figure 1: Hierarchy of evidence [2]



the shiny car on the forecourt really is the best one for you. You will need to think about what it is you really need from the car – is a sporty convertible with two seats and no boot space going to suit your lifestyle? Maybe it is.

Most people will search the internet comparing various cars on independent websites; they will look in magazines or speak to friends and family beforehand. So, when you arrive at the showroom you already have an idea of what you are looking for and what you need from a car. At this point you have carried out the first stage of an evidence-based approach: Asking the right question. You have also begun the second stage: Searching for the best available evidence.

When you have identified a potential car, you will want to continue your search for evidence to support your decision to buy. You will want to know more details about the service history, you might inspect the paint work, check how many miles it has done and ask about previous owners. You will combine this information with what you found out previously and check the quality of the evidence before you. This is stage three: Critically appraising the evidence.

Next comes the big decision; whether to go ahead with the purchase. After carefully considering all the evidence you have available, you may or may not decide to buy the car, this is stage four: Applying the evidence.

The final stage is evaluating the outcome. This will take place in the months and years to come when you will be driving the car. If the car keeps breaking down and needs multiple new parts, you might question your approach and the evidence upon which you based your decision.

In this article we will cover stages one and two of the evidence-based approach.

Asking the right question

Evidence-based dentistry starts with a clinical question. You need to be clear about what it is you are trying to find evidence for. A good technique to help develop your question is to use PICO.

What is PICO?

PICO is an acronym for Population, Intervention, Comparator and Outcome. It is used when developing a question regarding a clinical scenario. Say, for example, you are a general dental practitioner; you suggest that the five-year-old patient in your chair should have fluoride varnish applied to her teeth. The patient's parent questions this; he asks you "what good will it do?", and at this point he does not provide consent.

Using the PICO approach, we can build our question and start our search for the evidence. First of all, we need to establish the key population group that we want to find evidence about. In this case, it is children.

Next, we need to think about what treatment we are proposing and what the alternative might be. Here, we are proposing fluoride varnish application and the comparison

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would be no fluoride varnish. You could also choose an active treatment for comparison, such as fluoride mouthwash or toothpaste. Having an alternative prevention option might help win over the parent in this scenario.

Having a clear idea about what outcome you want from the treatment is important. Here, our key outcome is the caries rate in the child.

As a result of this process, we now have a PICO question we can use in a database search:

- Population, patient or problem: Children
- Intervention or treatment: Fluoride varnish
- Comparison: No treatment
- Outcome: Caries.

Searching for the best available evidence (AQUIRE)

We now have a clear PICO question for moving forward with and have completed stage one. In the next stage, we need to think about the types of evidence there are and where we can find them.

This section will aid you in the search for the best available evidence. It has two parts. In the first part we will explore the hierarchy of evidence and the uses for each type, while the second part published in the next article, will take you through the practicalities of different databases.

Types of evidence

First let us think about the different types and levels of evidence available. The most common and easy way to think about evidence is as a pyramid or hierarchy as shown in Figure 1 on the previous page.

It is quite intuitive, with the highest levels of evidence found at the top of the pyramid. Each type of evidence has a role to play in shaping healthcare. We will work our way up the pyramid discussing each of the types of evidence in turn while exploring the pros and cons of each.

In vitro/animal research

Animal and in vitro research can be useful in the initial stages of developing treatment, for example when exploring causes behind disease or investigating an early idea or hypothesis.

The dental materials we use are initially tested in the lab. If they fail at this stage then there would be no point in testing the material in humans without overcoming the initial flaws identified.

With animal experiments there can be an issue when it comes to translating or replicating findings in humans. Some treatments may never work or they may actually be harmful to humans. The process of getting from the lab bench to chair side can take decades of refinement.

In this article, our focus is on what works best in the clinical situation and therefore this type of lab-based study is not immediately transferable into practice.

Initially, most people think their own ideas are great, but do they stand up to the scrutiny of others? Ideas need testing

Ideas, editorials and opinions

Initially, most people think their own ideas are great, but do they stand up to the scrutiny of others? As we mentioned above, ideas need testing. Personal opinions and written editorials often only provide one view point. Therefore, it would not be a good idea to change your practice based on a discussion over a cup of coffee or on a single editorial on a website, magazine or journal.

There are occasions when a combined opinion can be useful though. Sometimes professional groups come together to give an opinion or stance on a particular issue. This often involves bringing together a range of currently available evidence. The downside is that the opinion will include some of the group's own biases.

A recent example of a professional group summarising evidence is the Scottish Consultants in Dental Public Health Group, *Recommendations on the use of fluoride toothpaste and fluoride supplements in Scotland 2017*[3]. The document is clearly referenced and has been produced in consultation with a renowned guideline development group. This type of opinion holds more weight and can be taken more seriously.

Case reports/Case series

A large number of articles published in dental journals tend to be case reports or case series. They are based on one or very few cases. Treatment is often provided by one practitioner with a particular special interest or expertise. It may be difficult to directly replicate the treatment situation. Also the patient characteristics are unlikely to be exactly the same as your patient.

They are particular useful in the case of rare or serious events. A case series published in 2012 presented two cases of fatal anaphylaxis following irrigation of tooth extraction sockets with chlorhexidine[4]. Rare events such as this can change practice very rapidly.

Case control studies

Case control studies are retrospective observational studies. They do not test an intervention but are used to help find

out what might cause a disease or be associated with it. As the name suggests, they are made up of two different groups, cases and controls. Cases will have the particular disease of interest and will be compared to controls that do not have the disease of interest. Researchers will take extensive histories from both groups and compare factors such as lifestyle. They are useful for establishing risk factors that are associated with a disease.

Recently there has been a lot of interest in understanding the causes of dementia. With an ageing population, if we could find out how to prevent dementia then this could have a great impact on the health of the population. One hypothesis queries whether periodontitis has any association with dementia. A research group in Granada carried out a case control study to find out if there was such an association. They compared 180 people with cognitive impairment to 229 without any impairment. After controlling for known risk factors they found there was a statistically significant association between periodontitis and dementia[5].

As mentioned before, case control studies are useful for establishing if associations exist between risk factors and disease. A lot more evidence is required in order to prove causation and establish the sequence. In this example, one might question whether the periodontal disease came before the dementia or whether the patient developed dementia and then stopped brushing as well as before? If you want to learn more about causation, then a good starting point is to read about the work of Sir Austin Bradford Hill. Sir Bradford Hill was an epidemiologist during the 19th century, in an after dinner speech he set out a number of considerations that should be taken into account when trying to establish causation[6].

Cohort studies

Cohort studies are another form of observational study and are much more useful in establishing causes of disease. As the name suggests, they include a cohort of people with all the subjects included in the study initially free from the disease of interest. Detailed histories and in some cases examinations take place at the beginning of the study. The cohort is then followed up, often over a number of years, and observed for signs of the disease.

One of the most famous cohort studies took place in the US in a town called Framingham. The town in Massachusetts was to be the centre of a study that has now lasted 69 years. It focused on understanding the causes of cardiovascular disease as public health specialists recognised this as a major threat to the population of the US. People in the town who were free of cardiovascular disease were enrolled in the study and observed for many years. Detailed information on behaviour, lifestyle and other characteristics were recorded. Investigations including blood pressure monitoring and ECG's were carried out as the study progressed. It took 10 years for the first key finding to emerge. The researchers were able to show that as blood pressure increased, the incidence of coronary heart disease also increased[7]. The study produced the foundations of preventative medicine and discovered many of the causes for heart disease that we aim to prevent today.

Randomised controlled trials

A randomised controlled trial is the study of choice for testing new interventions in dentistry. They are experimental in

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GET INVOLVED

General dental practitioners have opportunities to get involved in clinical trials, especially in Scotland. A number of trials have been run from the University of Dundee including the IQuad trial which is an acronym for Improving the Quality of Dentistry. This trial looked at the effectiveness of the simple scale and polish on periodontal disease with published results expected soon. Find out more here http://dentistry.dundee.ac.uk/nihr-hta-iquad-trial.

The FiCTION trial, again it is an acronym, which stands for Fillings in Children Teeth Indicated or Not. Find out more here http://dentistry.dundee.ac.uk/nihr-hta-fiction-trial

Recruitment to the latest clinical trial called REFLECT is ongoing. The trial is focused on understanding more about the effectiveness of 5000ppmf toothpaste. Dr Carly Ross BDS (Gla) MJDF (RCSEng), clinical research fellow and honorary specialty registrar in special care dentistry at the University of Dundee Dental School, explains about the role of general dental practitioners in helping shape the evidence.

WHY DOES EVIDENCE-BASED DENTISTRY MATTER TO A GENERAL DENTAL PRACTITIONER?

General dental practitioners have an important role to play in evidence-based dentistry. Along with the current scientific evidence and the patient's needs, a GDP's own clinical expertise helps to shape the concept of evidence based dentistry. From this, clinical guidelines can be produced which assist GDPs in providing high quality clinical care using the best available evidence.

HOW CAN DENTISTS GET INVOLVED IN TRIALS AND SHAPING OF THE EVIDENCE?

Ninety per cent of dental care is provided in primary care so it is essential that research is conducted in this setting. Many clinical trials take place in primary care in Scotland so input from GDPs is important to allow high-quality research to be carried out. The REFLECT clinical trial is being carried out in general dental practices and aims to evaluate the effectiveness and cost benefit of prescribing high dose fluoride toothpaste in older adults. The trial is currently recruiting practices in Scotland to take part.

If you are interested in taking part, please email reflect@dundee.ac.uk or call 01382 381 213 for more information.

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nature and use randomisation techniques to reduce risk of bias and confounding factors that may influence outcomes. Patients are selected against strict inclusion and exclusion criteria ensuring they have similar baseline characteristics. There are then randomised into two arms, treatment and control. In the treatment arm, the subjects receive the new treatment under investigation. This is compared to the subjects in the control arm who will receive either placebo or current standard therapy.

Using a randomisation process to allocate patients to the different arms of a trial reduces the risk of selection bias, which is present when there are systematic differences between baseline characteristics of the groups being compared. Randomisation is best done using a computer-generated sequence that is independent of influence from the investigators. A trial that conceals group allocation from both the patient and the investigator is described as double blind, in that neither know if they are receiving the new treatment or the alternative be that a placebo or standard care. At the end of the trial, the outcomes from each arm are then compared for any differences and inferences drawn on whether the treatment is effective.

There have been many randomised controlled trials (RCT) in dentistry, all of varying standards. Although an RCT is high in the hierarchy of evidence, it is still important to critique how the research was carried out and to what standard. We will cover that in article two.

Systematic reviews

The highest level of evidence is a systematic review. They bring together all the existing evidence on a particular question. Systematic searches of the literature are initially broad and can result in thousands of hits on databases such as PubMed. The review team will set criteria to focus the review down to include studies that answer specific questions. They then carry out critical appraisal of the studies to assess quality. If the studies all measure similar outcomes then the results of the trials can be compared by extracting the data and using statistical techniques in a meta-analysis. This gives more weight to the studies.

Guideline development groups

Guidance documents aim to bring together the current best available evidence on a given topic and make recommendations. National Guidance Groups such as Scottish Dental Clinical Effectiveness Programme, Scottish Intercollegiate Network and the National Institute for Clinical Excellence comprise a team of expert researchers and clinicians. They have a formal methodical approach to appraising the evidence; they combine this with expert opinion to arrive at their recommendations. We will look more at guidance and the influence they have on practice in the next article, which will feature an interview with Dr Doug Stirling from SDCEP.

EDITOR'S VIEW

The Cochrane Collaboration carry out systematic reviews that include evidence derived mainly from randomised controlled trials. They use strict methodology and techniques for carrying out reviews and they can be thought of as setting the standard of how reviews should be conducted.

Dr Thomas Lamont, clinical research fellow and honorary specialty registrar in restorative dentistry at Dundee Dental School, is a clinical editor with Cochrane. Below he tells us in some more detail about the methods used in a Cochrane review and what his role is.

WHO IS INVOLVED IN A COCHRANE SYSTEMATIC REVIEW? WHAT IS THE SKILL MIX?

Cochrane systematic reviews will include multi-disciplinary teams including patient representatives, clinicians, clinical academics, methodologists, statisticians, health economists, editors and copy editors.

YOU ARE A CLINICAL EDITOR, WHAT IS YOUR ROLE?

As clinical editor, I help the review groups by providing clinical and methodological advice to the teams. I also help to peer review Cochrane reviews to ensure they meet the required Cochrane standards. I also provide lectures/seminars on the Cochrane review methodology to clinicians and academics.

WHY DOES REVIEWING THE EVIDENCE MATTER?

It is important that we review and integrate the evidence to ensure that we provide the best possible care for our patients. This cannot be done in isolation and needs to be combined with our own clinical experience and the wishes/values of our patients.

WHAT RELEVANCE DO THE RESULTS OF A COCHRANE REVIEW HAVE TO A GENERAL DENTAL PRACTITIONER?

Cochrane reviews provide high-quality evidence for use in the field. They add to the evidence base and distil a large amount of information, therefore making it easier for clinicians to make sense of all the available evidence.

Find out more about Cochrane here: oralhealth.cochrane.org

Conclusion

So now we have reached the top of the pyramid and it should be becoming clear that there is a wealth and variety of information out there. We should be mindful of what evidence exists for the treatment we are providing our patients. Each type of study or research has its own pros and cons. The next article will focus on the practicalities of where to find the evidence, how to get the most out of databases and, importantly, how to critique the evidence you find.

