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Scottish Dental

DECEMBER 2018

RRP £5.50

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Inaction plan

More needs to be done to raise the priority of the prevention and early detection of oral cancer

The Oral Health Improvement Plan. When this was launched at the beginning of the year, it raised some questions, and some eyebrows. Though the dental profession in Scotland cautiously welcomed the plan's overarching aims, there was significant concern about some core elements. Areas of controversy included the lack of any costings for the plan or any information about how it was to be funded; the focus on long-term prevention without any real short to medium-term solutions; and the one element that really grabbed the headlines – 24-month recall.

Fast forward to a couple of weeks ago, and I'm in a meeting room in Holyrood with dental professionals, politicians and survivors of oral cancer. We've been brought together by the BDA Scotland, for the launch of their Oral Cancer Action Plan. Incidences of oral cancer are increasing, and at a faster rate than any other cancer, now killing more than three times as many people in Scotland as car accidents. The three main causes of oral cancer are alcohol, HPV infections and tobacco, and data cited by the BDA shows that 90 per cent of cases could be prevented.

The same figures suggest that survival could be improved from 50 per cent to 90 per cent with early detection. Which leads to one question – does the OHIP support the prevention and early detection of oral cancer? The short answer seems to be, no. Oral cancer is mentioned only once in the entire plan, action 17, which states that the Scottish Government will ensure that the [oral cancer] clinical pathway across Scotland is safe, consistent, clear, and effective. Good. There is no doubt that the current pathway is complex, and with current figures suggesting that 40 per cent of new oral cancer cases present through GPs rather than GDNPs, there is clearly a need for all primary and secondary healthcare services to have a clear, joined-up approach. However, this on its own will simply not be enough. Worse than falling short, though, is the issue that the OHIP may actually work against early detection. Yes, we're back to that pesky 24-month recall.

BDA figures show that 97 per cent of Scottish dentists believe longer recall intervals would pose a risk for oral cancer detection. Dentistry is unique among healthcare services in that it provides a regular touchpoint for patients. The value of this for early detection cannot be underestimated. What happens when this touch point is removed? Remember those 40 per cent presenting through GPs? It would be interesting to research how much that figure might increase and, ultimately, how many cases would just not be caught because the patient didn't think anything was wrong so didn't go to their GP, let alone their GDNP.

Surely though, patients can be educated

to take on some responsibility for early detection, can't they? In its action plan, the BDA talks about raising awareness of the early signs of suspected oral cancer. The Scottish Government certainly seems to have latched on to this. At the event, in his response to the BDA's concerns about 24-month recall, Joe Fitzpatrick, Minister for Public Health, Sport and Wellbeing, said that the government was keen to encourage people to self-examine and learn how to spot symptoms of oral cancer. Can't argue with that. Self-examination has certainly improved breast cancer figures. Except oral cancer is not breast cancer. Let's make no bones about it, oral cancer diagnosis is not easy. Indeed, it is nigh on impossible, even for those who see cases every day and, in their examinations, have access to every part of a patient's oral soft tissue, access that an individual could never achieve at home.

At the lectures on oral cancer recognition and referral at our last Scottish Dental Show, clinical slides of various oral cancer signs were shown. The lecturer asked the audience to say which they would refer as high risk. I think it is fair to say that the audience found it very difficult. Slides which everyone agreed could only be malignant proved to be benign, and slides which showed cases that looked innocuous were quite the opposite. The advice from the lecturer? If in doubt, refer. Good advice. What's the advice to the public though? If you see anything suspicious get it checked out. But checked out by whom. The public is conditioned to go to their GPs with concerns about cancers, not their dentist, the actual expert in oral health. That 40 per cent presenting through GPs is climbing again.

Which leaves us with prevention. This is something where the public really can have an impact. Stopping smoking, eating more healthily, cutting down on alcohol, all things individuals can do themselves. Except, it's not as simple as that. Achieving this requires not just a significant public engagement and education campaign, a few posters and leaflets won't cut it I'm afraid, but a public health and private sector infrastructure that supports individuals to live healthier lifestyles. Minimum alcohol pricing certainly might help: the cuts to alcohol treatment and smoking cessation services won't. And this is all before we get onto the issue of the disparity of cost between 'healthy' and 'unhealthy' food. Best not to get me started on that one.

The final mention should probably go to one significant cornerstone of oral cancer prevention – HPV vaccines. It is wonderful that the HPV vaccine is going to be administered to boys. It will really make a difference to the 29,000 12-year-old boys across Scotland destined to receive the first wave of vaccinations. It will be even more wonderful when there's a date for it.

And just imagine how wonderful it would be if the Scottish Government agreed to a catch-up programme of vaccinations for the 140,000 older boys still at school.



The problem of millennials: a cautionary tale

The world wants dental appointments 24/7, but there's a huge disconnect between the desires of patients and the desire of young dentists to work. They are not interested in five days, let alone weekend work

Def: Baby Boomers, born from WWII until the mid 60s; Generation X, until the late 70s/early 80s; Generation Y or Millennials, until the early 2000s and now Generation Z. All working in dentistry except Gen Z who won't start for another 5-10 years depending on definitions.

Why am I telling you this? I have a reasonable amount of contact with young practitioners, but it doesn't make me an authority on the thinking processes of millennial dentists. I do talk to them occasionally. I certainly don't pretend to understand them! I'm a bit of a workaholic, I do lots of hours and work more like a Baby Boomer than a Gen Xer. This makes me suspicious of young dentists who feel like four days a week is as much as they'd like or need to do. They appear to like world travel, holidays, a broad range of experiences and to have something called a "work/life balance".

OK, I'm joking... a bit. However, they seem to think quite differently about their working commitments, and this is not limited to dentists. As a practice owner, this presents a bit of problem in terms of my service provision and staffing. The world wants dental appointments 24/7, but I don't have the dentists to staff it. They're not very interested in five days, let alone weekend or out-of-hours work. For all the connectivity they crave, they don't interact with "old-fashioned" CPD events or governmental consultations or professional bodies or negotiators. Although I feel this is more likely to be about how the profession(s) interacted historically with their members than an absolute lack of care from young practitioners, they are hard to engage.

There seems to be a huge disconnect with the desires of patients for service and the desire of young dentists to work. This is not a dig. I think all professions and sections of society are going to suffer horribly from this problem. The French recently legislated against online, out-of-hours working, yet society demands a level of service that results in workers having to work harder for more hours and at times outwith their contracted hours. Fortunately, until the dental robots are built, dentists still need to see patients. We can't really do this online, and I am massively glad about this.

Unfortunately, this still drives longer opening times for surgeries without the young dentists able or willing to staff them. For the record here, I don't think the

young dentists wanting to work fewer hours is wrong. If I had my time again, I'd cut my cloth differently and not work so many hours. It's too late for me, but if you never start and set out your stall for a shorter working week, living within your means, I suspect you'll be able to work the 40-odd years that the current pension regulations seems to dictate. A much more important point is how this affects workforce planning for dentistry.

Here is the real problem with the millennials: it's not the dental professionals, it's not the public demand, it's not the change in dental requirements for future oral health, workload, consent, note taking, CPD/revalidation, increased litigation or whatever the new OHIP demands. It's all of that and how it interacts. It is very complex. I think it is fabulously challenging. I worry that the powers that be don't have the perspective or understanding of the reality of the situation, let alone the effect of the millennials. Here's my take.

Fundamentally, I don't believe caries and periodontal disease are totally preventable. It's not that I don't think it's possible. I just don't believe humanity can be controlled or educated to avoid harm. People like sugar; they forget to brush their teeth and no matter how much you tell or tax them to modify their behaviour, they won't. It's human nature. In the future there will still be oral disease and wear and tear requiring treatment.

There are many more teeth in peoples' heads. Treatment is more complex and the time you have to take to ensure all the GDC, NHS and medico-legal requirements are met is greatly increased. Combine this with the millennial effect of reduced working hours and the greater number of women in dentistry resulting in more part-time working and maternity time out. Multiply it by the expectations of the public for greater availability. Compound it by the reduction in students. Exponentially explode it by the delivery of a new Oral Health Improvement Plan. I reckon our workforce planning is stuffed. I think the idea that we need fewer dentists in modern dentistry is wrong. I think we are heading to a repeat of our inability to meet demand like the late 90s and early 2000s.

I might be wrong, but take this as a warning: look closer at the working patterns of young dentists. They are the future of our service provision. It takes a long time and a lot of money to fix workforce planning mistakes.



BDA Scotland launches oral cancer action plan

Diagnosing oral cancer in practice is not at all easy, and incidences are increasing at a faster rate than any other cancer. The BDA's latest report underscores the need for urgent and far-reaching changes to tackle the issue, but it does not hold all the answers

THE figures around oral cancer in Scotland make for sobering reading. It now kills more than three times as many people in Scotland as car accidents, and it's on the increase. In November, the BDA Scotland launched *Oral Cancer: A plan for action*, a report which lays out its recommendations for tackling this growing issue, focusing on three key areas: prevention; early detection; and joined-up services.

There is no doubt that oral cancer needs significant focus, and the BDA report has done much to raise awareness in the media and, hopefully, with politicians that oral cancer is a growing problem and one that cannot simply be ignored or dealt with through simple public health initiatives.

Tackling this requires real investment in infrastructure and resources, major cultural changes and a willingness by the Scottish Government and others to listen to the dental profession and finally accept that, in the words of Robert Donald, BDA Scotland Chair, dentists "are not tooth-smiths, we are oral physicians".

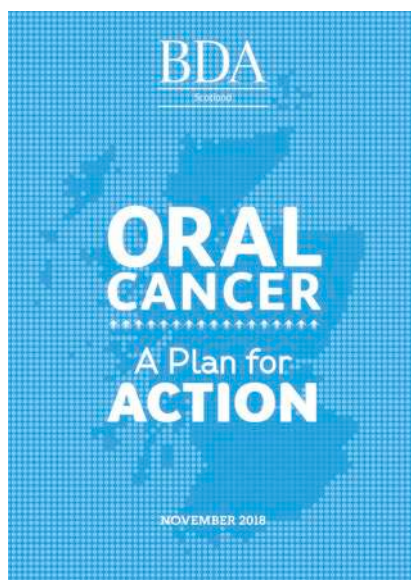
Prevention

The BDA action plan calls for sufficient resources to be available for effective smoking cessation and alcohol treatment services. This is critical, as alcohol and tobacco are two of the three biggest causes of oral cancer.

This also fits with the government's overarching public health objectives in these areas. It is hoped that the introduction of minimum pricing will go some way to help, and the recent announcement that the Scottish Government plans to consult on restricting the marketing of alcohol products has been welcomed, but this by itself may not be enough.

Certainly, the significant cuts to smoking cessation services in Scotland over recent years seem to fly in the face of this objective, and we must hope that more resources are made available.

The third major cause of oral cancer is, of course, the HPV virus. The Scottish



Government has indeed led the way in introducing the HPV vaccine for boys, and this development, which has followed years of campaigning, is to be applauded. There is now significant pressure from the same campaigners, including the BDA, to implement the programme of vaccinations as soon as possible, and, critically, to introduce a catch-up programme for older children who are still at school.

Speaking at the launch of the action plan, Minister for Public Health, Sport and Wellbeing, Joe Fitzpatrick, was unable to give a date for the implementation of the programme and would not commit to a

catch-up programme. It is to be hoped that more concrete plans about the initial programme, and a commitment to the catch-up programme will be announced soon.

Early detection

There is absolutely no doubt that early detection is critical. The BDA's action plan calls for approaches to target those individuals who "do not engage regularly with oral health services", as well as raising awareness of the early signs of suspected oral cancer to encourage dental visits. Both, laudable and important actions.

However, changing the behaviour and understanding of individuals requires significant, sustained and ongoing investment in major education and engagement programmes. It also requires wholesale change to how people view their interactions with the dental profession and access to dental services.

The Scottish Government response to this, and the BDA's ongoing concerns about the plan for 24-month recall intervals, was to highlight the new personalised care plans described in the OHIP, as well as to emphasise the importance of self-examination.

There is still a lack of clarity about the mechanics around the new care plans and the resources needed to carry out oral health risk assessments for every patient. Self-examination for oral cancer is fraught with difficulty, which is not to say that the public should not have awareness of warning signs and be educated to look out for them, but relying on self-examination to fill the gap in between longer dental appointments could be considered short-sighted at best.

There is the argument that 24-month recall will only apply to low-risk patients, but if there is one thing that we can be sure of, it is that cancer does not discriminate, and low-risk does not mean no risk. However, the ongoing disagreement around recall intervals is complicated,

**“
TACKLING THIS REQUIRES A
WILLINGNESS BY THE SCOTTISH
GOVERNMENT AND OTHERS TO
LISTEN TO THE DENTAL PROFESSION”**



Do you know which of these is cancer?

EVEN for experienced professionals, never mind the patients, recognising and diagnosing oral cancer is notoriously difficult.

At our Scottish Dental Show earlier this year, the audience at a lecture on oral cancer recognition and referral was shown these clinical slides of various oral cancer signs. The lecturer asked them to say which they would refer as high risk, an exercise, as it turned out, that proved very difficult for participants.

Slides that everyone agreed could only be malignant proved to be benign, and slides which showed cases that looked innocuous were quite the opposite. So, can you identify these conditions? (Answers below)

Recognition of head and neck skin cancer: A guide for GDPs – p40

The answers: 1 – denture stomatitis, Benign; 2 – early tongue cancer; 3, large alveolar cancer; 4, large drug-related ulcer, benign; 5, lichenoid reaction with fungal infection, benign; 6, peripheral giant cell granuloma, benign; 7, retromolar cancer; 8, small floor of mouth cancer.

with competing data on both sides of the argument, and should not be allowed to overshadow other elements required to tackle oral cancer.

Joined-up services

The BDA action plan calls for the simplification and streamlining of current referral processes to create one referral process for oral cancer across Scotland, citing the Glasgow Referral Pathway and Timeline as current best practice, while allowing that there is still room for improvement in it. There is no doubt that the current mixture of referral pathways is untenable, but there remain questions as to why the Glasgow Pathway has been recommended.

It will be important to thoroughly analyse pathway requirements, consult more widely among the surgical teams and oncologists dealing with oral cancer, and investigate, for example, why the current UCS (Urgent Cancer Suspected) pathway on SCI Gateway, which is used for all other cancers, could not work for oral cancer.

This is the referral pathway currently used by GPs who have urgent suspected oral cancer cases, and it is also already available to GDPs. It is also important to remember when considering this that oral medicine as a specialty is only available in tertiary centres, and any referral pathway must work everywhere.

It will also be important to tackle the elephant in the room. Many GDPs will refer for second opinion because they have a genuine fear of action from the GDC, should they make a mistake.

In summary, the BDA's plan for action is an important first step in tackling the growth of oral cancer. To really move forward, however, will require the further involvement of, and consultation with, the dental profession, as well as major investment and commitment from the Scottish Government, the NHS and other stakeholder organisations.

Tackling oral cancer is complicated and multi-factorial, but there is much that can be done with the will, the investment and the commitment of everyone.

ORAL CANCER

Key facts

Oral cancer kills **more than three times** as many people in Scotland as car accidents



Throat cancer rates have trebled in recent years making it the fastest rising cancer in Scotland



The annual cost to NHS Scotland for treating oral cancers is likely to double by 2035 from **£67m to £148m**

Cancer Research figures shows incidences of oral cancer are likely to increase by **33% in the UK by 2035**



People in Scotland's most deprived communities are more than twice as likely to develop and die from mouth cancer:

(RATE PER 100,000)

INCIDENCE

least deprived

6.7

most deprived

14.5

MORTALITY

least deprived

1.9

most deprived

4.5



9 in 10 cases of oral cancer could be prevented

Scotland has seen **40% cuts** to smoking cessation services



140,000[♂] BOYS

need protection through an HPV catch-up programme



Survival can be improved from **50% to 90%** with early detection



97%

of Scottish dentists believe longer recall intervals would pose a risk for oral cancer detection

All data from the BDA Scotland report Oral Cancer: A Plan for Action <http://bit.ly/GDC-ARF-consultation>

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Dr Monik Vasant

BChD MFGDP (UK) MSc



Drive to simplify complaint handling

TWENTY-EIGHT organisations from across the dental sector have joined forces to launch a set of universal principles for good complaint handling. The six core principles provide a simple template for best practice, helping professionals and patients to get the most from feedback and complaints, for the benefit of all.

According to the General Dental Council's (GDC) 2017 *Public and Patient Survey*, 97 per cent of dental patients report being either very (67 per cent) or fairly (29 per cent) satisfied with their dental treatment and only 8 per cent report having considered making a complaint. However, of those who have, 33 per cent said they had not done so because they didn't know where to start.

GDC Executive Director Strategy Matthew Hill said: "We all know that good complaint and feedback handling is an important part of being a dental professional, which is why we committed to developing a profession-wide understanding of what best practice looks like in *Shifting the balance*. There was really strong support from across the sector for this, so a working group was formed which went on to develop the six core principles. These set out a very clear picture of what patients can expect when providing feedback or making a complaint."

The six core principles to communicate to patients are:

1. All of your feedback is important to us.
2. We want to make it easy for you to raise a concern or complain, if you need to.
3. We follow a complaints procedure and keep you informed.
4. We will try to answer all your questions and any concerns you raise.

5. We want you to have a positive experience of making a complaint.

6. Your feedback helps us to improve our service.

The Director of Primary Care Commissioning at NHS England, Dr David Geddes, said: "Local resolution to complaints should always be encouraged, and this work will hopefully help dental practices be more confident in their complaint handling. It will also encourage patients and their carers to consider the different ways in which they can provide feedback, with the option of making a formal complaint being more clearly explained."

The working group's aim is for the principles to be clearly displayed and accessible in every clinical setting providing dental care by May 2019.

Deputy Chief Inspector of General Practice & Dentistry at the Care Quality Commission Janet Williamson said: "Good care not only understands the clinical needs of people using services, but also listens to their experiences and reacts to their concerns. These principles build on the work of the Regulation of Dental Services Programme Board and will help people using services to understand what they should expect when they raise a complaint – as well as helping people working in dentistry to understand that feedback and complaints can play an important part in driving improvements in the care that they offer."

More information and supporting resources, including a poster and leaflet, are available electronically from many of the working group members' websites. They are also available in hard copy on request.

Report reveals persistent Scottish oral health inequalities

LONG-STANDING oral health inequalities remain a problem in Scotland, according to the latest National Dental Inspection Programme Report*.

The report highlights stark differences across Scotland. For example, the percentage of Primary 1 children free from dental decay in Dumfries and Galloway (67 per cent) is 17 percentage points lower than in Orkney (84 per cent).

Similarly, the percentage of Primary 1 children free from dental decay in the most deprived areas is 30 percentage points worse than in the least deprived areas (56 per cent versus 86 per cent), and the gap increased by 3 percentage points from the previous report.

Figures also show that the percentage of children free from dental decay in the most deprived areas (56 per cent) still falls short of the government's 2010 target of 60 per cent.

The British Dental Association (BDA) in Scotland is urging the Scottish Government to go further and faster to tackle what it calls "the alarming oral health inequalities in Scotland". Robert Donald, Chair of the BDA's Scottish Council, said: "Dentists have applauded the progress secured through Childsmile, but this data is a stark reminder that the Scottish Government cannot rest on its laurels."

"Scotland's oral health gap had shown signs of closing, and we must ensure hard-won progress is not undone. Ministers now need to go further and faster to tackle the scandal of these deep and persistent health inequalities."

*** You can see the National Dental Inspection Programme Report at: <https://tinyurl.com/ychea42x>**

Patients face barriers to dental treatment

NEW research has revealed that patients with dental problems are facing barriers created by cost and access.

A study published in the *British Journal of General Practice* found that problems arose because there is easier access to GP services, people's previous experience of dental care made them turn to GPs, and there is unwillingness and inability to pay for dental care.

Patients with urgent dental problems usually require some form of operative intervention,

which GPs are neither trained nor equipped to provide.

It has been estimated that the 380,000 GP consultations referenced in the study cost the NHS £20.8m. Previous research has estimated 57 per cent of all patients with dental problems are provided with antibiotics, which are not a cure for dental pain. Surveys have shown that nearly one in five patients have delayed treatment for reasons of cost.

Dentist leaders have repeatedly warned that low-income patients are

turning away from NHS dentistry. Official figures reveal a fall of two million treatments delivered to patients exempt from NHS charges since 2013/14.

Henrik Overgaard-Nielsen BDA Chair of General Dental Practice, said: "Dental patients face growing barriers, from higher charges to longer journeys, where even those entitled to free care face the threat of fines for misclaiming. The result is millions are being wasted, and pressure piled on overstretched GPs."



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Treating gum disease may help to manage Type 2 diabetes

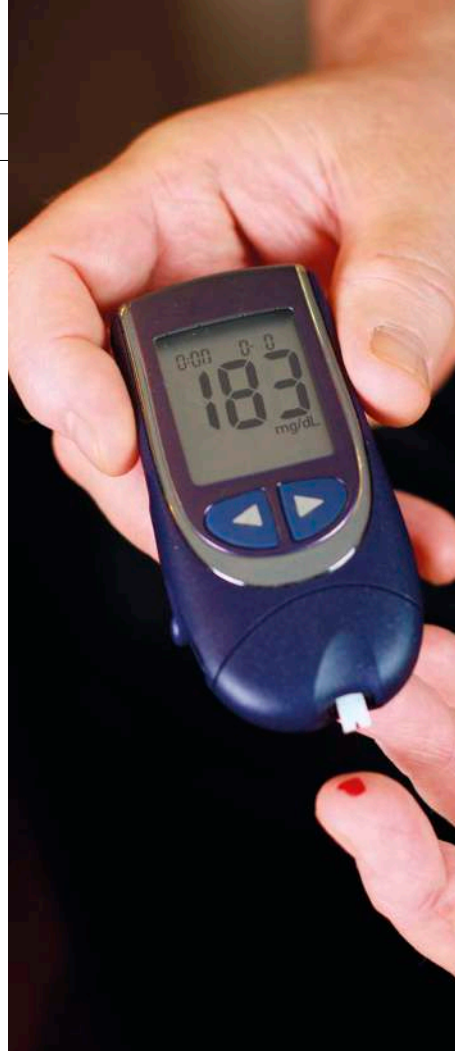
A **NEW** study has found that treating periodontitis (gum disease) could help people with Type 2 diabetes manage their blood glucose levels, and may reduce their risk of diabetes-related complications.

The study, funded by Diabetes UK, involved researchers at the UCL Eastman Dental Institute recruiting 264 people with Type 2 diabetes, all of whom had moderate to severe periodontitis.

Half the participants received intensive treatment for their gum disease, which involved deep-cleaning their gums and minor gum surgery. The other half received standard care, involving regular cleaning and polishing of their teeth. The treatments were provided alongside any Type 2 diabetes medications being taken.

After 12 months, participants receiving the intensive treatment had reduced their blood glucose levels (HbA1c) by on average 0.6 per cent more than the standard care group. This suggests that intensive gum disease treatment could help some people with Type 2 diabetes to improve their blood glucose levels.

The findings, published in *The Lancet Diabetes & Endocrinology*, are the first to link intensive gum disease treatment to improvements in kidney and blood vessel function and chronic inflammation. While more research is needed to explore this connection, the findings suggest that treatment may help to reduce the risk of serious diabetes-related complications, such as heart disease, stroke



and kidney disease, in people with Type 2 diabetes. The researchers also observed a link between the treatment and improved quality of life.

Professor Francesco D'Aiuto, lead researcher of the study, said: "Our findings suggest preventing and treating gum disease could potentially be an important way to help people with Type 2 diabetes manage their condition, and reduce risk of serious complications.

"The improvement in blood glucose control we observed, in people who received intensive treatment, is similar to the effect that's seen when people with Type 2 diabetes are prescribed a second blood glucose-lowering drug. We now need to determine if the improvements we found can be maintained in the longer-term and if they apply to everyone with Type 2 diabetes."

Dentists prescribing fewer antibiotics

NEW figures show that dentists in the UK are responding to the call to reduce the prescribing of unnecessary and inappropriate antibiotics. Issued in time for World Antibiotic Awareness Week (12-18 November), a report by the English Surveillance Programme for Antimicrobial Utilisation and Resistance (ESPAUR) revealed that dental practices had dispensed 23 per cent fewer prescriptions for antibiotics in 2017 compared to 2013.

This news came after another report from the Health and Social Care Committee (HSCC) at Westminster had urged the UK government to make antimicrobial resistance (AMR) a top priority. The MPs acted after hearing an estimate that AMR could kill up to 10 million per year by 2050.

The HSCC is asking the Prime Minister and ministers to raise the profile of AMR at home and abroad, and for a dedicated budget to help make more rapid progress on this vital topic.

The committee acknowledged a 13 per cent reduction in primary care prescriptions in the past five years, but expressed concern that no new classes of antibiotics have been discovered for decades because pharmaceutical companies are concerned about the profitability of new antimicrobial drugs.

It also noted that antibiotics are still being prescribed in as many as 60 per cent of sore throats, even though most are viral and antibiotics are only effective in approximately 10 per cent of these cases.

Accordingly, the MPs believe there must be more consistency in prescribing, and the public needs to be more aware of the risks of antibiotic resistance, and to heed advice about when they need antibiotics.

In Scotland between 2013 and 2017, there was a 24.5 per cent reduction in antibiotics prescribing by dentists.

New front opens in war on sugar

PUBLIC health leaders, academics and campaigners gathered at the British Dental Association in London in November to help take forward the war on sugar.

The BDA Sugar and Oral Health Summit was designed to set out policy responses to tooth decay and systemic diseases following the introduction of the Soft Drinks Industry Levy and the Childhood Obesity Strategy.

Tooth decay and obesity remain the most prevalent non-communicable diseases in the UK and worldwide. Tooth decay is the number one reason for hospital admissions among young children across the UK.

Representatives from the World Health

Organisation and Public Health England, as well as leading dental and medical organisations, looked at new ways to secure behaviour changes by consumers and industry. They also sought to evaluate lessons drawn from campaigns and officials working to lower salt and calorie intake.

The BDA's Health and Science chair Russ Ladwa said: "Dentists see the damage Britain's sugar addiction does every day. We've won the argument for a sugar tax, but that must not mark the end of tough action on a common agent fuelling epidemics of tooth decay and obesity.

"Our objective is to look at the latest evidence and innovative policies that can open up the next front on the war on sugar."

Legal protection urged over cost of negligence claims

DENTAL Protection is calling on the Government to introduce a package of legal reforms that would protect dentists from the spiralling cost of clinical negligence claims.

The proposals include:

- a fixed recoverable cost scheme – to stop lawyers charging disproportionate legal fees
- an increase in the small claims track threshold for clinical negligence claims up to £5,000 – so more low-level, straightforward claims are routinely managed within the small claims track and the cost of these claims are reduced
- a minimum threshold for cash compensation relating to claims for minor injuries – to reduce the cumulative cost of damage pay-outs where only very minor injuries are sustained.

The rising cost of clinical negligence claims against doctors and wider the NHS has received significant attention in recent years. The NHS spent £2.2bn on clinical

negligence claims last year – a 30 per cent increase on the previous year. This has led to the government pledging to introduce a clinical negligence strategy to control the amount of NHS funds being spent on claims.

However, Dental Protection believes the impact of rising clinical negligence costs on dentists has received insufficient attention and is urging the government to ensure that the forthcoming strategy tackles this problem head on. Without reform, there is significant concern that the cost



IT IS NOT UNUSUAL FOR COSTS AWARDED TO CLAIMANT LAWYERS TO BE SIGNIFICANTLY HIGHER THAN THE DAMAGES PAID TO THE PATIENT"

of clinical negligence claims will continue to rise. This is especially concerning given the substantial number of claims received relating to the diagnosis and treatment of periodontal disease, which 'no-win, no-fee' lawyers increasingly target due to higher financial rewards for them.

Raj Rattan, Dental Director at Dental Protection, said: "It is not unusual for the costs awarded to claimant lawyers to be significantly higher than the damages paid to the patient – sometimes it can be two or three times higher. This is inequitable and unreasonable and we are working with the government to address this problem.

"We also need action to ensure straightforward claims are dealt with in a more proportionate way and also to stop claims from being taken forward in the first place when only minor inconveniences have arisen."

The survey also showed that a full time dentist in the UK can now expect to receive two claims over a typical career.

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Nine in 10 dentists fear being sued by patients

A DENTAL Protection survey of more than 1,100 dentist members reveals that nine out of 10 (89 per cent) are increasingly fearful of being sued by patients. Of those, three quarters (74 per cent) feel that the fear of being sued impacts on the way they practise.

This fear is not without foundation as 43 per cent of the public believe there are now more marketing and media campaigns by 'no win, no fee' firms compared to five years ago, according to a YouGov survey of 2,000 people.

The survey by Dental Protection found that three-quarters (74 per cent) of dentists feel that the fear of being sued is affecting the services they are able to offer, while 64 per cent of respondents feel that the fear of being sued has resulted in them making more referrals.

Nearly all respondents (98 per cent) believe that we live in an increasingly litigious society and 79 per cent of them are

concerned about the impact this is having on their welfare and the way they practise, with 77 per cent of respondents admitting that the fear of being sued has caused them stress or anxiety.

Key areas where Dental Protection is seeing claims include the diagnosis of caries, periodontal disease and the outcome of endodontic treatment. Issues around consent also often feature in clinical negligence claims.

Raj Rattan, Dental Director at Dental Protection, said: "Dentists work in an increasingly challenging environment. It is worrying that three out of four full-time GDPs fear being sued by patients and understandably this will undoubtedly impact on the way they practise and add to already high stress levels.

"Without proper consent and comprehensive, well-organised records, a dentist will be severely disadvantaged in defending any allegations that may surface at a later date."

Goodwill – a divided nation

PERHAPS rather aptly for the current political climate, a National Association of Specialist Dental Accountants and Lawyers (NASDAL) survey for the quarter ending 31 July 2018 shows a divided country with a huge disparity in practice goodwill values.

Across the quarter, NASDAL members acted for their clients in the sale of practices with a range of values between 47 per cent of gross fees and 313 per cent of gross fees. A wide range indeed.

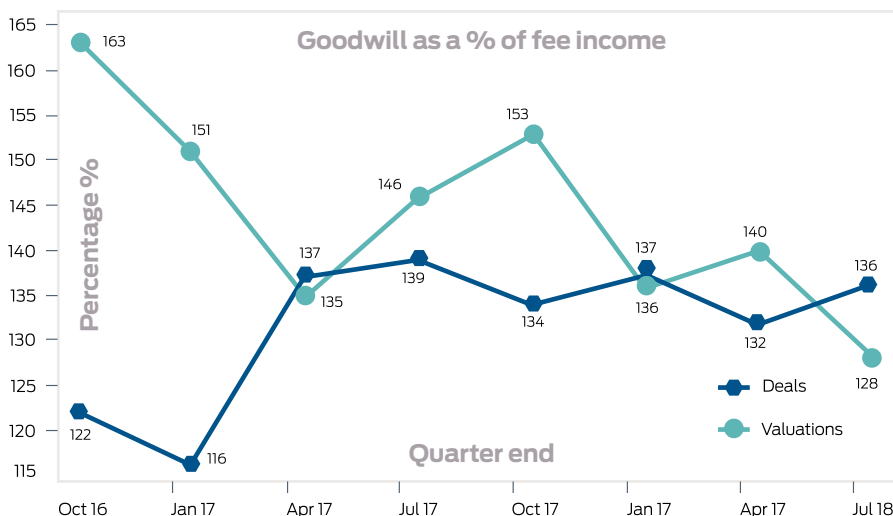
The headline figure for deals was up slightly – an average goodwill value of 136 per cent of gross fees, a return to the level of the quarter ending 31 January 2018. Average valuations saw a big drop of 12 per cent from the quarter ending 31 July. NHS practices are still in huge demand with a significant number of sales in the quarter at considerably more than 200 per cent of gross fees.

Alan Suggett, specialist dental accountant and partner in UNW LLP who compiles the survey, said: “I think that a range of more than 250 per cent illustrates how divided dental practice sales are in the UK (and also how difficult it is to make predictions for the UK market as a whole). When I started specialising in dental accounting, if someone had suggested a goodwill value of 313 per

cent, they would have been laughed at! But, if your practice ‘ticks the right boxes’ then it seems that the market will pay what you want. However, if it doesn’t, you may have trouble selling it at all.”

In Scotland, Cliff Fleming, partner at Condie & Co Chartered Accountants in Fife, said: “The valuations attributed by certain valuers have been in excess of what the

market has been prepared to bear, primarily dictated by what the financial institutions are prepared to fund. As a result, during 2018, valuations have moved closer to deal prices rather than the other way around. This has helped to alleviate difficult discussions between buyers/sellers when buyers have to educate sellers as to what their practice is actually worth in the market place.”



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NEWS
IN BRIEF**The Queen's
new Honorary
Dental Surgeon**

Group Captain Mark Richardson (pictured), Vice-Dean of the Faculty of General Dental Practice UK, has been appointed Honorary Dental Surgeon to Her Majesty The Queen.

The honour follows his recent promotion to Chief Dental Officer of the RAF. Two Honorary Dental Surgeons are appointed from each of the three Armed Forces, and while the role is honorary, they assume responsibility, on a rotation with the Queen's Honorary Surgeons, Physicians

and Nurses, for medical arrangements at Investitures at Buckingham Palace, Windsor Castle or the Palace of Holyroodhouse.

Mark, who joined the RAF in 1989 after graduating from Dundee University, is also a Fellow both of the Faculty of Dental Surgery of the Royal College of Physicians and Surgeons of Glasgow, and of the Faculty of Dental Trainers at the Royal College of Surgeons of Edinburgh.

**NEBDN diploma
re-approved**

THE National Examination Board of Dental Nurses (NEBDN) National Diploma has been re-approved by the General Dental Council as meeting their Education Standards, which means that students who achieve it can apply to be registered and can work as a dental nurse.