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Niall McGoldrick BDS, MFDS RCPS(Glasg), is a specialty registrar in dental public health and is currently studying for his masters of dental public health at the University of Dundee. He graduated from Dundee Dental School in 2013 and then went onto complete longitudinal dental foundation training and dental core training in a range of specialities in Scotland including a placement with the SDCEP. He is a co-founder of the Scottish Charity, Let's Talk About Mouth Cancer that is focused on the early detection of mouth cancer. He has received multiple awards for his work both inside and out of the NHS. Most recently, he received a National Award, NHS Young Achiever, from NHS Scotland and Scottish Government.

VERIFIABLE CPD QUESTIONS

AIM

To provide an introduction to the need for evidence-based dentistry, and outline core skills and concepts.

OBJECTIVES

- To demonstrate the process of developing a good clinical question
- To explain the hierarchy of evidence and define each of its elements
- To highlight the pros and cons of the different types of research study
- To share details on current research studies in Scotland and information on how dentists can become involved.

LEARNING OUTCOMES

After reading this article you should be able to:

- Describe the hierarchy of evidence
- Recognise the need for an evidence based approach to dental practice
- Recognise different types of research
- Be aware of how research can influence practice.

GDC Development outcomes covered: C – Maintenance and development of knowledge and skill within your field of practice.

EXAMPLE QUESTION:

There are five stages to practising evidence-based dentistry, the first two are:

A. Asking the right question
B. Asking a scientific question
C. Searching for the best available evidence
D. Searching for a journal article.

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.

QUICK, AESTHETIC RESTORATION

RESTORATIVE

The Scottish Dental Show 2018 keynote speaker Monik Vasant presents a posterior restoration case in a patient found to have caries under an existing amalgam filling

A new patient in her early 30s attended for a check-up. A routine radiograph revealed caries under the amalgam filling on the upper right second premolar (UR5). When advised the tooth needed treatment, the patient revealed she had been unhappy with how it looked. The filling was very visible and shiny when she smiled. The dark appearance of the tooth also made her self-conscious. The patient had thought treatment would be long and expensive, so she hadn't bothered to ask.

The options were to have another amalgam filling or a composite restoration. The patient was advised that further composite treatment could be needed buccally to mask any remaining grey discolouration, if she was not satisfied with the outcome. As she was concerned about the appearance of the tooth, the patient did not want an amalgam filling and decided to have the composite restoration.

Preparation

After a local anaesthetic was given, rubber dam was placed, with a clamp on the UR6, exposing the UR 4, 5 and 6. This was secured in place with floss ties. The old amalgam and caries were removed. The final portion of discoloured dentine was left behind as it was very deep, but the pulp was not exposed and it was still firm.

A sectional matrix band was then positioned mesially on the UR5, with a wedge and separation ring (V-ring). Initially, the enamel periphery alone was etched with 37 per cent phosphoric acid for 15 seconds. Etch was applied to the rest of the cavity for a further 15 seconds, before rinsing. A cotton pledget was used to protect the dentine during the drying process, to ensure dry enamel and moist dentine.

A two-bottle adhesive, with separate primer and adhesive, was used to complete the preparation. The dentine was primed and left for 30 seconds. The adhesive was placed on both the enamel and dentine, and allowed to sit for 30 seconds before curing.

The patient was delighted after having endured an unsightly amalgam filling for years

Restoration

In this case, Venus Pearl composite was used. This material exhibits good levels of opacity to block out discolouration and excellent handling for posteriors, making it a very easy-to-use product.

In this restoration, a small amount of Venus Flow base liner was placed and cured. This was to mask the greyness and dark discolouration from the base of the cavity. Next a thin layer of Venus Pearl A2 shade was applied to build up the mesial wall against the matrix. The height was built up to the level of the adjacent marginal ridge. The material was then manipulated with a sharp probe at a 45 degree angle. This ensured the edge of the wall was not straight and the natural curved shape of the marginal ridge was maintained. The dentine mass was built up in increments with Venus Pearl ODC shade.

Enamel A2 shade was placed over the occlusal surfaces cusp by cusp. Complete separation of the masses was achieved by creating fissures down to the dentine layer, using a sharp probe. Secondary anatomy was manipulated into the unset material before light curing.

A mix of Venus Color 'corn' and 'choco' stains was applied to the fissures using a probe, and pressed in with a long- bristle brush. The excess was wiped away with a conventional micro-brush and the stain was cured. Highlights were placed on the ridges using Venus Color 'white' mixed with a little 'corn', to give a milky colour. Final adjustments were carried out before rough, dry polishing. The restoration was then sealed with a protective clear coating, covered with glycerine and cured.

Outcome

In this case, the clinical outcome was good. The tooth is regularly monitored for vitality and the patient has had no problems with it. As the caries was so deep, in the long term the tooth may require root canal treatment, but it is currently sound. The patient was delighted with the result after having endured an unsightly amalgam filling for years.

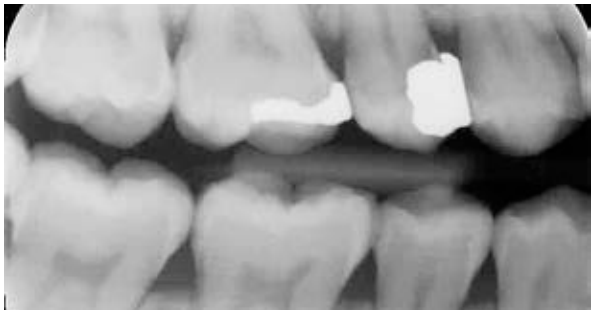

FIGURE 1
A routine X-ray revealed caries under the amalgam filling in the upper right 5

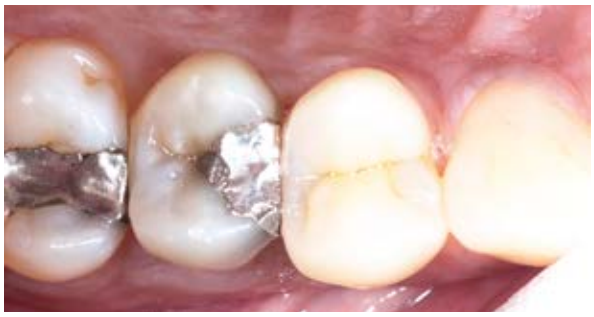

FIGURE 2
The UR5 filling was very visible when she smiled and the dark appearance made her self-conscious

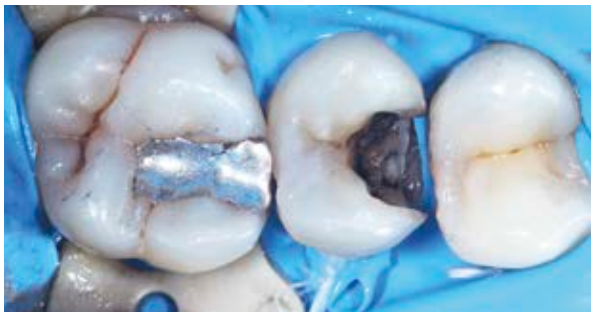

FIGURE 3
The old amalgam and caries were removed following rubber dam placement

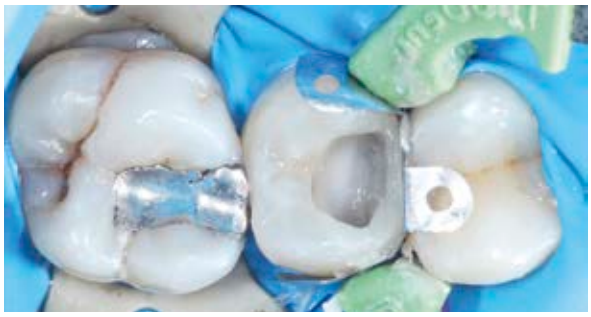

FIGURE 4
Kulzer Venus Pearl A2 shade was applied to build up the mesial wall

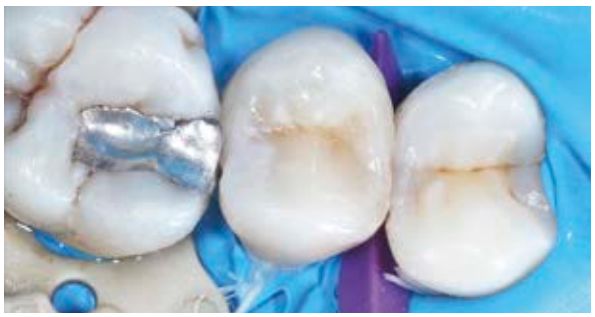

FIGURE 5
Separation of the masses was achieved by creating fissures down to the dentine layer and then stain was applied

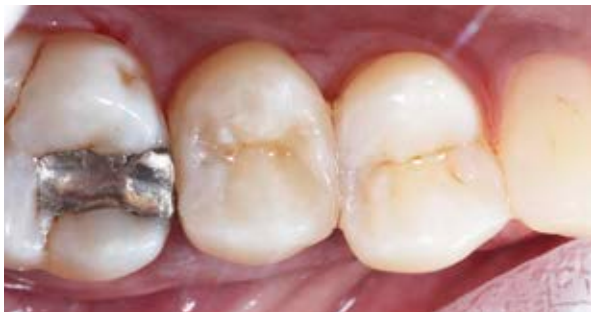

FIGURE 6
The patient was delighted with the result after having endured an unsightly amalgam filling for years

ABOUT THE AUTHOR
Dr Monik Vasant BChD MSc is a highly experienced clinician with a special interest in minimally invasive aesthetic dentistry. He has trained under many of the world's leading clinicians and has an MSc in aesthetic and restorative dentistry.

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Monik is a global key opinion leader for several dental companies and has co-authored several books on various aspects of general practice.

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Monik is the keynote speaker at the Scottish Dental Show 2018, to be held at Braehead Arena on 27 and 28 April. He will be presenting two lectures on Friday 27 April, 'Composite artistry' and 'Composites and digital dentistry'.
To find out more and to register for your FREE delegate pass that will get you access to 140 exhibition stands and more than 50 lecture and workshops sessions, with up to NINE hours of vCPD, visit www.sdshow.co.uk

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES
- To present a case describing cost-effective, minimally invasive treatment for replacing an amalgam filling
- To inform readers of a technique for masking discolouration caused by amalgam fillings
- To inform readers of an incremental composite restoration technique to achieve an aesthetic outcome.

LEARNING OUTCOMES
- Readers will gain an understanding of techniques for providing cost-effective, minimally invasive treatment for replacing an amalgam filling.

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ENDODONTIC DECISION-MAKING

DIGITAL IMAGING

Does the use of CBCT in endodontics have an influence on clinical decision-making? Arvind Sharma presents the first part of a structured critical review to evaluate this question

Imaging is essential in endodontics. Traditionally, X-rays (radiographs) have been used and more recently cone beam computed tomography (CBCT) is used to give the clinician more detailed tooth information as part of a clinical examination.

Radiographs have been an invaluable tool in the dentist's armamentarium in the diagnosis and management of dental problems, (Grondahl and Huumonen, 2004), since their introduction in 1865. Radiographs may be taken as single parallel images or two images applying the parallax technique. Radiographs fundamentally represent a two-dimensional representation of a three-dimensional spatial relationship. The shortcomings and limitations of radiographs are; a degree of magnification – 5 per cent or more (Voorde and Bjorndahl, 1969), superimposition, geometric distortion and lack standardization or reproducibility.

Aria et al 1999 and Mozzo et al, 1998 independently developed a new tomographic scanner known as CBCT and this was specifically for maxillofacial and dental use. CBCT (Fig 1) is a modern three-dimensional imaging system which produces high-quality images using relatively low doses of radiation (see Table 1).

COMPARISONS OF SCANS REPRODUCED FROM ESSENTIALS OF DENTAL RADIOGRAPHY AND RADIOLOGY, 4TH EDITION 2007

Type of scan	Approximate equivalent in terms of dental radiographs
Conventional CT scan	200-300 OPG's
Large volume CBCT	2-8 OPG's
Low volume CBCT	As low as 2-3 periapicals

CBCT differs from 'medical' multi-slice CT (MSCT), as the whole volume of data is acquired in a single sweep with rotations varying between 180-360 degrees. The scanning time is reduced, typically 10-20 seconds, and radiation dose to the patient is less since the cone shaped (not fan shaped as MSCT) beam is pulsed, reducing exposure times to only 3.5 seconds. Approximately 580 images are produced and the field of view (FOV) can be as small as 40mm x 40mm, which can be useful in endodontics (SEDENTEXCT 2012) (Fig 2).

FIG 1 An Accuitomo small volume CBCT scanning machine (Image reproduced from J.Morita USA Inc)

Application of CBCT in endodontics

Limited volume (small FOV) CBCT scanners capture small volumes of data that can include just two or three individual teeth. CBCT allows the operator to view data in three planes: sagittal, axial and coronal (Fig 3). As all the information is obtained in a single rotation, it is very important that the patient is stationary throughout the exposure.

Spatial resolution is a drawback with CBCT since there is only approximately a tenth of the resolution that is currently available with digital and conventional radiographic films. "Increased resolution usually comes at the expense of an increased dose to the patient, as a result of longer exposure times to acquire more 2D projections to a more detailed reconstruction," (Christiansen et al 2009).

Another limitation of CBCT scans are their vulnerability to beam hardening and streak artefact, which can reduce the image quality even further by producing dark bands or streaks in the image.