The qualification, delivered by individual providers directly approved by the NEBDN, was quality assured by the GDC as part of its duty to protect patients and promote high standards within the professions it regulates.

**IFEA Congress
set for Glasgow**

The IFEA congress is coming to the UK for the first time – Glasgow in 2024. During the

International Federation of Endodontic Associations (IFEA) World Endodontic Congress in Seoul, South Korea, in October, a team representing the British Endodontic Society (BES) won its bid to host the congress, which is held every two years.

IFEA brings together endodontic associations to share fellowship and education. It has 41 member countries and 61 countries were represented by the delegates in Seoul.

"We are delighted to have been successful in our bid" said Dr William McLean, honorary treasurer of the BES and organising committee chair. "Glasgow is a beautiful city, highly accessible, and offers every resource we need for a successful congress. The Scottish Events Campus as a venue will be a great home for the congress."

The 2020 Congress will take place in Chennai, India.

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13 DECEMBER

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Edinburgh – RCSEd**

9-10 JANUARY 2019

2nd European Conference of Health Education and Research 2019

Dublin – Royal College of Surgeons in Ireland (RCSI) #

18 JANUARY

Scottish Orthodontic Conference

Glasgow – RCPSCG*

18 JANUARY

Clinical Trainer Development: An Overview

Glasgow – RCPSCG*

18 JANUARY

GDPR: NHS Practices – How to be a DPO in dental practice

London – BDA***

21 JANUARY & 25 FEBRUARY

Royal College Advanced Certificate in Clinical Education

Glasgow – RCPSCG*

23 JANUARY

BDA Dundee and Perth Section – Practical management of tooth wear

Dundee – Almond Suite, Dundee Dental Education Centre***

25 JANUARY

Training essentials – Handling complaints and managing difficult patients

London – BDA***

28-29 JANUARY

The Edinburgh Head and Neck Course – Module I (Resectional Tactics in Head and Neck Surgery)

Edinburgh – RCSEd**

31 JANUARY - 1 FEBRUARY

The Edinburgh Head and Neck Course – Module II (Head and Neck Reconstruction)

Edinburgh – RCSEd**

8 FEBRUARY

Training essentials – NHS claiming regulations

London – BDA***

9 FEBRUARY

Preparation Course for the Diploma in Implant Dentistry (Dubai)

Dubai – RCSEd**

21 FEBRUARY

Royal College Advanced Certificate in Clinical Education – Heathrow

Brunel University, London*

22 & 23 FEBRUARY

One Day Membership in Orthodontics Process Course

Edinburgh – RCSEd**

22 FEBRUARY

Reception and telephone skills for the whole dental team

London – BDA***

28 FEBRUARY

Informed Consent: Sharing the Decision (ICONS) (Birmingham)

Birmingham – RCSEd**

* More information for RCPSCG events at: <https://rcpsg.ac.uk/events>

**More information for RCSEd events at: www.rcsed.ac.uk/events-courses

***More information for BDA events at: www.bda.org/events

More information for RCSI events at: www.rcsi.ie/eventscalendar



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ACCESS ALL AREAS

Remote and rural communities need health services like the rest of us, but attracting dental professionals to live and work among them appears to be a hard sell. Why?

Over the last few years, various reports on healthcare workforces have highlighted that there is a continuing difficulty in recruiting to posts that serve remote and rural populations.

This poses a significant potential issue in Scotland, which, according to Scottish Government figures, classifies 70 per cent of its land area as “remote rural” with a further 28 per cent classified as “accessible rural”. Seventeen per cent of Scotland’s population resides within this rural land area, with more over 55-year-olds living in remote rural areas than in any other type of area in Scotland.

Scotland clearly needs to be able to provide accessible dental services to people living rurally, but it seems that living and working remotely and rurally may not be attractive to dental professionals.

Those electing to practice in urban, densely populated areas cite concerns around access to support and allied services for their patients; potential issues with accessing their own professional training and CPD; and the more personal issue of maintaining personal and professional distance with their patients while living in smaller, more isolated communities.

Those that work in remote and rural areas,

however, clearly do not feel the same. Instead, they talk about the breadth of practice they can undertake; the strong professional relationships they can build with their patients; and the quality of life available to them personally. With more and more training and CPD available on-line, and access to courses in an increasingly wide variety of physical locations, training doesn’t seem to be an issue either.

Of course, the attractiveness, or not, of working in remote and rural areas is really down to the individual, but there is no doubt that accessing services can be an issue for patients.

Many people living and working in rural communities have professions which operate outside the more urban 9-5, and work in locations where taking an hour off to pop for a check-up is simply impossible.

But what does this mean in reality, and what is life really like for dental professionals who choose to provide services to them? We spoke to dental professionals and patients to find out the good, and the bad.





WORDS
STEWART
MCROBERT

Island life

The pros and cons of operating in remote and rural areas have been examined by Hannah Cousins and Anmar Al-Ansari. The pair are final-year dental students at the University of Aberdeen and each spent four weeks at the Western Isles Dental Centre in Stornoway in early 2018

Here they describe their experiences and also those of dentist Matt Alexander, a former Aberdeen student, who now works for the public dental service on Lewis and Harris





Eye-opener

Students Hannah Cousins and Anmar Al-Ansari (below) discovered that life as a dentist in Stornoway (above) and the Western Isles is far from bleak



It's part of the ethos at the Institute of Dentistry at the University of Aberdeen – give senior students clinical experience through outreach in remote and rural locations. So, it was no surprise to final-year students Hannah Cousins and Anmar Al-Ansari when they were told that they would be part of an outreach programme in Stornoway during early 2017.

Instead, the eye-opening came when they had completed their placement and realised that life as a dentist in Scotland's Western Isles is far from bleak and windswept.

"Spending time in Stornoway has been one of the highlights of our dental journey so far," said Hannah. "Having the opportunity to explore a new place, and experience an alternative clinical setting, has been crucial for personal and professional development."

Both began with few pre-conceptions: "I didn't know what to expect in terms of the location," said Anmar. "I knew it would be a very different environment from the one I'm used to and I was a little apprehensive about treating a smaller population where everyone knew everyone else. However, students who had gone before only had positive things to say about the experience."

Hannah explained: "I'm from London originally and many of the places I've explored during my time in Aberdeen are new to me. I tried to go with an open mind and take it for what it was."

They found a dental centre in Stornoway that is part of the town's hospital campus. It has 12 surgeries and is staffed by half a dozen dentists. The public dental service (PDS) based there is the only place on Lewis and Harris – and surrounding islands – where you can receive dental treatment, though there are plans to set up a general dental practice in the near future.

Over and above the points raised by Matt Alexander (see page 29), the two students had a few observations of their own. "People on the islands recognise that it is



“

SINCE ACCESS TO SERVICES WAS HISTORICALLY POORER THAN IT IS NOW, PEOPLE ON THE ISLANDS APPRECIATE THE SERVICE THEY RECEIVE”

HANNAH COUSINS



more difficult to deliver a service in a remote and rural community and, since access to services was historically poorer than it is now, they appreciate the service they receive,” said Hannah.

Anmar added: “Dentists we spoke to did say there is the potential for professional or social isolation. Therefore, among other things, you have to be proactive in involving yourself in the community.”

After completing their outreach, the pair compiled a list of the benefits they believe can be had from practising in this type of remote and rural location.

- **Consistency** – being able to treat generations of families and build a lasting rapport with them provides great job satisfaction; the movement of people is less in comparison to a big city practice

- **Community** – a sense of togetherness in the dental team and between clinicians and patients cements a positive working environment

- **Career** – as there are fewer members of staff employed by the NHS dental service compared with the mainland, healthcare professionals have more autonomy in terms of career development and shaping of the service

- **Complexity** – staff and students are encouraged to provide more complex treatments within their skill set to avoid sending patients off the island for treatment

They also noted the warm welcome they had received from colleagues in the dental centre and the wider community – and they confirmed that their horizons had been broadened. “I would never have thought about practising in somewhere like Stornoway before I went there. Now, I would certainly consider it,” said Anmar.



Community cohesion and complex treatment

Hannah and Anmar interviewed Stornoway dentist and graduate of the University of Aberdeen Matt Alexander about his experience on the island.

An inherent sense of community, friendly people and a dental centre that's modern, well-equipped and has been designed with teaching in mind. It's simple for Matt Alexander to list the benefits that drew him back to Stornoway. During his time as a student he enjoyed his outreach placement in the town and subsequently decided to complete his vocational training (VT) there.

He believes that working in a remote and rural service during VT offers specific benefits. "As access to secondary care services is challenging, referral is considered only where absolutely necessary. Exposure to, and involvement with, more complex treatment planning was certainly of great benefit to my personal development."

In terms of advantages for patients, the close-knit environment can help in the process of promoting oral healthcare. An example is the success of the Child Smile programme on the island, which is extensive and well received.

Matt explained: "We have an annual themed 'Child Smile' week. During this week, school-aged children come into the dental centre for a check-up and are allowed to explore the facilities. This allows children to become more familiar with the dental environment and encourages their oral health to be closely monitored."

The challenges to delivering services including staff recruitment and retention. "Most dentists who work in the service are not originally from the islands," said Matt. "We also have to compete with logistical difficulties; for example, sending lab work to the mainland means turnaround times can be slower."

Similarly, patients can be faced with limited choice when it comes to treatment. At the moment, the Western Isles Dental Centre is the only practice on the island and it

delivers NHS care solely. However, there is an aim to open a new centre offering private treatment, which will provide residents with greater options.

Operating in a remote location most often means dealing with a smaller community of people. This could throw up sensitive ethical issues for the unwary.

"There is always a potential for there to be confidentiality issues," said Matt. "In a remote or rural community you are more likely to see patients and their families outside of work. As one of a relatively small group of healthcare professionals you tend to be fairly well known. In general, the staff know many of the patients and their families outside of work so this has to be kept in mind."

On a personal development level, it can be challenging to fulfil CPD requirements. This almost always involves travelling, although Matt said there are provisions in place to facilitate this. "CPD is carried out through a combination of travel to the mainland and online learning."

"There is always the potential for professional isolation, and it is necessary to take a proactive approach in combating this. We do have some practical courses on the island, but these tend to be those relevant to all members of the team, for example, training on medical emergencies."



“

**DENTISTS WE SPOKE TO DID SAY
THERE IS POTENTIAL FOR
PROFESSIONAL OR SOCIAL
ISOLATION, SO YOU HAVE TO BE
PROACTIVE IN INVOLVING
YOURSELF IN THE COMMUNITY”**

ANMAR AL-ANSARI



Fishermen spend a long time a long way from home. Their precarious living makes it difficult to maintain a regular oral health routine, and many suffer the consequences. An initiative by three charities has helped to bring the treatment to the patients and encourage in them an awareness of the importance of their dental wellbeing

WORDS
STEWART
MCROBERT

All at sea?

Few, if any, UK workers operate in more remote conditions than the country's fishermen.

Their working pattern is wholly unpredictable. They spend long days miles from home, in the middle of turbulent seas, operating at the limit of physical and mental endurance. It's no wonder they find it difficult to follow a regular, consistent oral health routine.

As a result they are one group of people who can benefit from help to look after their mouth and teeth.

Recently, a short series of Health and Wellbeing Days took place in Peterhead. They were organised as part of the wider Seafit programme being delivered by The Mission to Seafarers and the Seafarers Hospital Society. Dentaïd, the charity that provides emergency dental provision for people who are not able to access NHS dentistry, was there to help treat those fishermen who were able to attend.

Naomi Roche, Project Manager at Dentaïd, was one of those helping out. She said: "Fishermen live a precarious existence. If they don't go out to sea and get a catch they don't

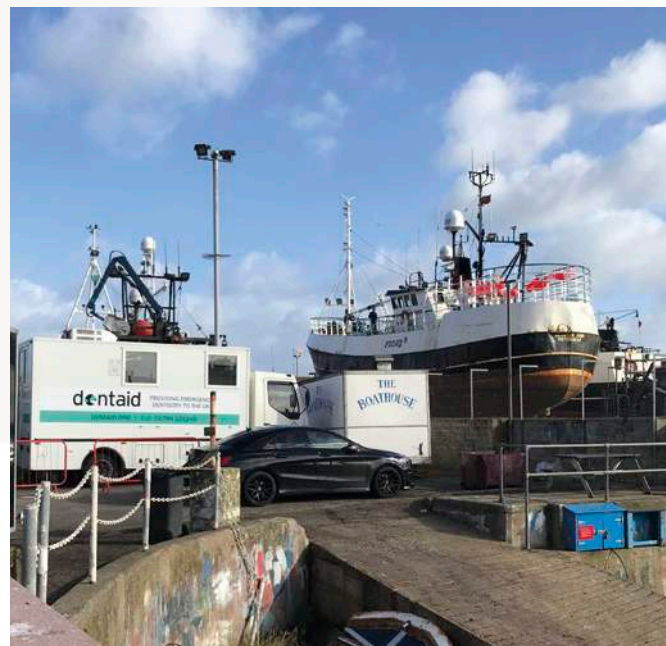
get paid. So that's their first priority. When it comes to dentistry, even if they are registered with a practice, they often miss appointments. For most, their dentition is quite poor. There are some exceptions, of course, but many of the guys who do the day-to-day fishing face the biggest problems."

It's easy for fishermen to find themselves in a damaging cycle; because they miss appointments they get removed from their dentist's patient list, which leads to increasingly poor oral health.

Naomi said: "One person I interviewed during the Health and Wellbeing Days hadn't been to a dentist for 12 years. People fall out of the habit of attending, or don't even get into the habit in the first place. Worryingly, some end up self-administering pain relief in the form of alcohol or drugs."

It's not a question of ignorance. Naomi noted that everyone she spoke to knew they should clean their teeth twice a day. However, crack-of-dawn starts and long working days meant other tasks took priority.

At the same time, the fishermen were conscious of their poor dentition. "Self-esteem was an issue – many talked with their



Quayside service

Dentaïd's mobile dental unit (MDU) parked by the dry dock and slipway in Peterhead, ready to treat fishermen home from the sea

Below: the Dentaïd team give a crewman a check-up



“**ONE FISHERMAN I INTERVIEWED HADN'T BEEN TO A DENTIST FOR 12 YEARS**”

NAOMI ROCHE, DENTAID

Practicality the key

Fisherman based in the north-east of Scotland do have services they can access, but despite best intentions that's not always possible.

Diane Lawson is oral health team leader, Aberdeenshire North, based in the Childsmile Department at Ugie Hospital in Peterhead and volunteered to help Dentaïd. She explained: "At present access to emergency dental treatment for non-registered patients is through a system known as DIAL where you leave a message and your call is returned usually within an

hour with an appointment time and dental practice to attend. This could be anything from two to 35 miles away.

"Outwith normal working hours people are referred to A&E who will only treat bleeding, swelling and trauma.

"There is also a service on Friday evening, all day Saturday and Sunday morning, but it is based in Aberdeen."

Diane, whose partner is a fisherman, said the issue is not accessing a NHS dentist since most are aware of DIAL and use it when necessary.

"The issue is the practicality due to the working patterns of the fisherman. Fisherman may only be onshore for a very short time when the boat arrives back into port. They land the fish, take on food stores, ice and boxes and often return to sea within six hours.

"At the same time a trip has no set time, it could last anything from seven to nine days, but there is no guarantee. This makes follow up appointments difficult."





→ hands in front of their mouths,” observed Naomi.

“It’s a community where there’s a lot of bravado. Rather than address a problem they might ‘get busy’ or ‘persevere’ until any pain abates.”

Even the chance of a free check-up could be met with a certain wariness. “It takes one of the guys on board, especially a skipper, to say they are going to get their health/teeth checked before others will follow suit.”

And, like in every community across the land, there is a section of people who are genuinely nervous about visiting the dentist. “That’s something we’re conscious of during our sessions,” said Naomi. “We don’t ship people in and out. Instead, I sit down and get their medical history, which often leads on to conversation about their background, family circumstances and so on. It helps

Dock dentistry

Dentaid’s MDU and campervan provided fishermen with free dental checks, including oral cancer screening, health education and treatments

Left: Dentaid CEO Andy Evans with Dentaid dentist Jane Lelean and volunteer Diane Lawson, NHS oral health team leader for Aberdeenshire North

them relax before they see the dentist.”

One of Dentaid’s main aims is to help people achieve a level of dentistry that makes them feel less self-conscious and more confident about using NHS dental services regularly. And the Seafit programme is a UK-wide initiative that will see activity across a number of the country’s ports.

The goal is to make sure the health and wellbeing of fisherman is not overlooked. At the moment it appears the crucial factor is the skipper – the most enlightened are always ready to look after the interests of their men.

Naomi believes that lack of care is not just bad for individuals but has wider implications. She noted: “It’s vital to look after the crews if we want to have a successful fishing industry.”

Seafit support for seafarers

The Seafarers Mission and the Seafarers Hospital Society held Health and Wellbeing Days at Peterhead between 2-4 October.

Two emergency dental clinics were held and a total of 21 patients were seen – a mix of UK nationals and others from abroad who were contracted to UK boats.

The Dentaid team comprised two dentists, a dental nurse, Dentaid CEO Andy Evans and Naomi Roche.

Free emergency dental treatments were available to all fishermen. Those treatments included:

- extractions
- fillings
- scale and polish
- fluoride varnish.

All patients had oral health screening including oral cancer screening.

If anyone needed further investigation they were referred to local NHS hospital services or a local practice.

After treatment every patient had the chance to speak with an NHS professional regarding oral health and hygiene.

The Health and Wellbeing Days were part of the Seafit programme and also included blood pressure, cholesterol and diabetes checks. The fishermen were able to speak with health professionals about alcohol abuse, depression and cancer.

“
IT’S VITAL TO LOOK
AFTER THE CREWS
IF WE WANT TO HAVE
A SUCCESSFUL
FISHING INDUSTRY”

NAOMI ROCHE

What lies beneath

Dentists are reporting worryingly high levels of stress in numbers far above the national average. There is evidence to suggest that this is leading to an increasing number of suicides within the profession. The stigma around suicide means it is not often discussed, but one charity is trying to change this

WORDS
ANDREW
COLLIER

The dental profession is often viewed with envy. Outsiders perceive it as an ideal career: interesting, socially worthwhile, well-paid and bringing huge personal satisfaction.

But they don't see what lies beneath. For some practitioners, dentistry is delivering little but misery.

High levels of stress, worry about negligence claims and even low pay are taking their toll, driving them into depression – and worse.

A recent research paper commissioned by the British Dental Association highlights the issue of mental health well-being in dentistry. Covering Great Britain, the study looks at the causes of stress, burnout and mental illness.

Among the factors identified are pressure from regulators, patient expectations, self-employment, isolation, social pressures, work conditions, boredom and even the NHS itself. As a result, participants reported low morale, low patient care, a decline in professional standards, having to change career and early retirement as being among the outcomes.

Barriers to accessing support are seen as an important

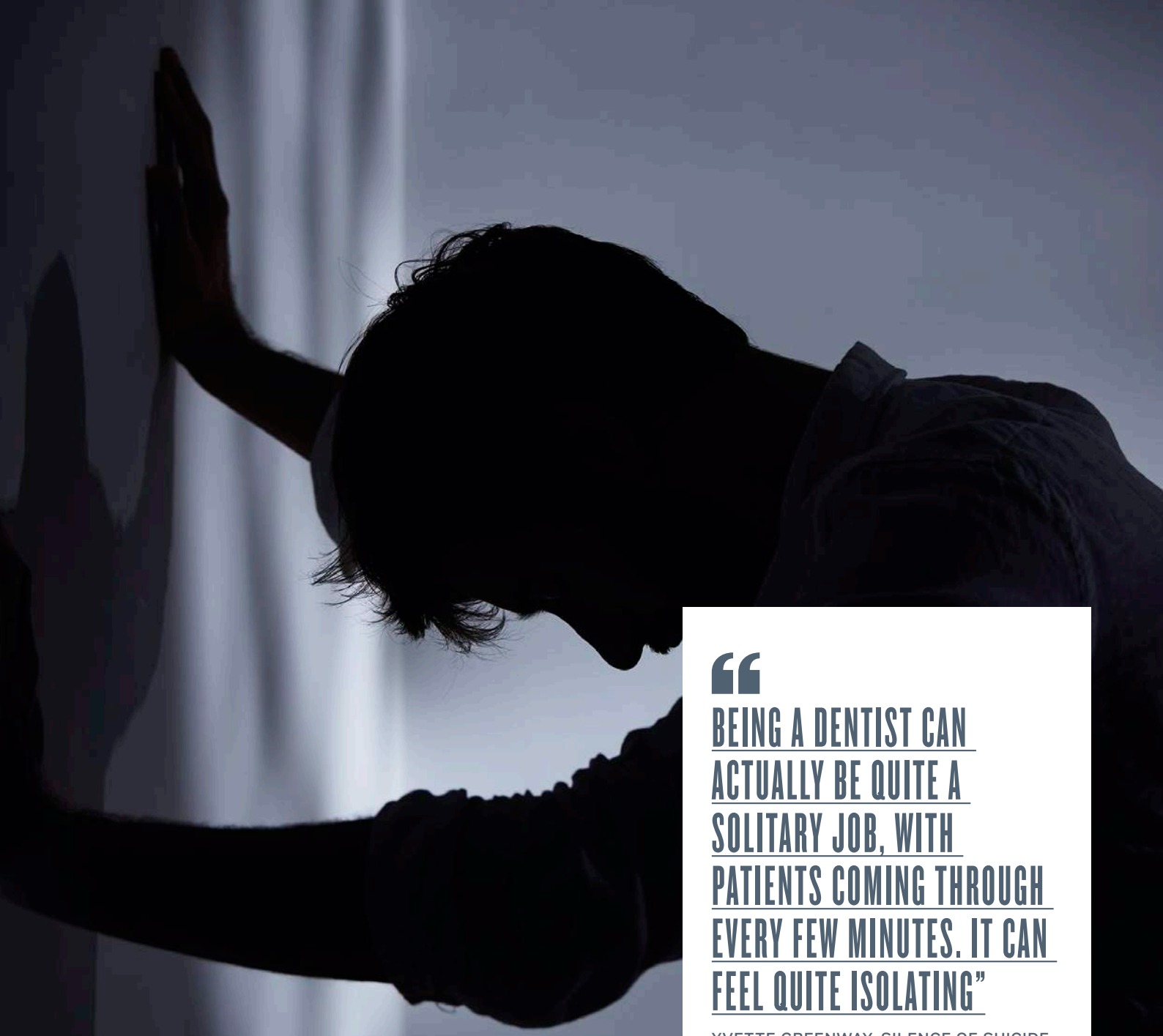
issue. “At what point do you just give up and realise that this – or perhaps any – career just isn't suitable?” said one dentist who took part. “As soon as you start looking at the cracks the whole thing falls down and you are left with nothing.”

The problem of stress is seen as particularly acute in Northern Ireland, which was not part of the recent GB survey. At least eight dentists in the province have committed suicide in recent years. Given that there are only just over 1,000 people working in the profession in the north, this is an alarmingly high level and reflects the serious pressure individuals are under.

The British Dental Association's Branch President in Northern Ireland, Martin Curran, recently hosted an evening seminar on stress and suicide in Belfast along with Michael Mansfield QC and Yvette Greenway, co-founders and trustees of the charity SOS Silence of Suicide.

Both Michael and Yvette have experienced loss in this way, most recently Michael's daughter Anna in 2015. The silence, stigma and shame surrounding suicide and mental health in general made them realise more talking, listening and understanding was needed and so Silence of Suicide SOS was formed.

Yvette explained that SOS started as a support group, travelling all over the country and inviting people with an interest or who had been affected by the issue to come



“
**BEING A DENTIST CAN
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EVERY FEW MINUTES. IT CAN
FEEL QUITE ISOLATING”**

YVETTE GREENWAY, SILENCE OF SUICIDE

along and share their thoughts, feelings and experiences. As well as dentists, the charity has held sessions with lawyers and in schools and prisons.

SOS is the only charity she is aware of that brings together anyone affected by this issue, including those bereaved by suicide or contemplating it and individuals who have attempted to take their own lives.

“Discussing things can create quite upsetting situations, but people do like participating, especially when they realise they are not as isolated as they thought,” she added. “The people they meet may not be known to them, but those people understand the issues and what they are going through perfectly.”

“The BDA is very mental health-aware and has strong support mechanisms for members of the profession, which is fantastic.”

She continued: “We were asked to go over to Belfast to talk to dentists, and the evening was really successful. It was a good turnout, though there were concerns about those who weren’t there and were under huge stress, trying to do their jobs and working long hours while attempting to look after their own mental health at the same time.

“Being a dentist can actually be quite a solitary job, with patients coming through every few minutes. It can feel quite isolating. Do you get out for lunch and if not, does someone go out and bring you a sandwich back?”

“It’s about that kind of human factor – looking out for and caring for each other. The best thing anyone can do, whether it’s a dentist or anybody else, is to take an interest in somebody else – to ask if they’re OK and if there’s anything else they can do.”

Interacting with patients in the surgery as well as colleagues in dentistry can help both sides in identifying mental well-being issues, Yvette said. The important thing is to talk about it. “It can be like lighting a touch paper. It may create a two-way exchange that is beneficial to both sides. Once people realise they can speak freely, without being judged, open and honest discourse follows easily. Some people just want to listen, others simply wish to be heard.

“Communication is really important. We can only eradicate this problem by not feeling ashamed about it. Our message is not to be frightened. Don’t stop talking and listening.”





The BDA survey has shown that some 40 per cent of dentists are affected by worryingly high levels of stress. In the general population, the figure is much lower at 15 per cent. Martin Curran, a Belfast-based specialist in oral surgery, said there is no evidence that this means a higher level of suicides, though he added: “We know that younger dentists are leaving the profession because of the pressure.”

He cites figures from Queen’s University Belfast (QUB) showing that at least five students who qualified last year have left dentistry already. “They have gone into a job and found they can’t cope. It’s getting to the point where dentists won’t recommend any longer that people come into the profession.”

Why, though, are professionals literally under suicidal levels of stress? “One reason is fear of complaints or litigation. They are under time pressure requiring them to see more and more patients, and that’s particularly true of younger practitioners working for corporates.

“The demands of patients are also becoming more and more problematic. People believe they have a right to have treatment carried out to 100 per cent standards every time. There’s also the issue of difficult patients, long hours and the increase in paperwork. Everything has to be done sequentially, and people are finding it very difficult to keep up.”

As if this were not enough, Martin added, regulatory costs are also increasing. Last year, a medical doctor paid a yearly retention fee of £425. This year it went down to £380. A dentist pays £890. This is partly, he said, because the General Dental Council is spending a fortune on investigations.

“It’s making dentists risk averse. They won’t do something in case they have a problem. A lot of younger practitioners are sending patients to hospitals even to get very simple work done.”

Income is another issue: it has fallen by more than a third in real times in the last decade, impacting on the ability of practice owners to fund the necessary

“
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MARTIN CURRAN, BDA NORTHERN IRELAND



Above: Yvette Greenway with Martin Curran, BDA Branch President in Northern Ireland, and Michael Mansfield QC, her co-founder of Silence of Suicide

equipment. “It has also dropped here because there’s no functioning assembly in Northern Ireland. That means a pay increase for the community dental service can’t go through and it’s been sitting like that for the last three years.”

How can these issues be addressed? The Belfast seminar followed Michael and Yvette’s strategy, attempting to deal with the problems head on by discussing them openly. It discussed the language and stigma around suicide, stressing it was an illness and inviting the 70 people present to talk about their own experiences.

A framework document is now being put together by a number of health-related organisations, including the BDA, examining how dentists might be able to train to help share their stresses and mental pressures with each other.

“We need to be looking after our colleagues. Suicide is the ultimate in terms of stress,” Martin Curran said. “It can build on dentists until they just can’t see a way out. It’s very hard to get at those people, so we’re trying to offer the help before they get to that stage.

“I speak to a lot of dentists, and it may be that I meet one who has got a problem. Sometimes they’ll talk about it and I can then direct them to an organisation that can help. But people having suicidal thoughts are often very good at masking these things.

“The meeting we held was about that process of communication and stressing that it’s good to have a conversation about it.”

More details at www.sossilenceofsuicide.org

Lives in your hands

The deployment of defibrillators in dental practices has put staff in the frontline as potential life-saving first responders. But a recent incident has raised practical issues

By and large, life in a dental clinic is free of incidents of high drama. However, all that changed for Dr Stuart McLaren, a dentist in Rutherglen, Glasgow, on the day in October this year when his dental associate received a phone call out of the blue from the Scottish Ambulance Service.

A man had suffered an out-of-hospital cardiac arrest – something that happens in Scotland nearly 9,000 times a year – on the street just around the corner. Like all dental practices in Scotland, Stuart's surgery was officially listed as a first responder in cases of emergency, so he and his associate, Natalie Graham, grabbed their defibrillator, oxygen, emergency kit and gloves and rushed out to the scene.

Bystanders were already performing CPR, when Stuart, who is the principal at the local Prestige Dental Clinic, quickly took over and unpacked the defibrillator and its pads. "I applied a shock and then started to clear the man's airway," he recalls. "He had a Miami J cervical collar on his neck, indicative of recent spinal injury, and that made his airway control significantly harder, plus there was an open head wound he'd sustained as he fell."

Four shocks were delivered before the paramedics arrived eight minutes later. With CPR continuing, the patient was stretchered into the ambulance and away to hospital. Sadly, he did not survive.

As a first responder, Stuart was ideally qualified to deal with the situation: as well as being a dentist, he is also a qualified doctor in emergency medicine, working regularly in the accident and emergency department at the city's Queen Elizabeth University Hospital. In addition, he is a

WORDS
**ANDREW
COLLIER**

clinical lecturer at the University of Glasgow.

The incident highlighted the importance of the Scottish Government's strategy of equipping dental practices with defibrillators as a matter of routine. Funding is provided, and staff are then meant to use their own expertise in administering the treatment required.

However, after using the defibrillator equipment for the first time, Stuart believes that the system, while well intentioned, does have some deficiencies and that there are useful lessons to learn from his own practical experience.

"The hardware is provided, but you also need things like gloves and to remember to keep them as part of your emergency kit," he says, "We do that, but these things are not provided with the defibrillator and I don't think

other dental clinics would necessarily have these in their pack as essential additional items, ready to go."

Another issue he identifies is that on returning to the practice, the defibrillator pads supplied, which are for a single incident only, had then been used. "We then had to ask if we should shut down for the rest of the day as we couldn't treat another cardiac arrest case if one came up. We'd used our pads and that was it until we got hold of more."

"I've spoken to colleagues about this since and no-one really thinks about having to buy another two or three sets in case this happens. The defibrillator only comes with one set."

“
**AS I'M AN A&E
DOCTOR, I KNOW HOW
THE KIT WORKS, BUT
EVERYONE IN A CLINIC
NEEDS TO KNOW**”





“Obviously this isn’t about the money, but when I asked about the issue of reimbursement for defibrillator pads, the clinical director recalled that it was agreed with the Scottish Government that practices should be reimbursed for these items but the mechanism for doing this is unclear.

“I was advised that the dental practice advisors’ group will meet with the Scottish Government soon, and as the details outlined are causing concern across all health boards, they are on the agenda for discussion.”

The incident also taught him about the importance of having all potentially necessary equipment in one rucksack. “My airway adjuncts were with another oxygen cylinder and my associate had to go back to the clinic and get those. It would obviously be better to have everything pre-packed and ready to go but you have to organise that yourself.

“You want to give the patient the best chance you can. When we arrived, they may not have been medically evaluated. They might not be in full cardiac arrest or might need further attention when they come round. You need more than the defibrillator.”

The experience taught him another thing: the human emotional impact of having to deal with this kind of emergency. “People could be dying or actually dead in front of you. The health board was quite supportive in this and said counselling was available if needed. We had a debrief later and Natalie had said the adrenaline carried her through at the time, but she hadn’t managed to sleep a wink that night.”

Use of the defibrillators also raises practical questions about the availability of training. Dental practices have update sessions on life support annually, as do other workplace environments both inside and outside medicine, but this equipment may not be covered as part of these. In general, the amount of training received is assessed as a tick-box exercise, but the quality of that training is not scrutinised.

Stuart thinks this is an issue that needs to be addressed. He also believes that some of his colleagues in other Scottish dental practices are apprehensive of the defibrillator. “We actually had ours before the general availability of funding for them in 2015, as we carry out

Restart a Heart Day success



The European Resuscitation Council event in October for World Restart a Heart Day was a huge success in Scotland where the dental faculties of Dundee, Edinburgh and Glasgow linked up to deliver training in the life-saving skill of CPR.

The day also raised public awareness on out-of-hospital cardiac arrest and the availability of defibrillators held within general dental practices, which are also public access defibrillators and mapped with the Scottish Ambulance Service.

It is hoped that by training members of the public, the survival rates from an out-of-hospital cardiac arrest will increase and get closer to the Scottish Government target of an additional 1,000 lives saved and 500,000 people trained by 2020.

The joint event trained 369 members of the public, which was a significant achievement – 104 were trained in Dundee, 75 in Edinburgh and 191 in Glasgow.

Lezley Ann Walker, dental team



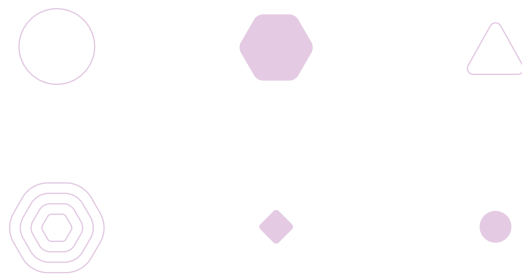
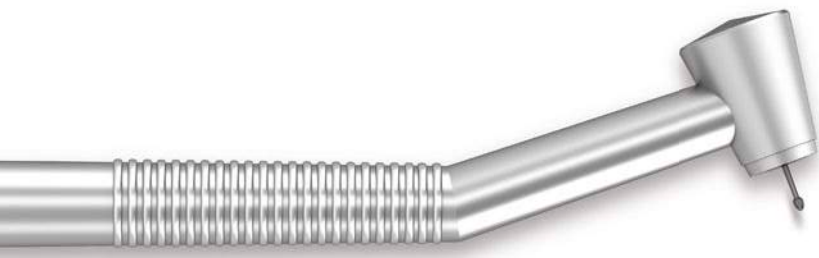
tutor at Glasgow Dental Hospital and School, who organised the event, hopes to expand and link with more dental colleagues and increase the numbers.



sedation in the surgery and need that advanced life support knowledge and equipment. So we’re familiar with it.