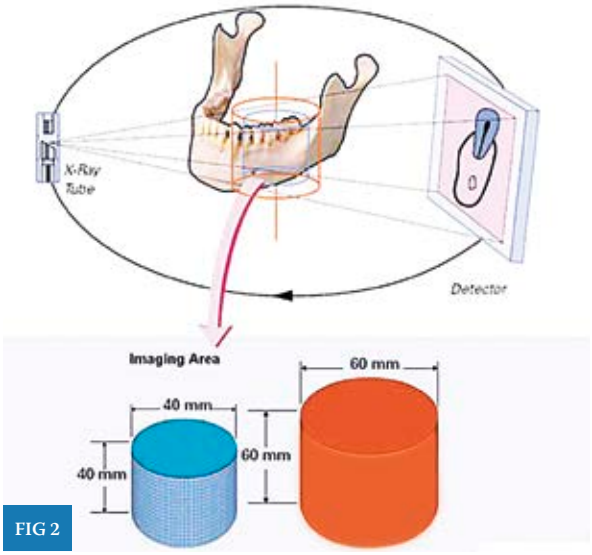

FIG 2

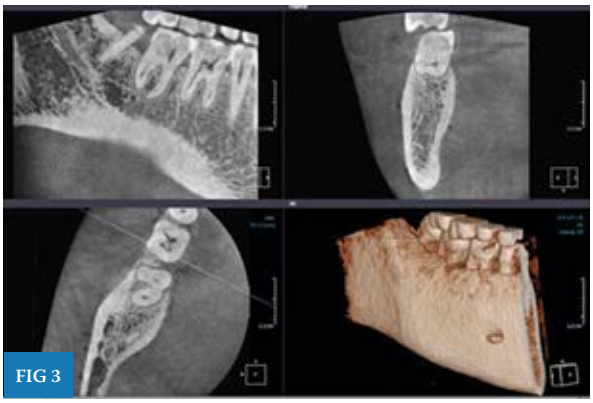
FIG 3

FIG 2: Basic concept of CBCT

FIG 3: CBCT image planes

Notwithstanding the above limitations, there are a number of applications for CBCT in endodontics which may overcome the limitations of conventional and digital radiographs and ultimately improve patient management. CBCT with a limited FOV may be considered in the below situations as recommended by the European Society of Endodontology (ESE) position statement 2014:

The use of CBCT in endodontics:

- 1. Diagnosis of radiographic signs of periapical pathosis when there are contradictory (non-specific) signs and/or symptoms
- 2. Confirmation of non-odontogenic causes of pathosis
- 3. Assessment and/or management of complex dento-alveolar trauma, which may not be readily evaluated form conventional radiographic views
- 4. Appreciation of extremely complex root canal systems prior to endodontic management
- 5. Assessment of extremely complex root canal anatomy in teeth planned for non-surgical endodontic re-treatment
- 6. Assessment of endodontic treatment complications (for example, [post] perforations) for treatment planning purposes when existing conventional radiographic views have yielded insufficient information
- 7. Assessment and/or management of root resorption
- 8. Pre-surgical assessment prior to complex peri-radicular surgery.

As stated by Rosen et al 2015: "A web-based survey emailed to 3,844 active members of the American Association of Endodontists in the United States and Canada reported a significant increase in the use of cone-beam computed tomographic (CBCT) imaging; 34.2 per cent of 1,369 respondents indicated that they were using CBCT imaging for diagnosis and treatment planning purposes," (Dailey et al 2010).

Implications of CBCT in endodontics

There are a number of implications of CBCT in its application in endodontics, some of which have been discussed earlier, such as radiation dose and treatment outcome.

CBCT still uses ionising radiation and is not without risk. Radiation dose and 'stochastic effects' are important considerations. As discussed earlier, CBCT does expose patients to an increased radiation dosage. The principles of 'As Low As Reasonably Achievable' (ALARA) should always be applied to limit patient dose.

Every radiation exposure a patient has must be justified and optimised ideally with strict selection criteria as stated by the FGDP guidelines, 2013. The FOV must be reported on in its entirety since the clinician has a legal obligation to read and comment on the whole view. This highlights the training the operator must undergo before taking scans and the clinician must engage the advice of a suitably qualified radiologist if further advice/information is sought (Brown et al 2014).

The cost of CBCT scanners must not be allowed to motivate clinicians to take scans without first justifying the exposure. Ethical scanning is paramount.

Another implication may be the potential removal of metallic coronal restorations to avoid 'beam hardening', which would increase procedural time and patient cost.

Wu et al 2009 recommended that: "The outcome of root canal treatment should be re-evaluated in the long term using CBCT and stricter evaluation criteria", for the reasons as discussed earlier. This has led many researchers to argue and debate a very crucial question: What constitutes endodontic success? An asymptomatic patient or a 'healed' scan or periapical?

"This has a huge implication on clinical decision making and selection criteria when considering (re-) placing coronal restorations on teeth which have previously been endodontically treated and appear to have successfully healed on the radiograph," (FGDP 2013).

Some have asked for more clarification from the European Society of Endoontology (ESE), which has recently published a position statement: 'The use of CBCT in Endodontics', in 2014. The guidelines advise that "every image involving ionizing radiation, including CBCT, must be justified and optimised. A record of the justification process must be maintained."

"Clinical studies with a primary outcome measure of detecting the presence or absence of apical periodontitis

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and epidemiological studies assessing the prevalence of apical periodontitis in different populations may have to be re-evaluated," (Ng 2010).

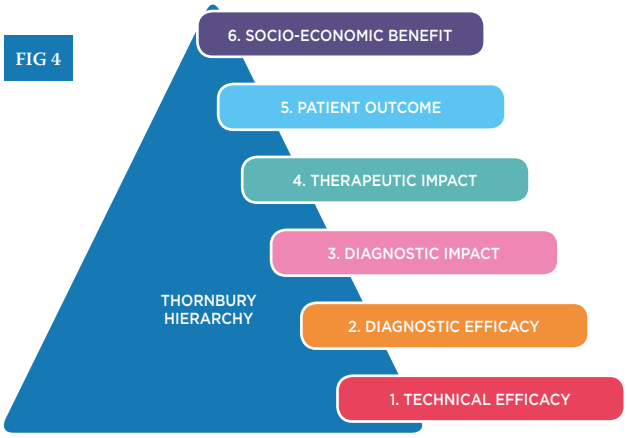
The question, therefore, may be posed as to how much relevance a CBCT has in clinical decision-making in endodontics? If a clinician has not obtained enough relevant information from a radiograph and has made the clinical judgement to expose the patient to a CBCT scan, does the information provided by the CBCT image have an effect on the clinician's clinical management of that patient? Does the exposure of the patient to a CBCT image have a net positive benefit to the patient? Is this justified following the guidelines discussed earlier?

The scoping searches showed a number of papers important to this review in the existing literature:

- Balasundaram et al 2012. Comparison of Cone-Beam Computed Tomography and Periapical Radiography in Predicting Treatment Decision for Periapical Lesions: A Clinical Study.
- Cheung et al 2013. Agreement between periapical radiographs and cone-beam computed tomography for assessment of periapical status of root filled molar teeth.
- Mota de Almeida et al 2014. The impact of CBCT on the choice of endodontic diagnosis.
- Estrela et al 2014. Characterization of successful root canal treatment.
- Mota de Almeida et al 2014. The effect of CBCT on therapeutic decision-making in endodontics.
- Rosen et al 2015. The diagnostic efficacy of CBCT in endodontics: A systematic review and analysis by a Hierarchical Model of Efficacy.
- Ee et al 2014. Comparison of endodontic diagnosis and treatment planning decisions using CBCT vs periapical rads.
- Hashem et al 2015. Clinical and radiographic assessment of the efficacy of calcium silicate indirect pulp capping: a randomised controlled clinical trial.
- SEDENTEXCT Project. Radiation Protection 172. Evidence-Based Guidelines on Cone Beam CT for Dental and Maxillofacial Radiology [Internet]. 2011 [cited 2012 Dec 10]. Available at: http://www.sedentexct.eu/content/guidelines-cbctdental-and-maxillofacial-radiology. Accessed August 6, 2012.

Scoping searches to formulate an idea of the current state of knowledge of the topic literature showed limited studies in this area. Studies that were found appear mainly to be in-vitro with few in vivo studies. This, of course, highlights the justification of performing in vivo studies in humans where ethical issues are paramount in the 21st century. Scoping searches were performed using the PROSPERO, PubMed and Google Scholar databases. Scoping searches also identified a number of well-published authors who appear to be leaders in the field of CBCT: S Patel, C Durack, F Abella, M Roig, H Shemesh, P Lambrechts and K Lemberg.

FIG 4



CBCT can overcome some of the limitations of intra-oral radiographs, which are the primary imaging method in endodontics (Lofthag-Hansen et al, 2007 and Scarfe et al, 2009).Therefore, the usefulness of CBCT imaging can no longer be disputed, since they can complement radiographs. It is an important imaging tool in contemporary endodontics and "has been shown to be superior to conventional periapical and panoramic radiography in its accuracy and sensitivity in detecting endodontic related pathology" (Stavropoulos and Wenzel, 2007, Tsai et al, 2012, Liang et al, 2014).

As scanners become more affordable and radiation dose to the patient possibly reducing, more endodontic disease may be detected in the future, which inevitably means better patient management. However, Pope et al 2014 have discussed that more sensitive technology may cause over-diagnosis, which could potentially harm healthy patients.

Presently, academic opinion (ESE position statement, 2014) advises that "CBCT should only be considered in situations where diagnostic information from clinical examination and conventional radiographs does not yield an adequate amount of information to allow appropriate management of the patient. A case-by-case approach is recommended and a CBCT scan should have a net benefit to the management of a patient's endodontic problem".

Clinical decision-making in endodontics

Clinical decision-making in endodontics is a process which involves the clinician's diagnostic skills and the patient's presenting signs and symptoms. It is a conclusion reached only after assessment of signs, symptoms, examination, special tests,

consideration of expected outcome and, most importantly, the patient's wishes. Therefore, "decision-making depends on the skill and experience of the clinician and the treatment options available which is termed as evidence-based practice" (Sackett et al, 1996).

However, "the needs and preferences of the patient are what drives the treatment decision since only the patient is truly the expert as to how he/she feels about maintaining a tooth, what symptoms are tolerable, what risks are worth taking and of course what costs are acceptable" (Bergenholtz and Kvist, 2014). Therefore, a patient-centred outcome is ideal. "Diagnosis is seen as only one part of the medical decision process" (Ledley and Lusted, 1959). Once a clinical decision has been reached, only then should treatment be executed with the patient's informed consent.

Radiographs have been used as an imaging tool to base clinical decisions on and Strindberg developed a system in 1956. His system was based on biology and can be perceived as being dogmatic and inflexible. In the Strindberg system, a normal periradicular situation on periapical image with no patient symptoms was identified as endodontic success and a periradicular lesion apparent on a periapical radiograph was identified as endodontic failure. This has been discussed by Kvist 1994 and in a series of papers (Papers I-V, 1998, 1999 and 2000) where he proposed an alternative theory based on Praxis Concept (Jensen 1985). Praxis, which is Greek for process, is the process by which a theory or skill is enacted, embodied or realised. This theory states that personal values influence endodontic treatment and that clinicians use 'cut-off' points in their decision-making process.

Fryback and Thornbury (1991) have discussed the assessment of the contribution of diagnostic imaging to the patient management process in their seminal paper, The Efficacy of Diagnostic Imaging. In their study, they propose a 'Hierarchical Model of Efficacy', which is an organising structure for appraisal of the literature on the efficacy of imaging. There are six levels as listed in Figure 4:

- 1. Technical quality of image
- 2. Diagnostic accuracy, sensitivity and specificity of image interpretation
- 3. Change in clinician's diagnostic thinking?
- 4. Effect on patient management
- 5. Effect on patient outcomes
- 6. Societal costs and benefits of a diagnostic imaging technology.

According to Fryback and Thornbury (1991), with level three "the imaging information may change the differential diagnosis, strengthen an existing hypothesis, or simply reassure the physician". With level four, 'Therapeutic Efficacy', "an imaging examination result may influence the physician's diagnostic thinking and yet have no impact on patient treatment". With level five, 'Patient Outcome Efficacy', "is concerned with whether there is measurable effect of the image on the outcome experienced by the patient" since the ultimate goal of dental care is to improve, or return to normal, the health of the patient.

Therefore, this structured critical review will focus on levels three, four and five in the 'Hierarchical Model' (Table 2) since the question posed is the use of an imaging modality (CBCT) and how it influences clinical decision-making in endodontics.

So, with regards to the use of CBCT in clinical decision-making in endodontics, what does the current literature say? Evidence appears to be sparse. Mota de Almeida et al (2014) have concluded that "CBCT has a substantial impact on diagnostic thinking in endodontics when used in accordance with the European Commission guidelines". In their clinical study, Balsundaram et al (2012) concluded that "Lesion size and choice of treatment of periapical lesions based on CBCT radiographs do not change significantly from those made on the basis of 2D radiographs". Cheung et al (2013), concluded that "there were substantial disagreements between PA and CBCT for assessing the periapical status of molar teeth, especially for the maxillary arch".

TABLE 2 – A HIERARCHICAL MODEL OF EFFICACY: TYPICAL MEASURES OF ANALYSIS (FRYBACK AND THORNBURY 1991)

Level 6 Social Efficacy	Was the image useful from the social point of view? What are the results of cost-benefit and cost-effectiveness analyses?
Level 5 Patient Outcome Efficacy	Due to image results, does it make improvements to the patient? Unnecessary procedures were avoided? Does it modify survival or life quality?
Level 4 Therapeutic Efficacy	Was the image useful in treatment planning? Does it modify patient management?
Level 3 Diagnostic Thinking Efficacy	Was the image useful on the diagnosis? Does it modify judgment?
Level 2 Diagnostic Accuracy Efficacy	Does the image provide a correct (TP/TN) or an incorrect diagnosis (FP/FN)?
Level 1 Technical Efficacy	What technical parameters present the image (resolution, definition)?

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It is clear that there is not an agreement of opinion and whether there is a clear benefit to the clinician and to the patient in taking a CBCT scan. An investigation of available evidence as it relates to levels three, four and five, may clarify the role of CBCT in endodontic decision-making.

The research question for this study: Does CBCT influence clinical decision making in endodontics?, arose from the author's interest in the imaging modalities used in endodontics. In the author's almost 20 years clinical experience, it has been noted that many Scottish patients wish to keep their teeth and avoid extractions. People's attitudes to dentistry, which may be media and culturally led, appear to be changing. The limitations within the National Health Service (NHS) in Scotland, may have led patients to look at private options to restore their teeth with a view to avoiding costly dental implants.

In the author's opinion, root canal treatments are being considered more by patients, not only on the NHS but also privately. The author has found that since patient expectations are sometimes high, the diagnostic process must give the clinician and patient as much information as possible so the patient is able to make the correct informed decision. CBCT may offer more information, as discussed earlier, but does this information make a difference in the decision-making process? CBCT, being a relatively new and exciting diagnostic tool in endodontics, is used by some general dental practitioners and specialists in the UK but its use should be only when radiographs do not prove diagnostically beneficial. The question arises, when is this?

As discussed earlier, ESE guidelines are quite specific. CBCT should not be taken routinely in the diagnostic process but only when there is a net benefit to the patient. Clinically, a patient may present to a clinician with symptoms which cannot be diagnosed either upon clinical examination or with a radiograph. In this scenario is a CBCT useful?

The aim of this study is to perform a structured critical review on the current published research and to draw a conclusion as to the influence of CBCT in clinical decision making in endodontics.

The objectives of this review are based on nine basic steps, as suggested by Boland et al (2014):

- 1. Performing scoping searches, identifying the review question and writing the protocol
- 2. Literature searching including the search strategy
- 3. Screening titles and abstracts
- 4. Obtaining papers
- 5. Selecting full-text papers
- 6. Quality assessment
- 7. Data extraction
- 8. Analysis and synthesis
- 9. Writing up and editing.

VERIFIABLE CPD QUESTIONS

AIMS AND OBJECTIVES

- To give the reader an understanding of CBCT as a modern imaging tool and its application in endodontics
- To provide details of the evidence surrounding clinical decision making in endodontics
- To highlight the clinical applications where use of CBCT in endodontics would be advantageous.

LEARNING OUTCOMES

- To understand the basics of how CBCT works and its clinical application in endodontics
- To be able to recognise when the use of CBCT may help clinical decision making.

GDC Development outcome covered: C – Maintenance and development of knowledge and skill within practice.

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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Arvind Sharma, BDS(Dund), MSc(Endo), MJDFRCS(Eng), MFDSRCPS(Glas), work in practice limited to endodontics and takes referrals at New Life Teeth in Edinburgh and Philip Friel Advanced Dentistry in Glasgow.

This article is based on the submitted dissertation in partial fulfilment of the requirements for the Degree of Master of Science in Endodontology, 2016. The author appreciates that much of the in-depth analysis has been omitted for the purposes of the current publication and readers are welcome to contact the author for more detail if they so wish – visit asendodontics.com for info.

References will be provided in full in the second part of the article, which will be published in the next issue of *Scottish Dental*.

CONFIDENTIALITY BREACH

CASE FILES

Aubrey Craig looks at what can be learned from a case involving a breach of confidentiality as well as complaints about the cost of treatment and consent

Mrs M attends her dentist, Mr A, complaining of pain in an upper tooth. They discuss treatment options and she agrees to undergo private treatment, including root filling and the fitting of a new crown. She signs a treatment plan which shows the cost of the work will amount to around £500.

The treatment is carried out without incident and Mrs M pays part of the bill before leaving that day. The practice sends out an account detailing the remaining total but, three months later, no further payments have been made. Mr A issues another written account to Mrs M but is then contacted by Mr M who says he is assuming responsibility, with his wife's consent, for the bill. He asks why the cost is so high but Mr A explains the treatment given and that the price was agreed in advance.

Five months after the initial appointment, still no further payment has been made. Mr A phones Mr M at home to discuss the matter. There is no answer but the phone switches to an answering machine, identified as belonging to Mr and Mrs M. He leaves a message asking Mr M to contact the practice about the unpaid bill.

One week later, Mr A receives a cheque for £150 from Mr M along with a promise that more money will follow soon. It is also accompanied by a letter of complaint from Mr M who is angry that the dentist disclosed information about the unpaid bill in the answering machine message. His daughter had dropped by while he was out and heard it, causing him considerable embarrassment.

Mr A sends a written apology to Mr M and agrees to let him pay the bill off over the next two months.

A short time later, however, Mr A is notified by the General Dental Council that a complaint has been made against him alleging a breach of confidentiality and claiming the cost of treatment was unfair and had not been clearly discussed.

Analysis/outcome

Mr A calls MDDUS for advice. It is recommended he writes a further letter of apology to Mr M. Mr A accepts that sensitive information about the unpaid bill should not have been disclosed in the phone message and that practice procedures have been changed to avoid a repeat of this error. It is also advised that Mr A waives the outstanding sum owed to the practice in recognition of the distress caused by the confidentiality breach.

Regarding the disputed fee, Mr A is confident that this was fully discussed with the patient in advance and he has the treatment plan signed by Mrs M to support this.

The GDC case is eventually closed with no action taken against Mr A.

Key points

- Never disclose sensitive patient information in telephone messages
- Be aware of the potential for third parties to intercept messages, even on personal mobile phones
- Always ensure costs are discussed and agreed upon, in writing, before treatment is carried out.

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

Management

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UNDER THE HAMMER

MAXIMISE THE PRICE OF YOUR PRACTICE SALE

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LOOKING FORWARD TO FUTURE POSSIBILITIES

STAFF AND EMPLOYERS ARE OFTEN FILLED WITH DREAD WHEN IT COMES TO CONDUCTING PERFORMANCE APPRAISALS, BUT THIS SHOULDN'T BE THE CASE, SAYS SUSIE ANDERSON-SHARKEY

SUSIE ANDERSON-SHARKEY

We have recently conducted our annual performance appraisals and it never ceases to amaze me the fear and dread it causes among the staff. I've noticed, talking to friends and colleagues, that no matter what business people are working in, those two words "performance appraisal" elicit the same response. And truly, this should not be the case.

Many people feel that a performance appraisal is a "necessary evil, box ticking exercise" that, given the chance, should be avoided at all costs. It is viewed, at best, as a pointless exercise where nothing changes so, what's the point? And that is a very valid question. Just what is the point to a performance appraisal? Just what are we looking at, why do we do them and what do we hope to gain from the process?

First off, it's not a chance to tell someone how badly they are performing. If they are performing badly then there is a structure where this can be explored and, if necessary, an improvement plan put in place where their under-performance can be managed. Neither should appraisals be a platform for giving a wage increase. Historically, performance appraisals have been used as a tool that was used to set a percentage pay rise (or not) but there are other reasons for giving a pay rise other than performance alone and we can perhaps look at this in another article.

There are plenty of templates online for carrying out performance appraisals, and this year I decided to use a slightly different one to the ones I have used before. Previously, I have used a score system where both myself and the employee separately score how they have performed in various headings such as customer service, team player, time keeping etc, then come together at the meeting, compare the scores and, where there is a difference, use this as a ground for discussion.

In an ideal situation, the scores for each competency should be almost identical, but occasionally you do come across an employee whose enthusiasm outweighs their ability and this has to be delicately managed in order not to crush the employee but, at the same time, give them pointers along the way. And let's be honest, no employee should be going into their performance appraisal not knowing how they have performed. I would be very surprised, and a bit concerned, if an employee attended a review and our respective views of their performance were diametrically opposed. The situation should have been managed well before it arrived at performance appraisal stage.

A performance appraisal should be a positive experience for both the employee and the employer. Where time permits, I would like to be able to take each employee for a coffee and a chat off the premises in a relaxing surrounding where we can chat openly and honestly to each other about career to date, career progression and make solid objectives for the coming year. Owing to time commitments in the surgeries, this is very seldom possible and the appraisal meetings are usually carried out in my office, but this doesn't have to be the case.

If you have to sit in the office, have a cup of coffee and a chat. Let the employee know that this is not a dressing down but rather a chance to look forward to future possibilities. Give them time to talk to you and make sure that they see you are listening, taking notes and value their feedback.

With the enhanced CPD being rolled out this year, I used this as the basis of our performance appraisals conducted just a few weeks ago. I spoke to each DCP about the new rules and regulations, the necessity of completing a personal development plan and how that plan should match both the roles they are carrying out within the practice and the roles that they would like to carry out in the future. This led to very interesting discussions regarding each person's career path and extended duties as dental nurses.

It helps to engage them with the practice but also to be engaged in owning their own career and being enthusiastic about moving forward and gaining further qualifications that will benefit both themselves and the practice. Each staff member has been given the task of finding information on further career developments and will come to me with the information and we will take things from there.

IF YOU WISH TO CONTACT ME REGARDING THIS ARTICLE OR ANY OTHER PRACTICE MANAGEMENT ISSUES I'D LOVE TO HEAR FROM YOU. I CAN BE CONTACTED AT SUSIE@DENTALFX.CO.UK

HOW WELL IS YOUR PRACTICE PERFORMING?

DENTAL PRACTICE PRINCIPALS NEED TO RECOGNISE AND BE ALERT TO TRENDS AND LEARN WHEN TO MAKE CHANGES TO THEIR OPERATIONS AND STRATEGIES, SAYS JAYNE CLIFFORD

A recent report published by IBIS World which focused on the dental industry and dental practices across the UK highlighted some interesting trends in the NHS/private dental market and also some useful financial benchmark statistics which are worth sharing.

According to the report published at the end of last year, the overall dental market size in the UK in revenue terms was £6.7bn in 2017-18, which is forecast to grow at around 1.1 per cent per annum over the next five years. This is up from 0.5 per cent per annum growth during the preceding five-year period.

The main reasons cited for the increase in growth were improving economic conditions and longer waiting times for NHS services, which have led to rising demand for private services.

The growing ageing population and an increasingly health-conscious consumer are also likely to lead to further demand for dental services. As people grow older and live longer, natural wear and tear on teeth will raise demand for treatments, and although the population at large will consume fewer sugary products over the next five years, which will lead to fewer dental problems, this health consciousness is likely to lead to people visiting their dentist more frequently and exploring more cosmetic-related dental treatments.

Interestingly, according to IBIS, women are nearly twice as likely to have had a dental check-up in the past 12 months as men, and women are also more likely to undertake cosmetic procedures than men. With much of the focus in the media of late about achieving gender equality for women in many walks and areas of life (and rightly so), it does look like dental practices should be adopting a male gender bias in their patient communications by specifically targeting adult males to help increase demand for their services.

ABOVE: Jayne Clifford

Although revenue is forecast to grow over the next five years, many dental principals may not see this growth in revenue translated into a growth in profits. Margins are likely to be curtailed by increasing competition and rising wage costs over the next five years which makes it even more important to keep on top of the finances.

Principals of dental practices need to recognise and be alert to trends and learn when to make changes to their operations and strategies. NHS income should be monitored monthly and will highlight whether the practice's volume is expanding or contracting. It is also useful to look at the income to payroll ratio and your net profit margin percentage.

Employee costs will vary from practice to practice, but it is estimated by IBIS that payroll costs, on average, absorbed about 58 per cent of revenue and net profit margins across the industry are about 5-6 per cent of revenue during the last 12 months.

Non-labour purchases – for example, materials such as fluoride, toothpastes, polishes, crowns, bridges, braces and other dental supplies – account for about 16 per cent of revenue expenditure in the dental industry in 2017-18. The continuing consolidation has made it easier for the larger players to achieve economies of scale thereby further increasing their profit margins.

Other costs, including insurances, PI cover, rates, rent and utilities, are also forecast to increase over the next few years, so do take this into account when you are looking at your management accounts and forecasting cash flows and margins with your accountant at your regular meetings with them.

Your accountant should be able to flex the forecast model to include increases in these areas and the impact that this will have on your cash flow and profit margins. It can be quite surprising how much difference a small percentage increase in some of your regular outgoings can have on your net profit margin, and just as equally, how much small but incremental price rises over the next couple of years, such as inflationary increases, can have on your bottom line.

Finally, as of 6 April, employers and employees are required to increase their contributions into their auto-enrolment pension. From this April the minimum employer contribution will be 2 per cent (rising to 3 per cent from April 2019) and the employees minimum contribution from April this year will be 3 per cent and 5 per cent next year. So be sure to factor this in to your income and expenditure projections for 2018 and 2019.