“Also, as I’m a practicing A&E doctor, I know how the kit works. But everyone in a clinic needs to know how a defibrillator should be operated. It might be, for instance, that the dentist is on a course and so it’s the nurse that is called out when an emergency arises. We should perhaps all look at increasing our proficiency when it comes to this.”

“YOU WANT TO GIVE THE PATIENT THE BEST CHANCE YOU CAN”



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CAM2796 10-18



Recognition of head and neck skin cancer: A guide for GDPs

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Introduction

The role of the GDP in the early recognition and management of oral cancer is well recognised and the subject of annual GDC core continuing professional development.

The old adage of a GDP seeing one oral cancer in a practicing lifetime has recently been called into question.

This may now be more accurately reflected as one case per 17 years of practice exposure.

ISD figures suggest 2,000 cases of oral cancer per year, though not all will see a GDP prior to diagnosis. In cutaneous malignancy, ISD figures for 2016 recorded nearly 13,000 cases of melanoma, squamous cell carcinoma (SCC) or basal cell carcinoma (BCC), in Scotland. If this is extrapolated to head and neck presentations, this represents nearly 8,000 patients with cutaneous malignancy potentially presenting to GDPs, allowing for earlier diagnosis and appropriate onward referral.

The head and neck are affected in up to 80 per cent of BCCs, 60 per cent of SCCs and between 22 per cent and 14 per cent of melanomas, the difference being sex dependent.

The aim of this paper is to equip GDPs with the knowledge to facilitate recognition of potential skin cancers and

the confidence to make an appropriate onward referral.

Malignant melanoma

Definition

Cutaneous malignant melanoma (MM) is a malignant tumour of neural-crest derived cutaneous melanocytes. Melanomas can arise from a pre-existing pigmented lesion or from previously normal skin. It is both locally destructive, has a propensity to metastasise and is the major cause of skin cancer mortality. Early treatment of the disease is more effective and involves less morbidity. These factors make clinician education, patient education and prevention of the utmost importance.

Epidemiology

MM is the fifth most common cancer in women and the sixth most common in men in Scotland. There were 1,383 cases registered in Scotland in 2016 with an age-standardised incidence of 26.8 per 100,000 and 162 deaths were attributed to the disease. There has been an increase of the incidence from 2006 to 2016 of 15.2 per cent and a decline in mortality from the disease of 11.5 per cent. In terms of bodily distribution 22 per cent of melanomas present on the

head and neck region in men and 14 per cent in females.

Pathology

Melanomas are subdivided into types on the basis of clinical features and pathology.

Superficial spreading malignant melanoma (SMM): This is the most common type of melanoma. Characteristics include an asymmetrical pigmented lesion with irregular borders, irregular pigmentation. Patients may report a growing lesion, a colour change within the lesion, bleeding, crusting or a change in sensation in relation to the lesion.

Nodular melanoma (NM): This is the second most common type of melanoma. NM can present as a firm papule, nodule or plaque. Approximately 50 per cent have the typical dark pigmentation commonly associated with melanomas. The remaining 50 per cent are hypo/amelanotic and pink-red in colour. The surface of the lesion may be smooth, rough or crusted.

Lentigo maligna melanoma (LMM): The next in terms of frequency is LMM. This commonly presents on the head and neck region of elderly patients. This is the only type of melanoma that is well recognised to develop from



Figure 1: Superficial spreading melanoma nose



Figure 2: Lentigo maligna melanoma cheek

a pre-existing lesion that is a form of melanoma in-situ termed lentigo maligna (LM). Classically LM presents as a slow growing tan/brown macule or patch, which progresses on the surface of the epidermis prior to any growth into the deeper layers of the skin. Patients may report a pre-existing pigmented freckle or patch that has changed size, shape or colour.

Desmoplastic type melanoma (DM): This is an uncommon variant of melanoma, accounting for less than 4 per cent of primary cutaneous melanomas. It has a higher tendency for persistent local growth but less frequent nodal metastasis? Clinically DM can be a challenge to recognise as it often presents as amelanotic nodules or plaques, or as ill-defined scar-like

lesions. As with LMM it is commonly found in the head and neck region.

Aetiology and risk factors

Solar radiation has been recognised as a cause of melanoma. Exposure to high levels of sunlight in childhood, intermittent unaccustomed exposure and ultraviolet exposure due to sun beds are thought to have a role to play. Other risk factors include a large number of benign naevi and a tendency to freckle (fair-skinned individuals). (Figures 1 and 2)

Clinical Presentation:

Clinical diagnosis of melanoma can be difficult, but they can generally be related to areas of previous sunburn. Any suspicious pigmented lesion should

be examined in a good light with or without magnification. As an aid to diagnosis of pigmented lesions, SIGN ⁽¹⁾ recommends clinicians should be familiar with the seven-point ⁽²⁾ or ABCDE checklist ⁽³⁾ for assessing lesions and that health professionals should be encouraged to examine patients' skin during other clinical examinations. A check of the skin of the head and neck region could be incorporated in to a general dental check-up.

Seven-point checklist

Refer people using a suspected-cancer pathway referral (for an appointment within two weeks) for melanoma if they have a suspicious pigmented skin lesion with a weighted seven-point checklist score of three or more.



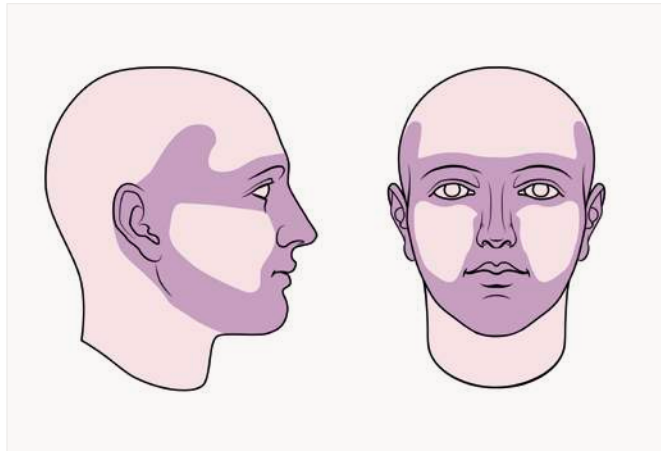


Figure 3: High risk H area of face



Figure 4: Superficial BCC



Figure 5: BCC temple



Figure 6: BCC

Weighted seven-point checklist

Major features of the lesions (scoring two points each):

- change in size
- irregular shape
- irregular colour.

Minor features of the lesions (scoring one point each):

- largest diameter 7mm or more
- inflammation
- oozing
- change in sensation.

ABCDE

Asymmetry – the two halves of the area may differ in shape

Border – the edges of the area may be irregular or blurred, and sometimes show notches

Colour – this may be uneven. Different shades of black, brown and pink may be seen

Diameter – most melanomas are at least 6mm in diameter. Report any

change in size, shape or diameter to your doctor

Expert or Enlarging – if in doubt, check it out! If your GP or GDP is concerned about your skin, make sure you see a consultant dermatologist or skin cancer surgeon.

The presence of any major feature in the seven-point checklist, or any of the features in the ABCDE system is an indication for referral. The presence of minor features should increase suspicion, as some melanomas will not demonstrate major features. Any suspicious lesions should be referred to the secondary care, to be assessed by dermatoscopy by a health professional trained in this technique.

Investigations

In order to obtain a diagnosis of melanoma, a tissue sample is required for histopathological examination. A suspected melanoma will be excised in

its entirety with a 2mm clinical margin and a cuff of fat. If this is not possible, a punch biopsy or incisional biopsy of the most suspicious area will be performed. Biopsies should not be performed in primary care. When the pathology report is available, the initial staging will dictate whether further investigations are warranted.

Not all patients that develop melanoma require any further investigations other than excisional biopsy. Individuals with melanoma over a certain stage will have directed CT examinations prior to surgery.

Patients over a certain stage may be offered a sentinel lymph node biopsy (SLNB). This involves an injection of a radioactive substance and dye, which will highlight the lymph node or nodes to which cancer cells are most likely to spread to from a primary tumour. Once identified, these nodes can be excised utilising a relatively small skin incision

to establish if there is in fact cancerous cells that have already metastasised from the primary lesion. SNLB at present is a prognostic tool rather than a technique to improve survival rates.

Treatment

In terms of the primary lesion, surgery is the only curative treatment for melanoma. The histopathological examination of the biopsy will establish the thickness of the melanoma in millimetres, otherwise called the Breslow thickness. This measurement will determine the extent of the lateral margin that is excised around the site of the original skin lesion, this may range from 5mm for in situ disease through to 2cm for thick > 4mm melanomas. This, of course, has to be limited with head and neck anatomy.

Basal cell carcinoma

Definition

Basal cell carcinoma (BCC) is a slow growing malignant epidermal skin tumour, which is locally invasive but rarely metastasises. The morbidity associated with BCC is due to tissue

invasion and destruction, which can be particularly problematic in the head and neck region when lesions are close to structures such as the eyes and nose. If neglected it can cause extensive damage, require radical treatment and ultimately can be fatal.

Epidemiology

BCC is the most common form of cancer in humans. The incidence increases with age and the most significant aetiological factors appear to be genetic predisposition and exposure to ultraviolet radiation. More than 80 per cent of BCCs occur on the head and neck. ⁽⁴⁾

Pathology

There are a number of clinical variants of basal cell carcinoma with a diverse presentation in terms of clinical appearance and morphology

Nodular basal cell carcinoma comprises the majority of cases and predominately occurs on the head and neck region. It presents as an elevated nodule or nodules with a pearly surface with telangiectasia on the surface and

periphery. The lesion may ulcerate or have a cystic element.

Superficial basal cell carcinomas present as a thin erythematous plaque. They are scaly and can appear eroded and crusty. A shiny periphery to the lesion can be identified on stretching the surrounding skin.

Morphoeic or sclerosing basal cell carcinoma presents as a yellow-white waxy lesion with poorly defined edges, and the skin involved may be depressed. As with other variants of BCC, it may be associated with localised telangiectasia. (Figures 3-10)

Diagnosis

BCC will be predominately diagnosed clinically. The accuracy of diagnosis can be aided by good light, magnification and dermatoscopy performed by an experienced clinician. If there is any doubt in diagnosis a biopsy can be performed. Imaging techniques such as CT or MRI scanning are reserved for patients in whom there is suspicion the tumour has invaded bone or other anatomically important regions such as the orbit.



Figure 7: Large BCC



Figure 8: Nodular BCC



Figure 9: Nodular BCC 2



Figure 10: Morphoeic BCC





Treatment

There are a wide variety of management options for basal cell carcinoma. Treatments can be divided into surgical and non-surgical techniques.

Surgical options

Excision with a predetermined margin involves excision of the BCC with some surrounding normal tissue. Small (<20mm) well-defined lesions excised with a peripheral margin of 4-5mm have a clearance rate of approximately 95 per cent. Larger and less well-defined lesions may require a wider peripheral clearance.

Mohs micrographic surgery involves staged surgical resection of a lesion and examination of the specimen's margins after each stage to ensure complete excision and extremely high cure rates.

Non-surgical options

Cryotherapy

Liquid nitrogen cryosurgery uses

extreme low temperatures to destroy the tumour and surrounding tissue. The disadvantage of non-surgical options is no tissue for histology.

Photodynamic therapy

Photodynamic therapy is used in superficial BCCs where a chemical is activated by light of a pre-determined wavelength leading to local tumour destruction.

Radiotherapy

Radiotherapy can be used as a primary treatment, but requires patient co-operation and is less frequently used as a primary modality.

Squamous cell carcinoma

Definition

Primary cutaneous squamous cell carcinoma (cSCC) is a malignant tumour, which may arise from keratinising cells of the epidermis or its appendages. It is both locally invasive

and has the potential to metastasise to other organs of the body. A commonly cited percentage is 5 per cent of patients go on to develop regional metastasis. Tumour factors such as increased thickness, fat invasion, diameter over 20mm, along with the patient factor of immunosuppression place individual patients in a high-risk category of developing metastasis. High risks clinical sites include the ear and scalp. ⁽⁵⁾

Epidemiology

SCC is the second most common skin cancer in the UK and worldwide, with up to 60 per cent involving the head and neck. ⁽⁴⁾

About 5 per cent of cSCCs in the UK metastasise, with lesions on the lip most likely to do so. ⁽⁶⁾

Clinical presentation

The appearance of SCC is variable. The classic presentation is of an indurated nodular keratinising or crusted tumour



Figure 11: Solar keratosis



Figure 12: SCC ear



Figure 13: SCC cheek



Figure 14: Infected SCC scalp with additional solar damage

with rolled borders that may ulcerate or as an ulcer without evidence of keratinisation. Other non-typical appearances include the growth of a keratin horn or nodule with an intact surface. As such, any new enlarging ulcer, mass, red patch or non-healing lesion on the skin should be treated with suspicion. More than 50 per cent of cSCCs occur on the anterior scalp, forehead and ears, with the lip being another common site.

Although the metastasis rate is low, patients with cSCC can present with regional disease. The parotid region is the most common site followed by the neck. Any head and neck mass should prompt a head and neck skin examination as well as an intra-oral exam. (Figures 11-14)

Diagnosis

As with BCC the initial diagnosis of cSCC can be on a clinical basis or histologically from a biopsy. In the case of rapidly enlarging clinically suspicious lesions, these may be excised with the appropriate surgical margins to avoid any delay in treatment.

Treatment

Surgical excision is the treatment of choice. In low-risk, well-defined tumours, a margin of 4mm gives

clearance in 95 per cent of cases. High-risk tumours should be excised with a margin of 6mm. ⁽⁷⁾

Radiotherapy can be considered in cases where the patient is unwilling or unable to tolerate surgery, and in unresectable cases. ⁽⁴⁾

Referral of suspected skin cancers

Dentists can refer suspected skin cancers, such as SCC or malignant melanoma to the patient's GP or directly to their local oral and maxillofacial surgery department. This should be sent as an urgent referral under the two-week rule. BCCs, unless large or site critical, are usually referred on a routine basis.

Conclusion

Skin cancers are common in Scotland and often present on the head and neck, therefore dentists, who will often see patients more regularly than GPs, are in an ideal position to incorporate screening for suspicious skin lesions into their routine extra-oral examinations. This paper gives an outline of the three main forms of skin cancer, including how to recognise them and how they will be managed in secondary care. Early recognition and referral of patients with these lesions will lead to improved outcomes.

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ACKNOWLEDGEMENTS

The authors would like to acknowledge the support of the multi-disciplinary skin cancer team at University Hospital Crosshouse, and the support of Medical Illustration

THE DOS AND DON'TS OF SOCIAL MEDIA

*Venting your angst on a very public forum is not professional.
What happens in your practice should stay in your practice*

[WORDS: SUSIE ANDERSON SHARKEY]

THE OXFORD ENGLISH DICTIONARY (2016) defines social media as “websites and applications that enable users to create and share content or to participate in social networking”.

We have read a lot about the pitfalls of social media, about what is/is not appropriate to say on a social media platform, but I am still surprised at some of the things I read in forums from professionals who are ‘supposed to know better’. As King Solomon of old said: “There is no new thing under the sun.” While you may not read any new concepts in this article (quite simply because there aren’t any), my hope is that this will cause you to ponder again how you present yourself and your profession on the social media setting.

Every business nowadays has a policy in place regarding social media, which may state something like “work-related matters must not be placed on any social media site at any time either during or outside of working hours and includes access via any computer equipment, mobile phone or PDA” (taken directly from my own staff handbook).

However, with the rise of social networking forums where work-related matters are frequently discussed, we need to look again at these sites and be careful we are not breaching company policy whereby either a member of staff or a patient could be identified or the company may be in some way undermined.

I came across a dental forum recently where a member of staff was all but named, and certain words were used where the individual could be very easily identified. After I commented on the fact that the discussion had moved from being professional to personal, comments to the thread were switched off.

As a practice manager, I am a professional working in a professional industry, and I owe it to myself, my colleagues and my practice to present myself in a professional

manner, no matter how frustrated I may sometimes feel. Venting my angst on a social media forum is not, and will never be, a professional way of dealing with a problem in my practice. What happens in your practice should stay in your practice, not brought out into a public forum. The social networking forums are there to help one another in the industry, and many of them serve a very worthwhile cause. It also

helps to build relationships with colleagues and build a support network, which is all very positive and beneficial. As a practice manager it is easy to feel isolated, and most people will agree that the social networking business forums go a fair way in helping to ease that feeling of isolation. But we need to be aware that there are boundaries that must

not be overstepped and we must keep our comments and questions professional and relevant at all times.