ABOUT THE AUTHOR
Jayne Clifford is a director at Martin Aitken & Co.
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BEWARE OF TAXMAN'S DOUBLE WHAMMY

IF YOU'RE NOT PREPARED, THE TAXMAN MAY DELIVER A NASTY SURPRISE. JON DRYSDALE EXPLAINS HOW TO AVOID UNPLEASANT SHOCKS

For many dentists, January is a painful month as it represents one of two pinch points in the tax calendar, the other being in July. January is probably worst as it offers HMRC the opportunity to mop up any underpaid tax from the previous tax year. This is called a balancing payment and may come as a nasty shock if you haven't been advised adequately or sufficiently well in advance by your accountant (because you waited until the last minute to provide the relevant financial information).

Being self-employed, you must make payments on account based on 50 per cent of your previous year's tax bill. If this was higher than your current year's tax bill, the payment on account will be higher. Hence the potential double whammy of balancing payment and payment on account.

HOW IT WORKS

Table 1 shows a situation where the tax bill increased by £20,000 from one year to the next and the knock-on effect on the twice-yearly tax payments. The payments in red are highlighted because they are above the norm. The increase in tax from one year to the next means an additional £30,000 is required in January 2018 (£20,000 for the balancing payment and £10,000 for the extra payment on account) and a further additional £10,000 is due in July (again for the extra payment on account). This is in addition to the pattern of amounts in previous years – resulting in a total tax charge payable in 2018 of £80,000.

TABLE 1 – EFFECT OF BALANCING PAYMENT AND PAYMENTS ON ACCOUNT ON TAX BILLS

	Tax year 2015/16	Tax year 2016/17	Tax year 2017/18
Total tax due	£40,000	£60,000	£60,000
Payment 1	£20,000 (50% of 2014/15 tax bill paid in January 2016)	£20,000 (50% of 2015/16 tax bill paid in January 2017)	**£30,000 (50% of 2016/17 tax bill paid in January 2018)**
Payment 2	£20,000 (50% of 2014/15 tax bill paid in July 2016)	£20,000 (50% of 2015/16 tax bill paid in July 2017)	**£30,000 (50% of 2016/17 tax bill paid in July 2018)**
Balancing payment	N/A (based on £40,000 total tax due for 2014/15)	**£20,000 (paid in January 2018)**	

To avoid nasty surprises, you can calculate balancing payments and payments on account – and do so earlier than you might think. For example, for the tax year 2017/18 this could be calculated as soon as 6 April 2018. While it may not be fair to expect your accountant to work out the figures immediately after the financial year, it does make sense to push for an early completion of your accounts and tax return. This is especially so if you have seen an uplift to turnover (therefore usually an increase to your taxable income). Company directors need to think carefully about the timing of dividend payments and discuss a remuneration strategy with their accountant.

NHS PENSION MAY CAUSE UNDERPAYMENT OF TAX

Dentists may have an additional tax charge to pay based on their NHS pension 'input amounts' in any given tax year. An 'input amount' is HMRC's way of describing the value of public sector pension contributions (employer and employee). The actual amount you pay is not relevant here. The annual allowance limit on pension contributions is £40,000. The NHS input amount can easily exceed this and where the limit is exceeded there will be a tax charge.

This is because the excess is deemed to be an over claim on tax relief. Unfortunately, the input amounts aren't available until after the end of the NHS financial year, so you can't simply adjust your NHS contributions to manage the situation. You can, however, request your Annual Allowance Pension Saving Statement from NHS Pensions in order to see if you underpaid tax in the previous year. If your input amount exceeds £40,000 you will automatically receive the statement – don't ignore it. If you make personal pension contributions and NHS pension contributions you should request the statement – because the combined personal pension contributions and the NHS pension input amount make take you over the £40,000 limit.

TABLE 2 – EFFECT OF HIGH INCOME ON ANNUAL ALLOWANCE

	Taxable income	NHS input amount	Personal pension contribution	Total input amount	Adjusted income	Reduced annual allowance
Example 1	£110,000	£35,000	£25,000	£60,000	£170,000	£30,000
Example 2	£150,000	£35,000	£25,000	£60,000	£210,000	£10,000

MORE ABOUT THE ANNUAL ALLOWANCE

There are further points to make in relation to the annual allowance. First, if you have taxable income over £110,000 you may lose some of your £40,000 annual pension allowance based on your adjusted income. For every £2 your adjusted income goes over £150,000, your annual allowance for that year drops by £1. There are two examples of this in Table 2.

In both examples, the total input amount exceeds the reduced annual allowance (by £30,000 and £50,000 respectively). This could result in a tax charge of £12,000 and £22,500 respectively, based on the prevailing tax rates. NHS pension members should ask themselves whether the scheme remains a viable option for retirement savings

Second, on a positive note you may be able to avoid exceeding the annual allowance by using 'carry forward relief'. This is where unused annual allowance can be brought forward from the previous three tax years. Advice is required here to ensure the NHS pension considerations are interpreted correctly in conjunction with your tax return.

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

Premium prices for Scottish practices

WITH RECORD LEVELS OF DEMAND FOR DENTAL PRACTICES IN SCOTLAND, PAUL GRAHAM, DIRECTOR AT CHRISTIE & CO, SAYS EXPERT HELP IS INVALUABLE TO MAXIMISE YOUR CHANCES OF GETTING THE RESULT YOU WANT

According to our recent report, *The Dental Market – A review of 2017 and outlook for 2018*, Christie & Co is experiencing record levels of demand from buyers looking to purchase a dental practice, and Scotland is beginning to emerge as a key dental market in the UK. As prices are generally lower than in England and Wales, buyers are moving north of the border to find better-value acquisitions for a quicker return on investment. However, with so much competition from established buyers who are already based in Scotland, prices continue to be pushed, with premium offers being achieved.

As this demand continues to grow, it can be tempting to accept an offer immediately, but how can you be sure you are getting the best price? Often what looks like a great deal may be subject to deferred payments and valuations, and you may even be tied to unfavourable and onerous terms. Selling your dental practice represents a change of lifestyle and the culmination of years of work. It's not something to be taken lightly and choosing an agent to help you is crucial to getting the best result.

Dentists understand the importance of regulations and similarly, the property industry is also highly 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.

Christie & Co is the only RICS-regulated specialist dental agent in the UK. Our dental team in Scotland can ensure that you get the result you want and achieve maximum value for your practice. Right from the start, we help you prepare your practice for a sale, then upon securing the right buyer, we will advise on the detailed negotiations, ensuring that you are always in control.

The full dental market review is available for download on the Christie & Co website.

MORE INFO

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

Are you prepared for the NHS funding changes?

AS WELL AS CLINICAL CHANGES, DENTISTS IN SCOTLAND NEED TO BE AWARE OF THEIR FINANCIAL RESPONSIBILITIES TOO, SAYS LOUISE GRANT OF EQ ACCOUNTANTS

The Scottish Government has recently developed an Oral Health Improvement Plan to assess patients based on risk, and address the link between deprivation and ill-health. It is clear from reading through the consultation papers that they are looking to implement changes towards a more preventive system for the NHS dental service together with simplifying the NHS dental charges.

The full report is available to download via www.scottishdental.org/library/oral-health-improvement-plan

In summary, the proposed financial changes as per the consultation will be:

- A new system of capitation payments to support preventive care and treatment in children and young adults, supported by monitoring
- A new system of enhanced continuing-care payments to support the introduction of Oral Health Risk Assessments for adult patients
- A simplified set of item of service payments for restorative care and treatment
- Changes to the General Dental Practice Allowance to incentivise general dental practices with patients from more deprived communities
- Changes to the reimbursement of rental costs to ensure that payments are based on an appropriate size of practice and taking into consideration its location
- A new NHS commitment criteria
- A single quality-based practice allowance which reflects the unique circumstances faced in both remote and rural areas and deprived communities.

It is extremely important that dental professionals address changes to their clinical responsibilities, but they must remember that they are also running a business and so must plan for these financial changes too. Please be aware that if you do nothing, it is only evident that your income levels will fall, resulting in lower profits and ultimately, lower remuneration for you.

At EQ Healthcare our experts can help you and your business plan for these changes to ensure your income levels are not adversely affected. It is critical to start planning immediately by communicating the changes to patients and staff and setting realistic targets for your practice and patients.

MORE INFO

For more information or support with these changes, get in touch with our EQ Healthcare team on 01382 312 100 or email louise.grant@eqaccountants.co.uk

The importance of being organised

MICHAEL ROYDEN FROM THORNTONS LAW EXPLAINS WHY IT IS IMPORTANT TO BE DILIGENT WHEN IT COMES TO SELLING A PRACTICE

Our dental team is regularly asked what diligence entails, why is it important, and how do I go about organising myself to do it justice?

Firstly, what is diligence? Put simply, it is the process through which the purchaser of a practice asks a series of questions in order to satisfy themselves that there are no issues with the practice that might be of concern to them. Much like kicking the tyres when buying a car.

They will ask questions on a range of subjects, including looking for details/documentation on:

- Employees
- Associate agreements
- Property title deeds/lease
- Practice contracts.

From a seller's perspective, there can be a temptation to answer the questions as quickly as possible, without putting as much thought into the process as they could.

That is partly understandable; dentists are busy people, and as may be expected, they are keen to draw the questions to a close and move on to the next stage in the sale process.

Unfortunately, undue haste and partial answers can be counter-productive, giving an impression of a disorganised practice or seller, which won't fill a buyer with confidence, and is likely to lead to even more questions.

For a seller, from our experience of dealing with practice sales (and knowing what we expect to see when acting for a buyer), there are steps which they can take to make diligence as painless as possible:

- Ensure that employment contracts are in place for all staff
- Put in place properly drafted associate agreements
- Gather together all contracts for the practice (such as practice software contracts, etc.)
- Know where your surgery title deeds are, and draw together any other property documents such as planning permissions for previous alterations.

Having this sort of documentation to hand will allow you to answer diligence queries fully and promptly, giving a positive impression of the practice, and hopefully leading to the sale process being as smooth as possible.

MORE INFO
Michael Royden is a partner in the Thorntons Law dental team. He can be contacted on 01382 346 222 or mroyden@thorntons-law.co.uk

Coping with fraud

THE AUTHORITIES ARE NOT VISIBLE ENOUGH TO SCOTTISH SMES WHEN IT COMES TO DEALING WITH THE FALL-OUT OF FRAUD

AILEEN BOYLE

A large percentage of Scotland's small and medium-sized enterprises do not know who the relevant authorities are to help them deal with fraud, new research from Braemar Finance's parent company, Close Brothers, has revealed.

In response to the Business Barometer survey, 65 per cent answered 'no' to the question 'Do you know who the relevant authorities are to help you deal with fraud?'; this compares to 58 per cent for the UK as a whole.

"Fraud can take many different forms, making it critical that business owners know who the relevant authorities are, even if they haven't been directly targeted," said Aileen Boyle, managing director of Braemar Finance.

"Much of today's fraud is driven by an increase in cybercrime, highlighting the importance of having the correct online checks and balances in place."

Fraud and legal advice

The same percentage of Scottish SMEs – 8 per cent – have both been a victim of fraud and had to seek legal advice.

"It's reassuring that business owners are contacting their legal representatives because being a victim of fraud can have a range of impacts, from loss of trust and reputational damage all the way through to business failure and jail terms for those involved," said Aileen.

"The figures confirm that no-one is immune and it happens in all walks of life, across all industries and in businesses of every size."

Insurance against fraud

Only 37 per cent of businesses are certain they are covered in the event of fraud, with 35 per cent answering 'no' to the question 'is your business insured against fraud?'; the remaining 28 per cent 'don't know'.

"If you don't know, then it's worth checking your insurance policies to see whether you are insured against fraud, theft or dishonesty," said Aileen.

"This could be via a stand-alone policy or as part of an insurance product like home contents, travel, or legal expenses.

"According to the Fraud Advisory Panel, it's also possible to sometimes buy 'after the event' insurance after fraud has taken place to help fund the costs of civil litigation.

"These policies provide insurance against the cost of trying to recover those losses through legal proceedings."

MORE INFO

Aileen Boyle is the MD of Braemar Finance, where she and the team have spent the past 20 years establishing the company as one of the main providers of finance for the professions in the UK. Contact Braemar Finance on 01563 852 100 to speak to a representative about your finance needs.

Realising your investment

MICHAEL EDWARDS DISCUSSES SOME OF THE BENEFITS OF SELLING YOUR PRACTICE EARLIER IN YOUR CAREER

MICHAEL EDWARDS

Practice principals– there are many non-financial rewards to owning your own practice, such as your autonomy in decision-making and being your own boss. However, have you considered if you receive enough satisfaction and financial reward to compensate for all the extra hours you invest in your practice and the stresses that come with being a business owner?

Just because you have taken the decision to purchase your practice in the past doesn't mean that you can't realise your investment well in advance of your retirement, in your thirties, forties or early fifties. In fact, selling your practice(s) well in advance of retirement can provide you with more options to maximise your sales value and potentially provide greater flexibility on your level of involvement in the practice post-sale.

More practice owners are freeing themselves of the burdens of practice ownership at an earlier stage in their careers, allowing them to swap the late nights looking over practice paperwork for time to spend with family and friends or advance hobbies that have been long-abandoned, while still doing the work they enjoy the most – delivering dental care to their patients.

At AAB, our team of advisors to the Scottish dental sector includes corporate finance specialists, who are experts in advising on buying and selling of dental practices, and also wealth experts who take time to understand your values and goals to help you to face your financial future with increased confidence, enthusiasm and security. The benefit to having your advisors being part of the same team means that we can work closely together to deliver advice that is aligned to achieve your personal goals.

MORE INFO

Please get in touch with Michael if you would like to have an initial no obligation chat around your practice and your goals for the future.

INTERESTED IN BUYING OR SELLING A DENTAL PRACTICE?

Every sale or acquisition will involve some individual or even unique elements. Colin Millar, partner and healthcare specialist at Scottish independent law firm, Wright, Johnston & Mackenzie LLP, provides some key pieces of legal advice

PLANNING AHEAD

Mapping out the process and timetable and planning for each step will make things go more smoothly. Involve your accountant and lawyer at the earliest stages. Your accountant will provide essential input on the value of the practice and how the price should be paid or structured. Your lawyer will keep you right on everything from confidentiality to conclusion of final documents. Anticipate any third-party consents – this could impact on timing and might include anything from the consent of landlords to ensuring that a bank's requirements are properly understood.

KNOW WHAT YOU ARE BUYING OR SELLING

Are you buying or selling shares in a limited company or goodwill and assets? For a purchaser, the former can be much more involved: you buy the company and everything in it, good or bad. That means that diligence needs to be more rigorous and the documentation more involved in terms of protections via warranties and indemnities. If you are buying or selling goodwill and assets, do you know what exactly is being sold and is anything being retained?

DON'T OVERLOOK ASSOCIATES

Some of the 'real' commercial value in a dental practice may be through the associates. The patient lists of associates may be more significant than those of their principal(s). This needs to be addressed early and, if necessary, involves direct engagement.

PROTECT YOURSELF GOING FORWARD

If you are a purchaser, you will want a comprehensive range of warranties and indemnities coupled with appropriate restrictive covenants from the seller. You don't want to purchase a business only to find out that the seller intends to open up in competition next door to you! If you are a seller, you will want to limit your exposure under warranties and indemnities so far as possible through financial and time limits. If you are not fully retiring, you need to make sure that what you wish to do is permitted in terms of the covenants, which the purchaser will expect you to give.

DO YOUR DILIGENCE

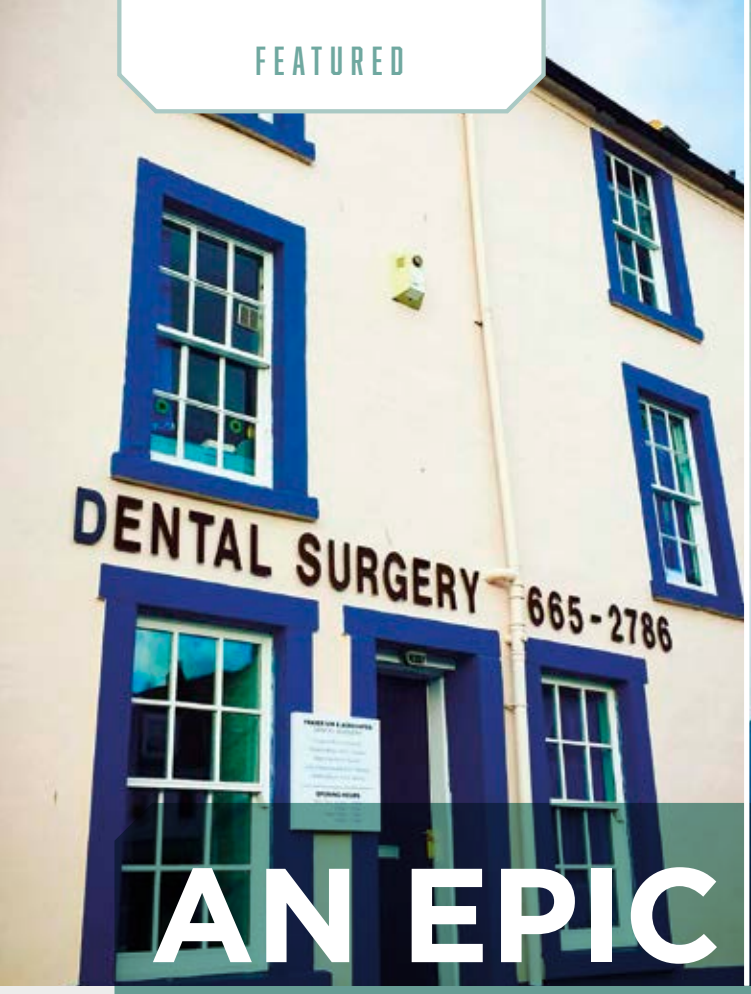
A purchaser will want to conduct financial, operational and legal diligence on the practice or entity it is buying. A seller will need to plan and prepare for that – so collate the key information, documents and ensure that any 'gaps' are addressed.

NHS AND/OR PRIVATE WORK?

If the practice does NHS work, there will need to be formal engagement with the Health Board in relation to transferring over patient lists etc. If the target practice does significant amounts of work with private providers, make sure that any necessary consents are obtained.

Buying or selling a dental practice is a complex process. Seek advice early from a good lawyer who understands the legal aspects of a dental transaction, who can guide you through the process to ensure a smooth purchase or sale and a successful close.

ABOUT THE AUTHOR
Colin Millar is the general secretary of the Glasgow Local Dental Committee and, over many years, has presented to GPs, dentists and practice managers, on legal issues affecting their particular sectors. He has a clear understanding of the issues facing GPs, dentists, etc. and offers pragmatic and solutions-based advice. You can contact Colin by email cjm@wjm.co.uk or call 0141 248 3434.



AN EPIC JOURNEY

MARTIN CHAN, PARTNER AT MUSSELBURGH DENTAL CARE, DESCRIBES HOW HE MADE THE TRANSITION FROM ASSOCIATE TO PRACTICE PARTNER AND THE INVALUABLE ADVICE AND SUPPORT HE RECEIVED ALONG THE WAY

I was first offered a partnership in December 2015. I had been working in my practice since I finished VT, and had built up a list from 800 to 3,700 over the years. I was comfortable with my patients, my dentistry and my staff. It was probably about time as well for me to begin a more managerial role. Little did I know that it would take me 22 months to finally become a partner.

Although I was thrilled, I had no idea what to do next, so I called up a couple of my old university flatmates, both of whom had bought practices over the years. Luckily for me, both had bought their practices through Trisha Munro from Strictly Confidental so for me it was very reassuring that I could trust her.

Trisha set up a very informative meeting early on a Saturday morning, out of surgery times, and guided me through the process of becoming a partner, all the steps and how much it was all going to cost. It was all very overwhelming. I was a practitioner, not a business person.

However, Trisha has her contacts and, after being given a lot of options, we assembled our team. She was my project manager.

She also taught me the importance of being aware of the levels of stock in the practice. There was one morning where I probably spent about four hours solid in the stockroom, listing all the materials, and how much reserve we had to see if we were overstocking.

She came over one weekend with a colleague and was able to count each and every instrument in the practice and put a value on them to go towards the value of the whole business.

Over the next few months, I was contacted by building surveyors, asbestos surveyors, dental accountants to extrapolate accounts and make sure the business was profitable, dental financial advisors who would make a business plan for me to get funding from the bank easily and personal financial advisors to help find suitable life insurances and income protection.

Finally, Trisha introduced me to lawyers who would walk me through the partnership contract and the buy-in contract. She wanted the contracts watertight to take care of me if anything went wrong.

Despite having a solid team, there were complications. The principal had two practices and so it did take a long time extrapolating the value of just one practice. His accountant was close to retirement and did not have a dental background, so it was almost impossible to split the two businesses. In the end, Trisha recommended a dental accountant to us and we did have to create reports from scratch for the bank.

As the process took so long, there were times of doubt, and feelings of helplessness. Trisha, being the workaholic she is, was always there for me, even at 10pm. She was always there to reassure and guide me. She was also my safety net. If I did not get to buy this practice, she had many practices around Scotland which she could have shown me and were ready to be purchased. All with valuations ready and just needing a buyer.

As the months went by and we chipped away at the purchasing process, we finally got there. It was an epic journey, one that I couldn't have done without Trisha. If I had to do it all over again I wouldn't have changed anything.

There were a lot of things outwith our control and I had the right person to guide me through it all. I guess the only advice I would give to myself is don't be impatient, and ask for all the deadlines from bankers and lawyers at the start. Once the deadline is known, it gives almost a sense of relief that there is an end to the journey.

TOP-QUALITY PATIENT EXPERIENCE

NEW GARROWHILL PRACTICE AIMS TO PROVIDE HIGH-QUALITY NHS AND PRIVATE TREATMENT IN A STATE-OF-THE-ART NEW PRACTICE

BRUCE OXLEY

AURA Dentistry doesn't look like your average mixed dental practice. The extensive use of glass and high-concept design of the fixtures and fittings makes this feel very much like a private, referral centre that wouldn't be out of place in the city centre.

On entering the building, based on Thornbridge Road in Garrowhill, the first impression is that of a state-of-the-art practice with a very distinctive style. The owners have created a welcoming and calming interior that aims to provide an enjoyable patient experience while being a pleasure to work in for staff.

Practice principal Usman Ullah, who also owns Merrylee Dental on Clarkston Road in the south of Glasgow, said: "We are delighted to have opened our new practice in Garrowhill and we can't wait to show people round our fantastic new practice. We know there is a real community spirit in the area and we can't wait to become part of this lively and exciting area of Glasgow. Our equipment is top of the range and our staff are highly trained and most importantly very friendly."

Usman graduated from Dundee in 2007 and went straight into general practice. He has developed an interest in minimally invasive restorative and cosmetic dentistry and has undertaken extensive postgraduate training with some of the UK's most respected names including Dr Hatem Algrafee, Dr Attiq Rahman and Professor Paul Tipton. He said: "I have a strong passion for dentistry and I always strive to ensure that my team and I always provide the best in clinical care. It is important to go out of your way to help patients and we have developed a forward-thinking practice that is centred on excellent patient care and satisfaction.

"I want patients to see us as approachable and the practice to have a very relaxed style, to make our patients feel comfortable and hence further enjoy their dental experience."

AURA Dentistry officially opened for business on 19 February and, as well as NHS treatment, will offer a wide range of other dental treatments including implants, whitening and straightening, as well as facial aesthetic treatments such as Botox and dermal fillers. AURA is also part of the Childsmile scheme, with local families, nurseries and schools being encouraged to visit the practice to get involved.

Joining Usman will be GDC-registered specialist periodontist Dr Hatem Algrafee, who will visit from his Harley Street practice in London. Hatem completed two masters degrees from the University of London as part of his specialist training, as well as two fellowships from the Royal College of Surgeons of England. Hatem has built up his considerable periodontal skills and experience in practices in and around London, and sees patients exclusively for periodontal and implant treatment. He is a member of the British Academy of Restorative Dentistry and Association of Dental Implantology.

Attiq Rahman will also be a regular visiting dentist at the practice and is widely acknowledged as being one of the UK's top clinicians, providing the highest level of cosmetic dentistry and dental implants. He admits to being a perfectionist, which is something that has been recognised by Dr Rahman's peers and colleagues and resulted in no fewer than 10 national awards including Smile Makeover of the Year.

AURA has already hosted the first of a series of CPD seminars at the practice, welcoming 58 dentists and clinicians to chat about the latest in implant and cosmetic dentistry as well as periodontal disease. Presenting were: Attiq Rahman, Dr Mike Gow, Hatem Algrafee and Dr Abid Faqir, president of the ADI. Award-winning

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specialist orthodontist Dr Imran Shafi and restorative treatment specialist Dr Bob McLelland were also at the seminar.

AURA appointed an interior design specialist to create a serene, relaxing and stylish practice to put patients at ease. Even though it was the company's first dental practice it had designed, the results are stunning. The focus is on the interior design, where the patient journey is a priority. Usman said: "The designers took our brief for the interior and seemingly effortlessly conjured up exactly what we were looking for. The end result is even better than I ever thought it would be."

AURA's origins date back to 2015 when Usman and his business partner Mohammed Riaz first started thinking about a new practice and where they might look to launch. In early 2016, they were recommended a site in Garrowhill and immediately realised its potential. After the site was secured, planning permission with change of use was applied for, and NVDC were appointed architects.

Farahbod Nakhaei of NVDC said: "The client's brief was to produce an efficient layout while, at the same time, creating an enjoyable environment for patients and staff alike. Given that all surgeries had to be internal, careful consideration was given to the surgery layouts, use of glass and artificial lighting to enhance the sense of space by dissolving the boundaries between private and public spaces and thus providing a more open plan, friendly, enjoyable and thus a less intimidating experience."