We must also be aware that commenting as a private individual and posting photos or other content as a private individual may also have repercussions for our practice. We need to think twice or even three times before we say anything of a controversial nature on Facebook, Instagram, Twitter or any of the other popular social network settings, and how it may impact on our work setting.

In our practice handbook, we have a section regarding behaviour outside of work that states: “Activities that result in adverse publicity to ourselves, or which cause us to lose faith in your integrity, may give us grounds for your dismissal.” This includes, although is not exclusive to, how we conduct ourselves on social media sites, and we must make it very clear that any statements made are entirely our own thoughts and do not necessarily reflect our working situation.

However, rather than having to use a disclaimer before we spout forth on social media, perhaps we should take a few minutes to think about whether it’s really

necessary to ‘spout forth’ at all! We do each have our own views on life, in fact it’s what makes life so varied and interesting, but we do have to think carefully about how our words and actions are impacting our work situation and our colleagues.

Once again I am only scratching the surface of what is a vast topic, and I realise I have only drawn attention to a tiny portion in the subject that is social media.

But to summarise this short article on the dos and don’ts of social media:

DO:

- think about what you are going to post before you post it
- know the policies in your staff handbook and how your statement will impact your work
- use a disclaimer
- remain professional.

DON'T:

- use social media as a place to vent your own frustration
- identify either patients or staff
- say or do anything that would bring your practice into disrepute.

And on that note, happy networking!



**PERHAPS WE SHOULD
TAKE A FEW MINUTES TO
THINK ABOUT WHETHER
IT'S REALLY NECESSARY
TO 'SPOUT FORTH'**

If you wish to contact Susie about this article or other practice management issues she can be reached at susie@dentalfx.co.uk



LEADERSHIP WHEN THERE'S NO ONE FOLLOWING YOU

The changing face of dentistry means there are fewer opportunities to be a practice-owning boss. So how can young dentists develop as leaders?

[WORDS: ALUN K REES]

“LEADERSHIP” IS A CURRENT BIG buzzword in dentistry. If you read the often confusing guidelines that pour out of the offices of the “powers that be”, one would think that every dental professional in all situations was akin to a general taking their troops into battle or getting prepared to confront the All Blacks. I can’t see Joe Schmidt basing his team talks to the Irish rugby team on the GDC’s “Standards for The Dental Team” nor it becoming compulsory reading at Sandhurst.

I am not trying in any way to diminish the role of leadership in both the personal and professional elements of our lives, but I do believe there needs to be a less “in your face” role model.

In the landmark book, *Good to Great*, Jim Collins and his team compared the high-profile, big personality leaders who make headlines and become celebrities, with the actual “good to great leaders”. The latter are self-effacing, quiet, reserved, even shy individuals who, with their blend of humility and professionalism, make huge differences to their organisations.

With the rise of corporate ownership of dental practices, there are fewer opportunities for associates to become principals. In the UK these have shrunk to 40 per cent of what they were a decade ago. The traditional leadership role of the practice-owning boss is being replaced by something much less obvious.

Accompanying the changes has come a tendency for increasing isolation, loneliness and a rise in mental health problems. Feeling that you are “just” a cog in a machine with

little say in the running of an organisation and no input into decisions that affect your working life, contribute to stress. Many young (and not so young) dentists, especially those working in the NHS, have described themselves as feeling like “clinical cubicle workers”.

Dentistry can be a lonely profession. Working in a small, very sensitive area of the body with conscious patients who are lying prone while you undertake complex work is highly demanding. Having to consider the legal and business requirements of what you are doing plus complying with often insensitive regulations makes the job even harder.

How do young dentists develop themselves and their leadership skills? Who and how can they lead?

WORK ON YOURSELF

Unless you are grounded and sure of yourself, you are unlikely to succeed or enjoy your success. On a personal level, routinely take some time to examine what your beliefs are, determine your core values and decide how your life can follow them.

SELF-RELIANCE

Defined as “the reliance on one’s own capabilities, judgement or resources; independent”. Self-reliance is based on the fundamental belief that you can, and should, change and control your circumstances. In the ideal world we would all be in control of our own destiny at all times, but in reality things don’t always work out that way.





HOW SHOULD WE BEHAVE WHEN THINGS ARE OUT OF OUR CONTROL?

In his book *Man's search for meaning*, Viktor Frankl described his experiences in Auschwitz and other concentration camps. He concluded that "between stimulus and response, there is a space. In that space is our power to choose our response. In our response lies our growth and our freedom". Never forget that you always have a choice in how you respond.

There will be times when things are out of your control, so work on setting an example in everything that you do whether that is seen or unseen. One definition of a professional is doing the right thing when no one is watching.

Servant leadership is a leadership philosophy in which the main goal of the leader is to serve.

The leader shares power, puts the needs of the employees first and helps people to develop and perform as highly as possible. Although, on first thought, this concept can appear alien, it has proved itself in practice.

In addition, as the characteristics of servant leaders include listening, empathy, healing, awareness, persuasion and commitment to the growth of others, this would fit with the traits of good dentists.

SELF-ESTEEM

Self-esteem is described as a person's overall sense of self-worth or personal value; in other words how much you appreciate and like yourself.

Insufficient self-esteem can leave people feeling deflated or even depressed. Too much, as seen in narcissistic personalities, can damage relationships. It is dangerous in a dentist and can result in hubris, or arrogance.

RESILIENCE

Your individual resilience must be strong. Everything I have described contributes to our personal resilience, or "bouncebackability" as it has been described, an essential for weathering professional and personal storms we all experience in our lives.

TO CONCLUDE

Leadership comes in many forms, not always the obvious. To be a leader in your professional, social and family communities takes an investment of time and energy in yourself first and then others.

The effort that you put into becoming and remaining a leader will be repaid not only in professional success but also personal satisfaction and happiness.

Alun K Rees BDS is The Dental Business Coach. An experienced dental practice owner who changed career, he now works as a coach, consultant, trouble-shooter, analyst, speaker, writer and broadcaster. He brings the wisdom gained from his and others' successes to help his clients achieve the rewards their work and dedication deserve.

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BUT IN REALITY THINGS
DON'T ALWAYS WORK
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DON'T LET WALK-INS JUST WALK OUT AGAIN

No matter how much you spend on designing your reception, the investment that will really pay off is the personal welcome and service patients receive

[WORDS: RICHARD PEARCE]

WHenever I get the chance

I drop into a practice and ask for an appointment. Last weekend I was in Cambridge and spied a practice that was open. It had a modern façade and looked bright, airy and welcoming. As I opened the door the expensive fit-out was clear – this was a private practice where interior designers had been employed. So far, so good.

The reception desk was right in front of me and the receptionist looked up (she was sitting behind it as is usual), she smiled and seemed almost pleased to see me! “Do you have an appointment?” she asked. “No,” says I, “I wanted to see about booking one.” Those words from me would, you would hope (if you’re a practice owner), ignite in a receptionist a challenge. All that expensive marketing, all the agonising over creating a welcoming space for customers has worked. A prospective new patient has walked through the door and asked for an appointment. I could have been a walking £20,000 piece of work (they did implants).

The next 30 seconds of interaction could seal the start of a practice-patient relationship that could last many years and be worth thousands of pounds to the practice. There was not just my patronage at stake but that of several friends and family I could refer – isn’t that what we were supposed to teach our staff?

Back to our interaction at the reception desk. “Well we do have a couple of appointments available later on this

morning,” she suggested. It’s all a bit impersonal at the moment, she could have immediately followed with, “Could I ask you your name?” As soon as she had that and started to use it, we might have started building a relationship. She didn’t but she did try to book me in for one of those (check-up) appointments, good try. Obviously, I didn’t actually want an appointment. Time for my delaying tactic and to ask for some information about the practice, so I could think about it.

This is where the experience started to fall down again. I was handed two A4 pieces of cheap paper, in black and white with lots of writing on them. Undoubtedly, they were produced in-house and not even by the enthusiastic desktop publisher. I was underwhelmed.



THERE WAS NOT JUST MY PATRONAGE AT STAKE BUT THAT OF SEVERAL FRIENDS AND FAMILY I COULD REFER

“OK,” I said, “I’ll take this with me and get in touch.” The receptionist now has one last chance to get some information from me so they can follow up. She could have said, “James, the practice principal prides himself on understanding what a patient wants from him and he really does fantastic dentistry, could I take an email address from you and send some examples of his recent treatments?” This would allow a professionally produced pdf to be sent, showcasing James and great dentistry, perhaps with a short video of him (I still don’t know if I’ll like him), showing that he smiles and sounds like he cares.

If I’m prepared to give an email address, I might also give my mobile too. But let’s rewind a little and discuss what could have been done differently in this practice.

THE INITIAL GREETING

Would it really have hurt for her to stand up, walk round the desk to me, shake hands and say, “Hi, I’m Jane, how can I help you?” There was only one other person in the waiting room and she had never met me before. When we meet someone for the first time we generally introduce ourselves with our name. Get their name and use it – we like having our own name used.

EMPATHISE AND ENGAGE

Just because I’ve asked for an appointment, doesn’t mean that’s what I need now. What about suggesting a tea/coffee (great coffee that is available in the waiting area) and

then a chat about what I am looking for in a dentist? If I agree, then there is a chance to build a relationship.

GET THE MARKETING COLLATERAL ON-BRAND

If you've gone to the expense of designing the layout and look of your practice, why not make sure that what you give to patients is consistent? It's the first thing a corporate does when they buy a practice, because it's so easy, cheap and effective. So, you can do it, but better.

So, we need to recruit and train the right staff to get the right outcomes. They also need the collateral at their fingertips (or the click of a mouse). This is what practices often fail to do but it could be the difference between appointments remaining empty and many more new patients.

Richard Pearce lives in Northern Ireland. Following a business career in various sectors and an MBA, he joined his dentist wife in dentistry. Richard combines his wide commercial experience with being attuned to what it is like for an associate dentist, a practice owner and a practice manager. His unique perspective ensures he can assist a practice owner with every area of the practice to create a more profitable practice and to achieve their smart objectives.

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MDDUS CASE STUDY:

CROWN CLAIM

Lack of clarity in patient's records leaves dentist 'vulnerable' in claim of clinical negligence over failed treatment

[WORDS: AUBREY CRAIG]

DAY ONE

Mr K is a 32-year-old sales manager and attends the dental surgery dissatisfied with the appearance of a crown on UR2. The crown had been fitted six years ago after he chipped the tooth badly while mountain biking. He is now unhappy with the colour. The dentist, Dr G, discusses options, including replacing the crown or whitening the natural teeth to better match the colour. Mr K agrees to whitening treatment and this is subsequently carried out.

ONE MONTH LATER

Mr K states that he is still unhappy with the appearance of the crown and requests a replacement. Dr G provides a treatment plan and cost, and the old crown is subsequently removed. The replacement crown is made on the first model as the fit was adequate, and Mr K attends the dental laboratory to ensure the best colour match. Ten days later the new crown is fitted, and the notes state that the patient is happy with both shade and fit.

THREE WEEKS LATER

Mr K re-attends complaining that the tooth feels too "tight", and Dr G notes that the crown is not properly seated. It is also evident that the patient's gingivae are irritated labially. The crown is re-prepared and a new impression is taken. Five days later a new crown is fitted, and Mr K is again happy with the colour but some gum recession is noted.

FOUR MONTHS LATER

Mr K returns to the surgery concerned over how much the gum has receded over UR2. The patient has a high lip line, and the fault is very obvious when he smiles. Dr G advises the patient on correct brushing techniques

and discusses further options, including an offer to refund treatment costs. Mr K refuses the refund.

LETTER OF COMPLAINT

The practice later receives a letter from solicitors acting on behalf of Mr K claiming clinical negligence in the treatment of UR2. It is alleged in the first instance that Dr G had recommended inappropriate treatment in the form of tooth whitening, which was unnecessary and resulted in sensitivity. It is also claimed that the dentist failed to correctly mould the subsequent replacement crown and ensure an adequate fit.

The claim also cites a failure to appreciate that an ill-fitting crown may cause gum recession, and that Dr G failed to resolve the complication. The letter states that Mr K is now self-conscious about smiling – a problem for someone who "works in sales" – and the only appropriate remedial treatment is replacement of UR2 with an implant-retained crown.

MDDUS instructs an expert dental surgeon to provide an opinion on the case, addressing each of the allegations. The expert considers that the choice of tooth whitening in the first instance was reasonable and, indeed, requested by the patient after discussion of the various options. Mr K was also advised of possible temporary sensitivity.

In regard to the ill-fitting crown, the expert considers that it was reasonable to make the replacement crown on the first model as the fit was adequate. He advises that it is not possible to guarantee a crown will fit when it is returned from

the laboratory and tried in, as there are numerous areas where the fabrication process can go wrong without any specific or obvious fault.

The expert states that it is unclear from the records what caused the gingival irritation and gum recession. It could be that the margin of the first new crown was not satisfactory and caused plaque accumulation. An excess of luting cement left under the gum margin when the crown was fitted could also have caused inflammation – or the gingiva may have been traumatised when the first crown was removed and the tooth re-prepared.

Any of these would constitute a breach of duty and leave Dr G "vulnerable" in court.

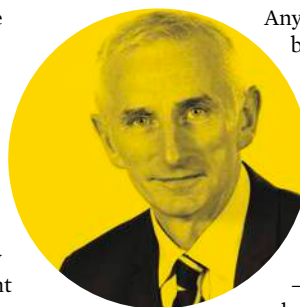
In regard to the consequences of the failed treatment, the expert agrees that with the patient's high lip line the gum recession is noticeable. Various treatment options are possible – including a replacement crown edged with gingival coloured

porcelain or referral to a periodontal specialist – but he considers extraction with a replacement implant wholly inappropriate at this stage.

Given the "vulnerability" cited by the expert, MDDUS agrees with the member to settle the case with no admission of liability.

KEY POINTS

- Keep adequate notes of patient discussions regarding treatment options and risks.
- Ensure patients have reasonable expectations of treatment outcomes.



Aubrey Craig is head of dental division at MDDUS



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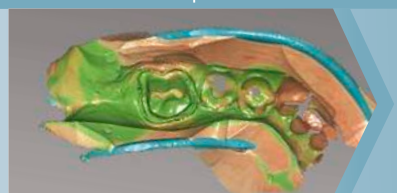
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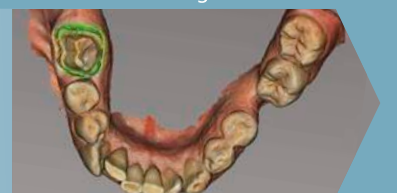
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scan impression



view merged data



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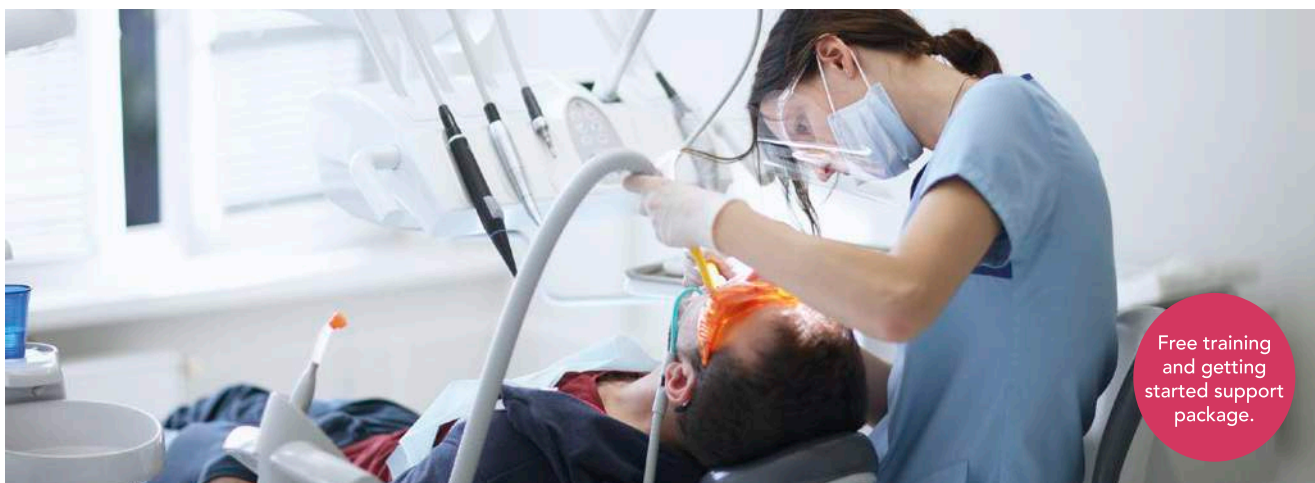
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A RARE PRACTICE READY FOR REFERRALS

Kalyani Dental Lounge in Glasgow is a practice with a unique identity and is perfectly equipped to offer a bespoke referral service



ABOUT THE PRACTICE

Kalyani Dental Lounge is located at 200 Bath Street, Glasgow. It's a unique, distinctive practice that's particularly suited to serve the group's desire to be a leader in referral treatment.

ABOUT THE OWNER

The owner is Michael Tang who qualified at Glasgow in 2002. Michael has a special interest in dental implant treatment and the digital workflow. He first became a partner in a practice in 2006. During that time he started visiting other practices to undertake implants. From 2015 he has acquired several more practices and is now involved in a group of six clinics.

Michael said: "We don't look to radically alter the practices we acquire. Instead, we identify what they're good at and grow those areas, as well as working to remedy any weaknesses.

"Similarly, we keep the original identity. Patients, staff and dentists seem to be more comfortable with that. We treat every practice

individually. It's not a case of replicating a single formula, but assessing each practice on its own merits."

DOES THE PRACTICE HAVE AN INTERESTING HISTORY?

Kalyani Dental Lounge has been in existence since 1996. It's a small, high-end private practice with a quirky history. It was originally set up as a dental practice and gallery. We liked





that and were keen to keep that distinct character, while fully modernising the facilities and equipment.

WHAT PROMPTED YOU TO TAKE OVER THE PRACTICE?

We decided to take over the clinic due to its excellent central location, which is great for access for our partner clinics. We also loved the historic philosophy of creating the most relaxed atmosphere and the best possible quality dentistry for patients.

WHAT CHANGES DID YOU PUT IN PLACE?

We undertook a major reconfiguration of the practice. In essence, the only things we didn't touch were those restricted by the building's 'B-listed' status. The surgery layout was completely revamped, necessitating the knocking down of some internal walls. In all, work took about four months.

We added a CBCT scanner, intraoral scanner, 3D printers, state-of-the-art sedation and

sterilisation facilities. We also improved our teeth-whitening treatment options, added facilities for processing blood for plasma rich fibrin to aid surgery and for facial aesthetic treatments. The facilities now allow treatment to follow a modern digital workflow philosophy, with implants planned digitally and surgical guides printed in-house.

We accept referrals for all aspects of implant treatment, including for CBCT scans and printing of surgical guides. We also run courses of the restoration of implants which has benefitted many colleagues.

WHICH COMPANIES DID THE WORK?

The majority of the refurbishment work was carried out by IWT Dental + Services. Modwood supplied and fitted all cabinetry, while Henry Schein supplied all sundries.

DID YOU REQUIRE ANY PLANNING PERMISSION OR FINANCE? IF SO, HOW DID THOSE PROCESSES GO?

Finance was obtained via Barclays and Performance Finance and everything went very smoothly.

CAN YOU TELL US ABOUT STAFF AT THE PRACTICE AND THEIR AREAS OF SPECIAL INTEREST

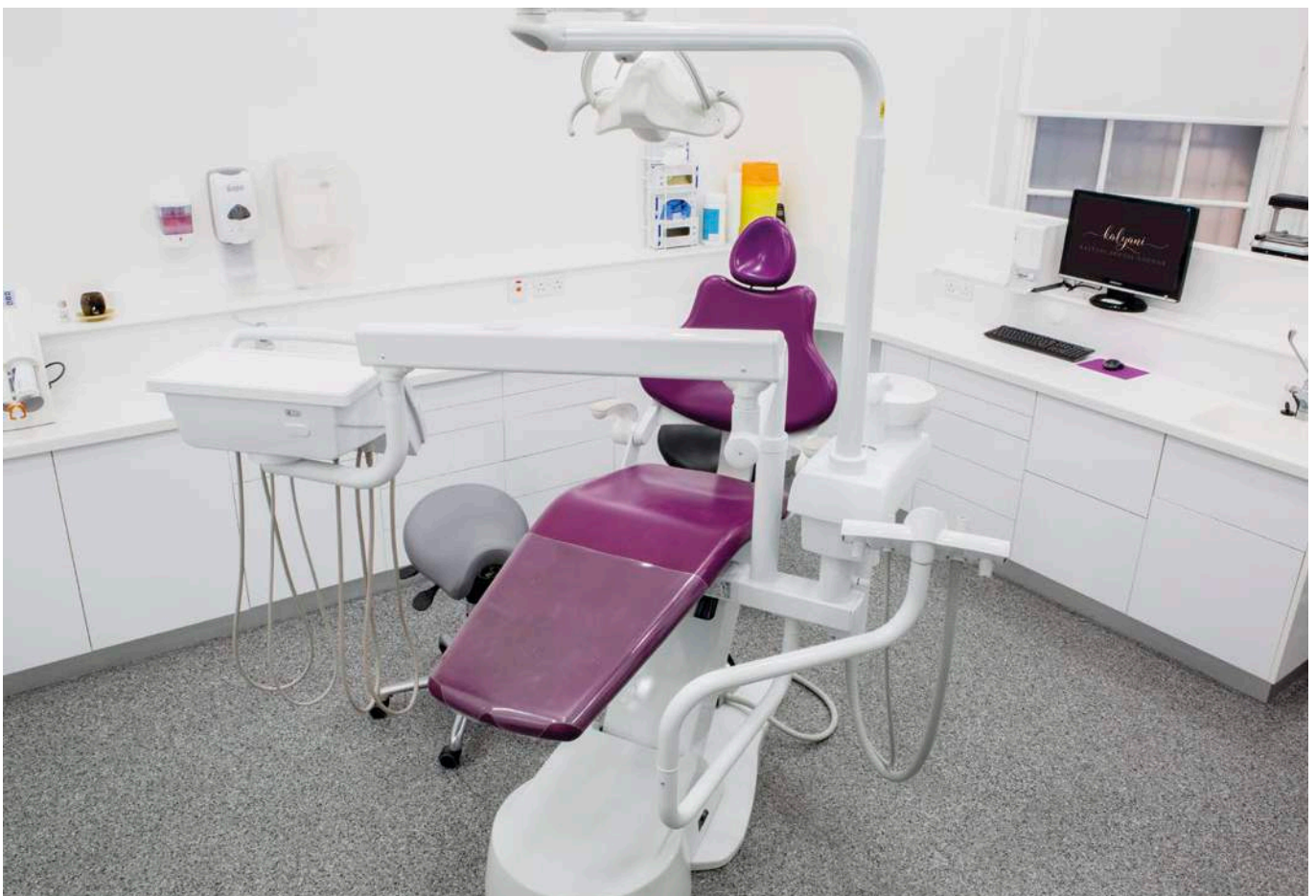
Our associate is Ambigai Jeyabalan, who has a special interest in adult orthodontics and smile makeovers. Susanne Wilson is our hygienist, and she is particularly experienced with nervous patients and those who have special needs.

WHAT SORT OF TRAINING DO YOU PROVIDE?

We make sure our team receive training in all aspects of the patient journey, from how patients are greeted and answering the phone, to clinical treatments. We look at everything because we firmly believe that it's attention to detail that makes the difference.

ARE THERE ANY FACILITIES SPECIFICALLY DESIGNED FOR THE BENEFIT OF EMPLOYEES?

The whole practice is geared towards providing a relaxed environment for patients and staff (see next page).





WHAT FACILITIES MAKE THE EXPERIENCE OF VISITING THE PRACTICE GOOD FOR PATIENTS?

From the minute patients walk through the door we provide a relaxing atmosphere with very comfortable decor, oils burning, and specially chosen music. Bottled water and tea/coffee are available. Anyone waiting can use a specially dedicated lounge, choosing their own DVD or CD.

The experience and expertise of the staff, as well as the state-of-the-art nature of the equipment, assures patients they are getting the best possible service.

Plus, the practice is completely digital. Everything is planned on a computer and 3D-printed. There are no impressions – it's all intraoral scans. We believe this gives patients a better experience and better treatment.

CAN YOU DESCRIBE THE ETHOS OF THE PRACTICE

The patient has to feel special. The treatment they receive should feel

very different to what they have experienced elsewhere.

HOW DO YOU SEE THE FUTURE FOR THE PRACTICE?

Continue accepting referrals and building relationships with colleagues at other clinics and working together to provide quality treatments.

We want to work more closely with dental colleagues to build our referral base, and be on the lookout for most up to date treatment to give patients better and more comfortable treatment.

For implant referrals, we can either carry out the treatment from start to finish, or we can refer the patient back to the referring dentist to undertake the restorative aspect of the treatment - we provide training and unlimited support to our referring dentists. This depends on the preference of the referring dentist and case complexity.

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We would like to take this opportunity to wish the team at **Kalyani Dental Lounge** every success for the future.





FINDING THE RIGHT SUPPORT IN SCOTLAND

Here Ted Johnston, a practice consultant from Dental Elite based in Scotland, considers the difference a specialist, quality broker can make to the outcome of a practice sale or acquisition.

In the past, Scottish buyers and vendors have not always had access to the same level of representation and support from brokers like other parts of the UK have. For the most part, this is due to a lack of choice because there are fewer companies operating in Scotland.

This is important to note, as finding the right support is essential to navigating a smooth transaction that ensures you achieve a successful sale or acquisition. This is because there are a number of pitfalls that can occur during the process – such as failure to secure funding, lease-length negotiations and communication breakdown, among other things – that can lead to an aborted sale. With the marketplace changing all the time, it can be difficult to keep up with the latest trends and practice values without the help of a specialist agency to provide appropriate, up-to-date guidance.

Scotland, after all, has experienced significant growth in recent years, especially the NHS sector and mixed practices. This is, in part, due to NHS practice allowances, attractive rent and rate reimbursements, and free check-ups and prescriptions, which have made these practices highly attractive to dentists looking to turn a profit. This has resulted in a strong demand for dental practices – particularly in the bigger cities. However, with the landscape ever changing, buyers and vendors always need to stay on top of what's happening in the market. The only way this can happen is to have a knowledgeable broker that has access to the

latest information as it occurs and understands how to apply that data to get the optimal outcome.

There are several other prerequisites that vendors and buyers should look for when choosing a broker. These include:

KNOWLEDGE AND EXPERIENCE

First and foremost, a broker must have experience in working with the dental sector and a thorough, up-to-date knowledge of the practice sales and acquisitions market. Only an agency with the right skills and a comprehensive understanding of the minutiae of the process will be able to guide the way through the transaction smoothly and effectively.

PROFESSIONALISM

The broker should be professional in all aspects of the service that they provide, from their people skills through to the way that they handle the various processes – including any problems that arise. You can usually tell if a broker is professional from the way they communicate and present themselves. However, there are several other indicators of their respectability and experience, including their customer feedback rating and testimonials.

SUPPORT

There's a lot of work involved with buying or selling a practice, so finding an agency that provides guidance from the beginning to the end of a transaction is invaluable. Look



For more information on Dental Elite, visit www.dentalelite.co.uk, or contact their Scottish practice consultant by phone on 07718 490506 or by email at ted.johnston@dentalelite.co.uk

for a broker that is hands-on and proactive rather than reactive. In other words, one that works actively to stay ahead of the curve in order to stay on top of market trends, provide accurate data and valuations, and ensure optimal results in line with current rules and regulations.

Naturally, it can be difficult to find an agent that does all these things well, but at Dental Elite, we tick all of the boxes – and now we are pleased to announce that the service has improved thanks to our increased presence in Scotland. With the support of the entire Dental Elite team behind me and their combined skills and experience, I will be working closely with the Scottish market moving forward to provide a professional, hands-on service from beginning to end.

As a Scot myself based in bustling Glasgow, I bring a fresh perspective of the Scottish market, which – when combined with the rest of the team's market knowledge – gives us a unique advantage that greatly benefits our buyers and vendors. Together with our consultative, proactive approach, dedicated single-point-of-contact service, and fair, transparent principles, we hope to offer customers greater choice in Scotland, so that they can achieve the best results possible.

On every level, the practice sales and acquisitions market is different in Scotland than in other parts of the UK. So, if you're thinking of buying or selling a practice, be sure to find a trusted dental broker that will provide the right support and guidance.

BUDGET 2018: OPPORTUNITY REMAINS

The Chancellor's decision to leave pensions alone for the time being offers continuity in planning a tax-efficient retirement

The giveaway Budget? Fiscal Phil, as the Chancellor styled himself, did seem to enjoy the occasion. The usual theatrics accompanied some key announcements, such as the increase of the Personal Allowance to £12,500 and the Higher Rate Tax threshold moving to £50,000, a year ahead of schedule. Taxpayers in Scotland will benefit from the Personal Allowance increase, but will have to wait for Derek Mackay's equivalent to fully understand their income tax situation, which hasn't occurred at the time of writing this.

For me, one of the most notable elements of the Budget was conspicuous by its absence. Pensions were left well alone, with

higher/additional rate tax relief, the £40,000 annual allowance and the exception from inheritance tax all surviving. For some commentators, these were obvious sources of revenue that could be used to combat a potential Brexit shortfall, and were up for review. Cue a collective sigh of relief and an appreciation of some continuity in retirement planning.

So what does that mean for the dental profession? With the generous allowances still in place, it presents ample opportunity for a tax-efficient retirement. Private pensions can be used to complement the NHS scheme or to pass funds to the next generation. For those in the dental sector running a private practice, employer



Andrew Reynolds,
Chartered Financial
Planner, Anderson
Anderson &
Brown LLP

payments can be made into directors' personal pensions, fully deductible for corporation tax. Private pension funding can work well, although care must be taken to account for benefits accruing in the NHS scheme counting towards the pension annual allowance.

The upshot is that there are, as always, opportunities available. The key is being aware of them, accounting for potential pitfalls and planning in advance.

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BUDGET 2018: THE KEY IMPACTS ON DENTISTS

A corporation tax reduction and increased allowances for business investment offer dental practices an incentive to upgrade and grow their business

The 2018 Budget delivered opportunities for dental practices and health sector businesses, which are intended to support and encourage them to invest. However, Philip Hammond's generosity was not all it appeared as the personal allowance and higher rate threshold will both be frozen in 2020/21, and he also kept many tax thresholds and allowances unchanged.

CORPORATION TAX WILL FALL NEXT YEAR

One of the key developments confirmed by the Chancellor – but originally announced in previous Budgets – is that corporation tax will fall to 17 per cent from 2020. This new low rate will make incorporation more attractive for smaller businesses and reduce the tax burden for companies of all sizes.

INCREASED ALLOWANCES FOR BUSINESS INVESTMENT

The annual investment allowance (AIA) will increase from £200,000 to £1,000,000 for qualifying investment. The increased



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allowance only applies to investment between 1 January 2019 and 31 December 2020.

Quite simply, capital allowances can reduce your annual tax bill. They can be claimed for some types of capital expenditure but, generally speaking, anything that is used for a business purpose that has a useful life of two or more years may qualify. See table inset below for examples of qualifying investment. They are treated like any other expense and can be deducted from your profits when calculating your taxable profits at the end of the financial year. The deductions recognise that assets and equipment can lose value as a result of general use, wear and tear. In other words, capital allowances are the tax equivalent of depreciation.

Alongside this, a new structures and buildings allowance has been introduced, which has been set at 2 per cent on construction or conversion costs over 50 years, where all the contracts for physical construction works were entered into from 29 October 2018.

So if you are considering building a new practice or converting existing premises into a dental practice, or you plan to upgrade practice equipment and fixtures and fittings next year, get in touch to discuss what tax-efficient options are available to you.

PERSONAL ALLOWANCES AND THRESHOLDS

A £650 increase in the personal allowance to £12,500 will come in next year, one year ahead of schedule. There will also be an increase in the higher rate threshold (and self-employment National Insurance on profits) to £50,000; however, we will have to wait until 12 December to find out if

the latter will be implemented in Scotland.

The pension lifetime allowance, widely tipped to be cut pre-Budget, was increased to £1.055m from April 2019. However, the personal allowance and higher rate threshold will both be frozen by the UK Government in 2020/21. A good example of the impact of frozen thresholds is the personal allowance that will continue to be tapered from an income level of £100,000. This threshold has applied since April 2010 and it creates high marginal rates for some dentists.

Combined with the increase in the personal allowance, for income between the taper threshold of £100,000 and the starting point for additional rate tax of £150,000: the first £25,000 will be taxed at up to 60 per cent (61.5 per cent in Scotland); and the next £25,000 will be taxed at 40 per cent (41 per cent in Scotland).

NHS SPENDING UP

By far the largest element of spending announced in the Budget was for the NHS with the Chancellor finding a further £20bn a year for the NHS, which when followed through will mean that the NHS will account for 38 per cent of all public spending by 2023.

We will have to wait until 12 December when the Scottish Budget is announced to find out if this increase in NHS spending is replicated in Scotland, and indeed we will also find out if the higher rate threshold which is due to rise in England, Wales and Northern Ireland next year will be applied in Scotland.

For the full Budget 2018 summary visit maco.co.uk. Our Scottish Budget 2018 commentary will be published on 13 December 2018.

PLANT & MACHINERY

Items that you keep and use in your pharmacy, e.g. PCs, surgery cabinetry and equipment

Business machinery, e.g. radiography equipment.

Computer aided machinery.

Space and water heating systems.

Air con and cooling systems

Hot and cold water systems (but not toilets and kitchen systems)

Electrical and lighting systems

Fire alarms and CCTV systems



SHAPING THE FUTURE OF DENTAL IMPLANTOLOGY

A stellar line-up of internationally renowned experts will focus on the three Ts – Techniques, Technology and Teamwork – at ADI Team Congress

The Association of Dental Implantology (ADI) is an organisation for dental professionals and all members of the team. Among the many membership benefits on offer is the highly anticipated biennial ADI Team Congress, entitled *Shaping the Future of Dental Implantology: Techniques – Technology – Teamwork*, which will be held on 2-4 May 2019 at the EICC in Edinburgh.