Usman said: "I have worked with NVDC in the past and have built up a good relationship with Farahbod. He's very well-known in the dental world and I love the style of his work and was hopeful of achieving something similar. They were very professional from start to finish, in

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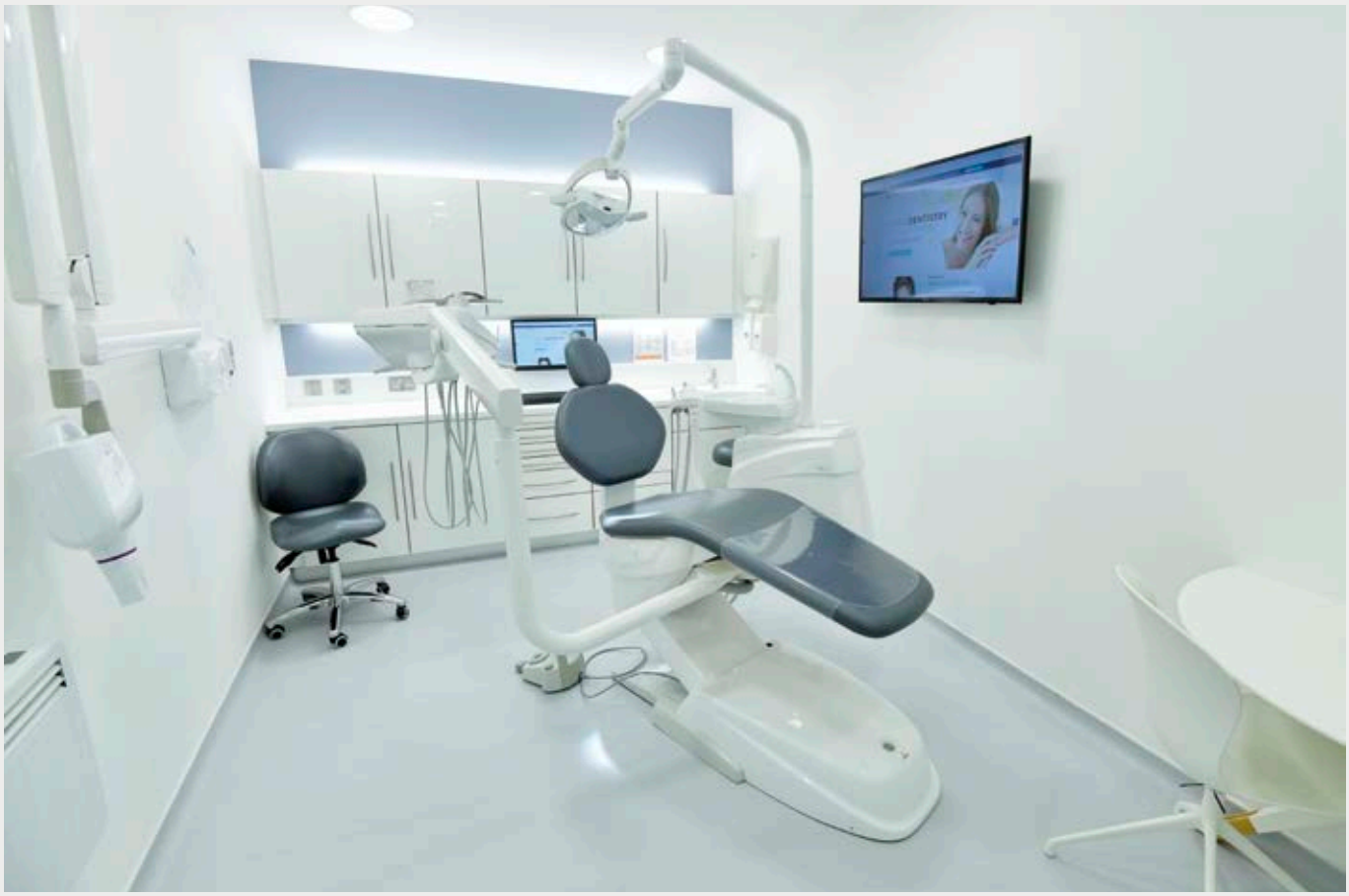

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terms of approachability, their understanding of what we were trying to achieve. I think the end product speaks volumes for their drive and vision."

In March 2017, ABC Builders were appointed and, while it was the first time they had worked on a dental practice, they came highly recommended by NVDC. Usman said: "ABC has been totally fantastic. Right from all the pre-build meetings they have been spot on with their point of view and extremely thorough and detailed. What's more, we were delighted that ABC is based in the east end of Glasgow, as it gave us the opportunity to place work with builders local to the surgery, supporting people who live in the area. They were really passionate about the build and they were as excited as we were."

A high-concept practice requires a high-tech equipment and support partner, and AURA appointed Bruce Deane and IWTech. Usman said: "Bruce was fantastic. He gave up his time to meet with us on several occasions to help scope the requirements, making changes where necessary and providing great detail, even without any initial commitment from us."

Looking back on the project in general, Usman said: "We wanted to create an environment which immediately puts people at ease. One that shows them that we care and that they are entitled to the best clinical care we can offer. We wanted to challenge the thinking on what people should expect from their NHS dentist, while also creating a space where the best of the UK's dental specialists can feel at home to provide the widest possible range of dental treatments.

"The project was all-consuming and a constant juggle of time to manage my existing practice at Merrylee while also being available for weekly site visits to AURA. Any time off was devoted to getting AURA off the ground. However, we are all delighted with the outcome and we are incredibly proud of what we have achieved so far. The future of dentistry in Garrowhill is very bright!"

AN HISTORIC DEVELOPMENT

THE DEVELOPMENT OF A VICTORIAN BUILDING IN SALTCOATS IS INVITING INTERESTED PARTIES TO CONSIDER MOVING TO THE NEW BUSINESS CENTRE

Moffat House is an important and historic building in the heart of Saltcoats town occupying a highly visible position.

With 11,237 sq ft of space set in two-thirds of an acre plot, we intend to provide a mixture of office and residential accommodation driven by local Three Towns demand.

With the announcement of the improvement to the marina and the proximity of the mainline train station entrance just 50 metres from site, this space, once brought up to date, will provide not only convenience along with plentiful parking but also modern facilities in a beautiful Victorian building.

Moffat House began its life in the 1870s and subsequently became the office of the Royal Bank of Scotland before becoming the headquarters of the A T Mays Travel group in the 1960s. In the mid-1990s the Moffats were persuaded to sell their shares to Carlson of America and, since then, Moffat House has had a somewhat chequered career.

It was acquired by Kilmarnock College in 2010 as part of their growth plans but it soon became redundant as plans for an entirely new campus came about and as we speak, the property has been unused for the last three years.

To their credit the college continued to honour their responsibilities during the rest of their stewardship until we took over in July 2017. At the beginning of September, a phased renovation of the property took place. Given its history, the new owners hope to be able to set up the Moffat House Business Centre and perhaps even include an incubator for local start-ups.

Businesses wishing to relocate to a more modern facility with plentiful parking from within the locality will be given priority, but remember, Glasgow Central is only 40 minutes away so businesses from there may want to compete for the space.

GOING ABOVE AND BEYOND FOR REFERRING DENTISTS

THE SCOTTISH CENTRE FOR EXCELLENCE IN DENTISTRY (SCED) PROVIDES A FIRST-CLASS EXPERIENCE FOR PATIENTS AND REFERRING DENTISTS ALIKE

It has been a great start to the year at SCED with increased numbers of dentists sending their patients for a full range of referral services. With the addition to the team of Colin Burns, an introduction evening was held at the centre for dentists to meet him. There were 20 dentists that went along and afterwards enjoyed a delicious meal at Mother India in Glasgow. Members of the referral team were there as well as Straumann, who kindly sponsored the evening.

SCED runs continuous courses and seminars throughout the year, please visit its website for full details. Two that are set to be very popular are on 23 March and 21 May. In March, Chris Barrow is presenting an evening talking about 'Marketing Dental Implants'. This is taking place at the Village Hotel Club from 6.30-9pm and the course is free. The May course is being held at the prestigious Loch Lomond Golf Club and the subject will be 'Immediate implant placement and provisional restorations – what is the evidence?' and will be presented by Jose Navarro. This will be a morning seminar with the choice of either golf or spa in the afternoon. The cost is £295. Bookings for these courses can be made via secretary@scottishdentistry.com

Lorna Cox (pictured) BDS, MFDS RCS(Ed), MSc (Glas) has a special interest in restorative dentistry and periodontology and is now accepting referrals for periodontology cases. She has enhanced knowledge and expertise in the non-surgical management of patients with complex periodontal needs including those that have previously had little success in stabilisation of their disease. Lorna joined the team last year and has carried out a wide variety of cases on referred patients, with great success.

SCED continues to go the extra mile – with continuous investment in up-to-the-minute equipment, the advanced training of the referral team and the commitment from everyone involved in patient care, this means that referred patients receive a first-class experience, which is a great reflection on the referring dentist.

A POSITIVE PATIENT EXPERIENCE

WITH MORE THAN 45 YEARS OF ORTHODONTIC EXCELLENCE, PARK ORTHODONTICS IN FINNIESTON PROVIDES A TOP-QUALITY SERVICE FOR PATIENTS AND REFERRING DENTISTS

Providing both NHS and private orthodontic treatment, the owners of Park Orthodontics, Andrew McGregor and Edward McLaughlin, have built a strong support team to help deliver excellent service to patients and referring dentists alike.

The practice is easily accessible by car or public transport and offers late night, early morning and Saturday appointments. Inside, the stylish waiting room relaxes patients before attending the private, individual clinics. From there, Andrew, Eddie and the team of highly trained dental nurses carry out comprehensive

assessments and record-taking, allowing them to discuss the full range of options. Administrative staff are also on hand to co-ordinate treatment, discuss interest-free finance and arrange appointments.

Throughout the patient journey, emphasis is placed on helping the individual feel at ease to make the right decision.

The team likes to work closely with referring dentists to keep them smiling too. By discussing the treatment options and working to the referring dentist's preferences, each patient can return with a healthy occlusion.

Probably the biggest area of growth for the practice has been lingual braces. Andrew has been using these appliances for more than five years, and, as patients become more aware of the types of brace available, he is finding more and more patients opting for invisible tooth alignment.

MORE INFORMATION

Getting in touch with the practice couldn't be easier. Dentists can message via email, website, phone or post and there is always an open invitation for anyone wanting to pop in for a visit if they are in the area enjoying the delights that Finnieston has to offer.

NEW ORTHODONTIC APPOINTMENT

ORTHO-CARE IS PLEASED TO ANNOUNCE THE APPOINTMENT OF CHRIS FLEAR AS ORTHODONTIC TERRITORY MANAGER FOR SCOTLAND

Although Chris has been in his current role with Ortho-Care for more than four years, he will now provide customer sales and support to its growing customer base throughout Scotland. Chris will also be available for prearranged 'Lunch and Learn' visits with CPD, and he is looking forward to this new role and to the opportunity of meeting both new and existing customers.

Chris was born and bred in the North-East of England but moved to Leeds from Durham at the age of 16 to do a goalkeeping apprenticeship at Leeds United. He is married to Joanne and has three boys: Adam (seven), Joe (13) and Luke (16). He enjoys rock music, watching his two older lads get beaten every Sunday for their respective football teams, spending time with his family and keeping a close eye on the progress (or lack of it) of Sunderland AFC and Leeds United.

This appointment further strengthens Ortho-Care's commitment to providing the highest levels of customer service and sales support to customers in Scotland.

TELL US ABOUT YOUR CAREER BEFORE DENTISTRY

For a number of years I played professional football (goalkeeper) enjoying a spell at Leeds United then in non-league in England. When that came to an end (letting too many goals in!) I decided to get a 'proper' job. I couldn't find one so entered the world of sales.

I have been blessed with working for a number of great organisations. I enjoyed my time in the competitive world of office supplies and then decided a change was needed and moved into FMCG with Nestlé.

I spent many years working for Nestlé in York managing some of their accounts and enjoying samples of every new chocolate bar they introduced to the market. I then moved into the world of fine art materials, again managing accounts across the UK. I worked for a company that sold fine art oil/watercolour paints, canvases for professional artists, students and hobbyists.

HOW DID YOU GET INTO DENTISTRY?

Ortho-Care was looking to recruit an external field sales representative for the North of England and Midlands in the October of 2013.

I applied for the role and was lucky enough to secure an interview. I remember wearing a red and white tie my wife had bought me a year previously, and as luck would have it, Kelvin Scott, director of Ortho-Care, is a Sunderland fan so that secured the role for me!

HOW LONG HAVE YOU BEEN WITH ORTHO-CARE?

I am entering my fifth full year now, and have just been appointed external field sales representative for Scotland, which I am very pleased about.

WHAT MAKES ORTHO-CARE STAND OUT?

Before I joined Ortho-Care in 2013, I had never worked within dentistry. So, before my interview I decided to engage over the phone with a number of hospital orthodontic departments and orthodontic practices throughout the UK to find out what on earth orthodontics is. And I asked if had they ever heard of a company called Ortho-Care. If I was to move on in my career I was keen to fully understand the customers' thoughts around Ortho-Care.

I spent a good two days doing this, speaking to practice managers, nurses, consultants, lab technicians, all of whom, amazingly, were more than happy to give up a little of their time to chat with me. All gave me a basic overview of orthodontics, but more importantly many of the practice managers, nurses, consultants and orthodontists were already using Ortho-Care and praised the company for

its customer service, speed of delivery and, above all, how friendly and knowledgeable the staff were at the head office in Saltaire.

So, for me, it's the people that make Ortho-Care. I feel that, as a team across all sectors of the business, we aim to understand the needs of all who work in an orthodontic department or practice and at times go that extra mile to ensure that not only are we meeting the needs of the practice, nurse, practice manager, therapist and orthodontist, but we are also ensuring the quality of the product fulfils the needs for excellent patient care. In addition, with the breadth of our product range, we are able to offer a one-stop-shop across treatment from the very start of the first appointment right the way through to retention at the end.

WHAT DO YOU ENJOY MOST ABOUT YOUR ROLE?

The variety which each week brings, from planning and preparing in the office with the internal team to hitting the road and seeing customers.

Each week brings its own challenges but more importantly it is an opportunity to ensure our customers are fully up to date with our product range on both new and existing products.

IS THERE SUCH A THING AS A TYPICAL DAY OR WEEK?

Not at all. And that's what is great fun and fulfilling about the role. Each week brings a nice mix of practice visits, new business visits, 'Lunch and Learns', study group meetings and a chance to visit some lovely areas of the UK.

WHAT IS THE BEST PIECE OF ADVICE YOU HAVE BEEN GIVEN?

It's nice to be important, but it's important to be nice.

HOW HAVE YOU SEEN DENTISTRY CHANGE IN YOUR TIME IN THE INDUSTRY?

When I first came into the industry, 3D technology was just a thing people were talking about. Now, five years on, many practices and laboratories have invested and the talking has changed to doing.

Aligner treatment is in growth for cases that are suitable. Private ortho seems to be in growth with adults being more aware of their smile as they enter the competitive workplace and, with the challenge of waiting lists, parents opting for private treatment.

WHAT ADVICE WOULD YOU GIVE TO SOMEONE WHO IS JUST STARTING OUT AS A REP?

That's a great question. Make sure you have plenty of fire in your belly. That's the advice I was given when I first started in sales. And, as I have got older, it's something I tell my three lads. Whatever you do in life, make sure you have plenty of fire in your belly. That fire radiates and warms others.

Ortho-Care HQ in Saltaire, near Leeds

WHAT ARE THE MOST IMPORTANT PERSONALITY TRAITS FOR A SUCCESSFUL REP?

I have been a rep now for many years and I have met many reps both in work and in my personal life.

Those reps that listen more and talk less seem to me to be the ones that not only understand the customer's needs more, but also, go on to enjoy a fulfilling career in sales.

Having the gift of the gab as they say is less important than the ability to listen, understand, empathise, clarify and summarise and finally meet the customer's needs.

WHAT ARE YOUR HOPES FOR THE FUTURE – PROFESSIONALLY AND PERSONALLY?

Professionally, I hope the NHS continues to see the value that orthodontic treatment adds to a child's life. As well as correcting a bite, it offers so much in terms of raising a child's confidence and self-esteem during such a delicate time. Two of my three lads have been through orthodontic treatment, and, as a father, I feel not only was the treatment of benefit to them physically but more importantly, mentally. Playgrounds can be a tough environment if you are seen as different in anyway.

I hope that my years at Ortho-Care continue.

LEARNING FOR LIFE

A COMMITMENT TO CONTINUING EDUCATION IS THE KEY TO SUCCESS IN DENTAL IMPLANTOLOGY

For all professionals in the dental industry, lifelong learning is essential because it enables the individual to provide their patients with the best treatment and service. By engaging in ongoing training, dental professionals can ensure that their knowledge and skills are up to date. The need for continuing education is particularly important in the field of dental implantology, as it is a rapidly evolving branch of dentistry. In addition, there is an increasing demand for dental implants by the general public, especially as there is a growing number of older people in the population who are more likely to be edentulous.

ONGOING EDUCATION

However, as instruction in the provision of dental implants is rarely included within undergraduate degrees, postgraduate education is required. Such training is offered by Nobel Biocare, which is dedicated to ongoing learning and development, and which has 'learning for life' as one of its key pillars. Nobel Biocare is a world leader in innovative implant-based dental restorations, and it is at the cutting-edge of training and education. Its expertise has been built on over 60 years of continuous product research, development and innovation, as well as its desire to ensure that clinicians have the necessary skills to properly use the solutions available.

ALL LEVELS OF EXPERIENCE

The practical hands-on training offered by Nobel Biocare is suitable for all dental professionals because it is specifically tailored to individuals' experience levels.

This means that the clinician can either begin with the basics of a technique or further develop their skills at a more complex level. Training is also available for various members of the dental team, including dental nurses and dentists.

There are three levels of training courses. The level one foundation/fundamental treatment courses provide information about how to perform surgical and prosthetic procedures in less complex cases that have highly predictable outcomes. The course topics include certification programs in implant dentistry, conventional two-stage surgical implant procedures, restoring a single tooth and overdenture treatment.

The level two advanced treatment courses expand on the level one training by bringing the individual's existing experience in implant dentistry to the next level. The courses include soft tissue management, optimal provisionalisation, guided bone regeneration, Immediate Function, guided surgery and rehabilitation of edentulous jaws using Nobel Biocare's original All-on-4 treatment concept.

The level three complex treatment courses deliver training for approaching challenging situations with advanced treatment planning and complex surgical and prosthetic procedures. These courses are suitable for those with significant experience in placing implants and cover rehabilitation concepts for edentulous patients, zygomatic implants and extensive and complex grafting procedures.

IMPROVING PRACTICE MANAGEMENT

In addition to the three levels of courses, Nobel Biocare offers training in practice management that will help professionals and practices to encourage business growth and long-term success. The practice management course includes information about patient communication, case presentation, and clinical photography and marketing, among other topics.

LEARN FROM THE EXPERTS

The training courses by Nobel Biocare are all provided by inspiring industry-leading professionals from around the world. The speakers are internationally renowned experts who share their knowledge of the latest exciting information and ideas.

THE NEXT STEP TO TRAINING IN 2018

High-quality training in dental implantology is valuable for ongoing education as well as for improving the success of both the individual professional and the practice. Nobel Biocare's three levels of courses, which cover all experience levels, are an excellent way to acquire knowledge in the field of dental implantology and to improve existing skills. The courses are offered across the United Kingdom as well as around the world.

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

A BREAKTHROUGH USING BIOLUMINESCENCE

THE NEWLY-LAUNCHED CALCIVIS IMAGING SYSTEM IS A RECENT BREAKTHROUGH IN THE DETECTION OF ACTIVE DEMINERALISATION ASSOCIATED WITH CARIES AND EROSION, MEANING EARLY DETECTION AND THEREFORE IMPROVED PATIENT ENGAGEMENT

Designed and created by CALCIVIS, an innovative UK dental biologic and device manufacturer, the system has the sole purpose of revolutionising the treatment of dental decay and therefore improving on preventive dentistry as it currently stands. Bringing together world-class experts in business and dentistry, CALCIVIS aims to reduce the sector's dependence on expensive and intrusive surgical treatments.

At the centre of the CALCIVIS imaging system is the CALCIVIS photoprotein which produces light when it reacts with free calcium ions released by actively demineralising tooth surfaces. A first in dentistry, it is comparable to what is observed in marine organisms that create bioluminescence in the sea, and glowworms and fireflies in the wild. Unique to the CALCIVIS imaging system, the resulting luminescence occurs only in the presence of free calcium ions (bound calcium in sound enamel does not generate the light signal).

The imaging device is designed exclusively to scan the tooth surface after delivering a defined application of the CALCIVIS photoprotein. The system is simple to use and to understand. It is easily initiated via a 'one-touch' computer controlled process. A specialised sensor incorporated in the device immediately detects the resulting luminescence or light flash. Integrated with a software system, in just one second, at the chairside, a demineralisation 'hot spot' image map is available for the clinician to view and then, most importantly, discuss with the patient.

There is no hanging around for results to come through or information to be processed. An action plan can be put in place immediately, such as a first-step preventive treatment, like fluoride varnish, high-calcium toothpaste or dental sealant. The patient is satisfied when they leave the practice knowing that the latest technology has been used on them to help manage their oral health treatment moving forward.

Research and clinical data on the CALCIVIS imaging system was recently presented at five separate sessions of the International Research Association at the 64th International Organisation for Caries Research (ORCA) meeting in Oslo, Norway. The results showed that enamel demineralisation is detected by the CALCIVIS imaging system at an early enough stage to allow for reversal and future prevention. CALCIVIS are pleased and proud to be launching a dentistry first in their home country, the UK, as well as looking to cater for other markets globally.

There has been a shift in the mindset of what dentistry should look like now; increasingly acknowledging that robust oral health can help with overall health and wellbeing. The type of dentistry carried out has been heavily influenced by the way in which the government funds the treatments carried out on the NHS and also the development of innovations. More recently, the government has begun work to explore a reimbursement contract that is more focused on preventive dentistry, and so CALCIVIS are confident that their imaging system fits well with this trend.

The CALCIVIS imaging system was recently well received at the All Parliamentary Group for Dental Innovation as part of the British Dental Industry Association's Innovation in Dentistry group, alongside the British Dental Association and the chief dental officer. Delegates learnt more about the system in preparation for the market launch.

It is an exciting time in dentistry as there is a move away from the historical 'drill and fill' mentality, towards being more proactive in preventing disease from an early stage. Engaging patients before their oral health deteriorates irreversibly by using clinical facts in a timely manner results in better motivation and commitment. Being at the forefront of preventive dentistry through the use of innovations like the CALCIVIS imaging system can make your dental practice stand out from the competition and serve your patients to the very best of your ability.

MORE INFORMATION
For more information visit www.CALCIVIS.com or call 0131 658 5152

CALCIVIS
dental enlightenment

KEY TO A HAPPY CHILD IN THE DENTIST'S CHAIR

Diamond Snappy Glass Ionomer Cement for children is just one of the Kemdent products on display at the Dentistry Show 2018. Find us on stand F02 and take advantage of the amazing special exclusive offers at the show.

Diamond Snappy Restorative Glass Ionomer Cement (GIC) is the ideal tooth restorative for children. It is extremely durable, versatile and hard-wearing.

Snappy is easy to pack and place, releases fluoride and leaves no bitter after taste. It begins to set in two minutes 15 seconds. This ideal GIC is resistant to saliva and adheres to dentine and enamel.

It is radiopaque and has a rapid snap set. Snappy's translucency continues to improve with time, ideal for children.

Dentistry Show exclusive offer: Buy one 10g/7ml Diamond Snappy for only £36.05 + VAT and get another 10g/7ml Diamond Snappy absolutely free

THE LATEST FROM CARESTREAM DENTAL

Discover how Carestream Dental solutions could make your life easier at our stand F33 at the British Dental Conference and Dentistry Show.

The team will demonstrate the latest features of the CS R4+ practice management software, including the various KPIs monitored in real-time through Springboard and the complete integration with DEPPA for massive time-saving benefits.

You'll also be able to find out more about The Exchange – a convenient online portal designed to enable the sharing of ideas with colleagues and experts to help all CS R4+ users make the most of their software capabilities.

For anyone seeking cutting-edge imaging technology, the CS 8100 portfolio will be on display for all your practice needs. The CS 3600 intraoral scanner is also set to impress.

For more information, contact Carestream Dental on 0800 169 9692 or visit www.carestreamdental.co.uk

A TRIP TO ITALY – CHAIRS FOR LIFE

"We recently worked with Clark Dental on our practice redevelopment," said Dr Simon Clarke and Dr Tom Huddleston, "and it's thanks to them that we have five new Anthos treatment centres.

"In truth, we hadn't even heard of Anthos before Richard Beal at Clark Dental recommended them to us. But he told us that they were worth considering, and even flew us out to the Anthos factory in Italy to see why.

"We were blown away. Anthos is one of the biggest dental chair manufacturers in Europe, and the quality of their products and manufacturing processes was just extraordinary. The chairs are also incredibly comfortable – they're memory foam and our patients love sitting in them."

Call Clark Dental on 01268 733 146, email info@clarkdental.co.uk or visit www.clarkdental.co.uk

TRUE GENIUS OF ORAL-B TECHNOLOGY

Oral-B's Genius brush, combined with the Oral-B App, provides the world's most intelligent brushing system, helping users to achieve the best at-home dental care.

It does this by combining the best cleaning technology – electric tooth-brushing – with the best guiding technology. Oral-B's oscillating-rotating-pulsating brush-heads provides an outstanding clean, while Oral-B's App makes sure that users brush for the right amount of time, with the right pressure, and that all zones of the mouth are covered evenly.

The position detection capability of the Oral-B Genius is what sets it apart. Other brushes cannot detect where users brush in their mouth as Genius can – their systems give recommendations on where to brush, but cannot track if indeed the user brushes where their app tells them to do.

Genius? It certainly is!

ECOSITE BULK FILL MAKES POSTERIOR RESTORATIONS QUICKER AND EASIER!

As a modern, definitive filling material, a packable bulk fill composite is the perfect alternative to amalgam. Ecosite Bulk Fill, DMG's newly developed posterior tooth composite, makes it even easier for dentists to perform quality fillings quickly.

The material is applied in one step, with no time-consuming layering required. Curing performed reliably up to 5mm in only 20 seconds. The low shrinkage stress values of Ecosite Bulk Fill minimise shrinking stress and ensure a durable and safe marginal finish, while the firmer material consistency ensures convenient and precise handling.

For further information, contact DMG Dental Products (UK) Ltd on 01656 789401, email info@dmg-dental.co.uk or visit www.dmg-dental.com

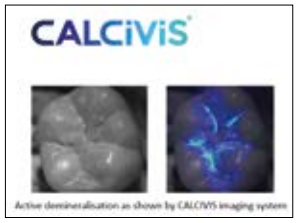
CALCIVIS SHEDS LIGHT ON DEMINERALISATION

Using a recombinant luminescent photoprotein and integral sensor the CALCIVIS imaging device identifies free calcium ions and produces a precise, visual map of active demineralisation on tooth surfaces.

The award-winning CALCIVIS imaging system enables dental practitioners to detect demineralisation at its earliest and most reversible stage and to plan prompt management and therapy.

With a luminous chair-side map, practitioners also have a clear and comprehensible communication tool that highlights hot spots and helps to educate and motivate patients for improved oral health.

See the new CALCIVIS technology on stand J85 at the Dentistry Show 2018.



For more information, visit www.calcivis.com, call on 0131 658 5152 or email at info@calcivis.com