WHAT CAN YOU EXPECT?

The event will focus on the three fundamental tenets required for successful implant dentistry:

Techniques – learnt and mastered over time

Technology – evolving constantly to deliver ever better results

Teamwork – creating a seamless workflow and exceptional patient care.

Shaping the Future of Dental Implantology: Techniques – Technology – Teamwork
2-4 May 2019,
EICC, Edinburgh

Inspirational lectures will be featured throughout the exciting programme, where a wide spectrum of topics will be covered to ensure a unique learning experience for delegates. There will be up to 19.5 hours of verifiable CPD available for all members of the team, with a line-up of internationally renowned speakers sharing their extensive expertise from around the globe.

WHY ATTEND?

As you can see, the ADI Team Congress 2019 will be packed full of learning opportunities with leaders in the field guiding lectures and discussions, and it will also be the ideal place to network with like-minded professionals.

There will be something for everyone, from dentists to dental nurses and practice managers, dental hygienists and therapists, dental technicians and students, plus the chance to make new connections to support your career and your business. In addition to the education on offer, you can also submit an electronic poster to help raise your profile by sharing your research or practice-based study.

Among the social activities will be the legendary Congress Dinner, held at the National Museum of Scotland. Plus, why not also make the most of the fantastic location and explore the historic city of Edinburgh for a dose of culture and fun? There is plenty to see and do with family and friends around the Congress, so visitors of all ages will be kept entertained!

Entitled *Shaping the Future of Dental Implantology: Techniques – Teamwork*, the ADI Team Congress 2019 is a not-to-be-missed event for anyone with an interest in dental implants. By acquiring new skills, using innovative products and involving the whole dental team, together we can shape the future of dental implantology.

DON'T MISS:



Istvan Urban, Hungary – *Perspectives on Vertical and Horizontal Augmentation*



Lyndon F Cooper, USA – *Comprehensive Therapies for Single Tooth Replacement: What is Enough?*



Mark Montana, USA – *Making Contact and Staying in Touch*



Alessandro Agnini and Andrea Agnini, Italy – *Surgical Veneer Grafting (SVG) Protocol: An Approach for the Immediate Implants in the Aesthetic Zone*



Markus B Blatz, USA – *The Evolution of Ceramics in Aesthetic Implant Dentistry*



Tord Berglundh, Sweden – *Peri-implantitis – Diagnosis, Prevalence, Risk Factors and Treatment*



Wael Att, Germany – *Three-Dimensional Engineering in Dentofacial Rehabilitation*



Anabell Bologna, Venezuela – *New Interdisciplinary Perspectives with All Ceramic Restorations*



Barry P Levin, USA – *Primary Stability: What Do We Know and What is 'Truly' Important for Success?*



John E Davies, Canada – *New Perspectives on Osseointegration*



Markus B Hürzeler, Germany – *Selecting Treatment Strategies in the Era of Evidence Based Medicine*



Craig M Misch, USA – *Changing Treatment Paradigms via Advances in Regeneration and Implant Design*



Daniele Cardaropoli, Italy – *Hard and Soft Tissue Management for the Aesthetic Outcome around Immediate Implants*



David Guichet, USA – *A Critical Look at Digital Treatment Protocols and Performance of CAD/CAM*

The ADI Team Congress 2019 will also present a major exhibition with cutting-edge innovations from implant-related companies, enabling you and your whole team to discover the latest technologies to benefit your practice and your patients. This will be perfectly complemented by the Corporate Forums, which offer an opportunity to learn about key developments in the dental implant market.

For more information about the event, please visit www.adi.org.uk/congress19

ADI members can attend at a significantly reduced rate, join online today.

NEW JOB – NEW FINANCIAL DECISIONS

For new associates and Dental Core Training dentists, Jon Drysdale offers independent advice on investing wisely

Many new associates and Dental Core Training (DCT) dentists taking stock of new jobs started in late summer. Getting used to a new practice or department and implementing the skills learned through training, while continuing to acquire new ones, takes a huge amount of effort. There are, however, non-clinical aspects of dentistry which should nevertheless be addressed.

One of the pleasing aspects of career progression is an uplift in income. In many cases, this will be significant and, typically, may be in the region of £20,000 to £30,000 per annum. With this comes added responsibility.

ESSENTIAL SAVINGS

You should put money aside for future payments of things such as tax, National Insurance contributions (NICs) and repayment of a student loan, as relevant. Certainly, if you are a self-employed associate in practice or have any self-employed income (e.g. for facial aesthetics) you will be liable for tax and NICs.

The current rules dictate that self-employed individuals need to pay their tax liability twice a year, in January and July. There is also a requirement to pay Class 2 and 4 NICs and student loan repayments at 9 per cent of your total income.

Your accountant should advise you what you need to pay and when you need to pay it. They can also suggest how much you should save each month to make these payments. This is generally estimated to be about 35-40 per cent of income for an associate earning approximately £60,000pa. The figure varies depending on the exact level of income and factors such as the size of student debt.

If you started your first self-employed job this summer, the first payments of tax and NICs and of student loan repayments may not be due until January 2020. This doesn't mean you should delay making provision – start saving now!

Those in salaried posts will receive their income net of tax, NICs and student loan repayments – i.e. your employer (NHS or otherwise) will take care of the deductions on your behalf.

BWARE OF PENSION MISTAKES

Unlike tax liabilities, NHS pension deductions for self-employed dentists are made by the practice. These can be incorrect, so it is worth checking the amount now rather than later. Errors can generally be rectified, although if you find out that you have been under-contributing for a long period it can be costly to make up the contributions. The level of deductions is dictated by your income. Check the accuracy of your NHS pension deductions for 2018/19 using this table.

GROSS ANNUAL INCOME (I.E. BEFORE TAX)	PERCENTAGE OF INCOME DEDUCTED AS PENSION CONTRIBUTION
Up to £15,431.99	5.0%
£15,432.00 to £21,477.99	5.6%
£21,478.00 to £26,823.99	7.1%
£26,824.00 to £47,845.99	9.3%
£47,846.00 to £70,630.99	12.5%
£70,631.00 to £111,376.99	13.5%
£111,377.00 and over	14.5%

Remember, your NHS pension retirement age is now linked to the State Pension age. For anyone born after 5 April 1977, this will be age 68 or perhaps later if the State Pension age continues to be increased.

Rarely before has there been a greater reason to make pension savings additional to the NHS pension – usually through a personal pension. After all, do you really want to work to age 68 or possibly older? The current tax system offers an incentive to making pension contributions. Here's an example of how it works:

Your pension contribution	£300
Added by the government	£70
Gross contribution – what goes into your pension	£375
Reclaimable if you are a higher rate tax payer	£75
Net contribution – what it actually costs you (£300-£75)	£225

Tax relief on pension contributions may not be around forever so make the most of it while you can.

REVIEW INCOME PROTECTION

Perhaps you don't have any income protection cover. Alternatively, you may have signed up to one of the income protection providers while studying, or soon afterwards. This doesn't mean the policy that you were sold remains the right one for you. Here are the key points to review, now that your job has changed:

- You may be entitled to NHS sick pay even if you are a self-employed associate. Does your current policy take this into account?
- If you have a new salaried job in hospital or community dentistry, does your cover reflect your NHS sick pay?
- Have you reviewed your level of cover in light of your income uplift?
- Does your income protection policy have reviewable premiums? If so, you might want to consider a policy with premiums that won't increase with your age or claims history.

Remember, it is vital to have an occupation-specific income protection policy otherwise you might not be able to claim if you can't work as a dentist but are deemed capable of other work. When reviewing your cover make sure you speak to an adviser who is a dental specialist.

A STITCH IN TIME

In dentistry, a little effort to fix a small problem straight away prevents it from becoming a larger problem requiring more effort to fix later. Similarly, tackling key financial decisions – with professional advice as necessary – sooner, rather than later, invariably pays dividends – not least in terms of peace of mind.



Jon Drysdale is an independent financial adviser for chartered financial planners, PFM Dental. Go to www.pfmdental.co.uk

DIVERSE MARKET OFFERS VALUE FOR MONEY

We recently published our first annual report on the dental market, 'The Dental Industry 2018: Staffing, Brexit and the Dentist Shortage.' The report provides an overview of the UK dental workforce, specifically highlighting key challenges facing the dental sector and especially operators, including staff recruitment and retention.

As covered in the report, the supply of dentists in the UK is most under pressure in Wales, followed by England, while Scotland and Northern Ireland enjoy a higher level of dentists, with one dentist per 1.4k and 1.2k of the country's population, respectively. Both countries also enjoy higher supply levels of dental care professionals, compared to England and Wales.

Challenges pertaining to recruitment aren't solely reserved to corners of the country that are more remote, such as

Inverness or Aberdeenshire. In fact, we recently sold two practices in Inverness that had the most consistent and longstanding associate base I've seen. Associates seek diversity and a practice that offers a modern environment, support and favourable patient base, regardless of its location, and it's these practices that will continue to flourish in the marketplace.

Practices across the central belt of Scotland face recruitment challenges, as well. Operators, especially corporates, looking for a fully associate-led practice will consider the supply of dentists and DCPs. An extensive pool of staff, often linked with highly populated areas, will always sit comfortably with decision-makers.

Demand for quality practices continues to exceed supply in most areas and market segments across the UK, and this is especially evident in Scotland, with an increasing number and variety of buyers



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

seeking opportunities north of the border.

As we come to the end of another record year with record sales achieved in the past 12 months, we note that the central belt and surrounding towns in Lanarkshire, Lothians, Stirlingshire and Fife remain in high demand. At the same time, Perthshire, Inverness and areas around Ayrshire have grabbed the attention of many buyers.

When compared to the market in England, the Scottish market represents a certain value for money. It is no wonder that we have seen so many first-time buyers purchasing their own practice to grow and perhaps sell on within the next five or 10 years. Equally, new entrants to the market include more corporate operators different from the usual suspects, who are moving north to capture a stable dental system. The market will continue to diversify, as consolidation and demand for quality practices continues to characterise the industry.

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BUDGET SUMMARY 2018 – AUSTERITY NO MORE?

For those looking to sell their businesses, the ownership criteria increasing to two years from one year needs to be kept in mind

“**S**preadsheet Phil” delivered his Budget with a clear health warning that it was based on a decent Brexit deal being secured.

The end of austerity was proudly announced, and the Chancellor headlined measures such as the extension of the annual investment allowance to £1m for capital expenditure (for two years from 1 January 2019) and the acceleration of the previously announced personal allowance and basic rate thresholds to £12,500 and £50,000 respectively with effect from 6 April 2019.

For those of us in Scotland, we await Finance Secretary Derek MacKay's address in December, but there is no doubt there will be pressure to provide Scottish workers the same benefits as their English counterparts.

Personal service companies and residential property landlords took yet another hit, and for those potentially looking to sell their businesses, the ownership criteria increasing to two years from one year needs to be kept in mind.

The two-year ownership criteria extremely important for any dental professional looking at succession planning



For more information or advice on how the Budget will affect your dental practice, please contact Louise Grant
louise.grant@eqaccountants.co.uk
or call 01382 312100.

to ensure the disposal of their practice qualifies for the 10 per cent tax charge.

Head of EQ Taxation David Morrison commented: “The speech from the Chancellor would broadly be welcomed by businesses, and there is no doubt he wanted to be seen to be giving away some of the savings secured in the past eight years. Call me cynical, but I smell the murmurings of a general election!”

For our full analysis of the Autumn Budget 2018, please download our Budget Summary at www.eqaccountants.co.uk

Your Practice. Energised.



At EQ Healthcare, our dedicated team of specialists act for numerous healthcare practices of all shapes and sizes. We enjoy working with clients who view us as part of the team, assisting their practices to grow and develop, to realise their personal ambitions and to make a real difference.

We can offer assistance when buying or selling your practice, ensuring you have a tax efficient structure, managing your day-to-day financial controls, or providing advisory support and practical solutions to your healthcare business challenges.

For further information please contact:

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www.eqaccountants.co.uk



SELLING UP MADE SO MUCH SIMPLER

“Like having a satnav – you don’t know how good it is until you have used it”
– how the Strictly Confidential team can guide you through the sale of your practice

Selling your practice is never easy, especially when the business concerned is one you’ve worked hard to build up over more than 30 years.

Frank Dolan wasn’t looking forward to letting go of his practice in Airdrie, which he had nurtured and developed throughout his dental career. However, he found the process a whole lot simpler and less traumatic when he turned to Strictly Confidential for help.

He said: “It was a bit of a daunting prospect. I’d heard stories from friends about how stressful it was and how much there was to do to complete the process. I wasn’t looking forward to it.

“I needn’t have worried. Once Trisha (Munro) and Gillian (Wyllie) got involved it was much easier than I expected. They explained how it all worked, from valuation to completion, and provided great insight as to what issues might arise.”

It helped that Frank had a long-standing relationship with Trisha and Gillian.

“I’ve known for Trisha for several years

and worked with her in 2015 when I received an offer for the practice that didn’t go through in the end.

“When Gillian arrived to help I was a little surprised, because I hadn’t realised she was working with Trisha. However, it made me feel even better about the whole situation. I’ve also known Gillian for a long time, through her previous work as a rep, and she is one of the most meticulous people I’ve ever come across.”

After that false start in 2015, Frank had considered selling again in spring 2017 and had a tentative conversation with Trisha. Ultimately, he decided to wait a little longer. Then, in October the thought re-surfaced – just as Trisha was contacting him again to sound out his feelings on the way forward. From that point on things were under way.

He describes the experience of being guided by Strictly Confidential as “a bit like having a satnav – you don’t realise how good it is until you’ve used it.”

The best thing, he said, was that he always felt he was being well looked after by people who knew exactly what they were

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doing. “There was always good advice on hand and it was never a problem to get in touch if I needed to. It’s a five star level of service.

“Both Trisha and Gillian are very supportive. Nothing is ever too much trouble, plus they keep things moving along.”

Frank realised from the outset that patience would be required. “When you’re selling up you know there’s not a long list of ideal candidates sitting around waiting to make you an offer.”

However, Trish and Gillian’s inside knowledge meant the sale was completed within seven months and the purchasers – Ray Musleh and Mo Al-Haddad – fitted the bill precisely.

Giving up a major part of your life always requires some adjustment. It’s not something Frank would be keen to re-live. In fact, just one thing would even make him consider it. “The only reason I’d want sell a practice again would be to get the chance to work with Strictly Confidential once more.

“The bottom line is that you really don’t need to look anywhere else.”



ROOMS WITH A VIEW

In a stunning and limited development by Westerwood, two homes offer an ideal rural retreat in the historic setting of Rob Roy country. This is a rare chance to live in a magnificent location by the edge of one of Scotland's most beautiful lochs.

If buying a Highland retreat is high on your wish list then this stunning new development in one of Scotland's most idyllic locations is well worth the view.

Situated in picturesque surroundings on the shores of Loch Voil next to Balquhiddy, Stronvar is one of Scotland's most idyllic locations but within commuting distance of Glasgow, Edinburgh and Stirling.

The lochs, rivers and glens around Balquhiddy are steeped in history, and the village is home to the final resting place of Scotland's famous outlaw Rob Roy Macgregor.

Created by Westerwood, Stronvar offers just two properties for sale, a furnished showhome and a viewhome, along with two plots for development.

Ready for occupation the showhome features an open-plan entrance hall and dining room with feature multi-fuel stove, a breakfasting kitchen with granite worktop



leading to a separate sun room, a living room, utility room, shower room, and the option of a family room or a fourth bedroom.

The upper floor includes a master bedroom with dressing room and en-suite shower room, two double bedrooms, a family bathroom and storeroom. An integral double garage is also included. As befitting a

property of this stature the specification offers an exceptional quality throughout, from the oak internal doors and ironmongery, to the choice of kitchen worktops by Jackson Moor and the Siemens appliances.

The viewhome also includes four bedrooms with a different, stylish fitted kitchen. Both properties are priced from £550,000.

Each home comes with shared ownership of approximately ten acres of land, which includes a woodland and a protected Site of Special Scientific Interest that provides access to the loch and will be managed by Scottish Woodlands.

Stronvar is also part of the River Teith Special Area of Conservation which aims to protect the unique ecology of the surrounding landscape.

Stronvar features eight plots in total but only two remain for sale, ranging in size from 0.43 acres, and priced from £140,000.

Further information on Stronvar is available from www.stronvar.net or from the Sales Office on 01506 413101.



YOUR STAFF – THE LIFEBLOOD OF THE PRACTICE

They're the faces that patients see first, a key element in the customer service experience that you offer and, as such, a valuable asset. It pays to make sure they are looked after

The dentists in the practice are important. Ultimately, they are the ones who treat the patients, and whose skill, care and professional abilities are an essential element of the service provided to your patients. However, you can have the best dental team but still fall short of a first-class delivery to patients if you don't have a wider workforce who do all that they can to ensure that every patient who walks through the practice door goes away having had the best possible experience.

As lawyers, we can't really assist you with securing the best staff for your practice. However, there are some simple steps that you can take to avoid some pitfalls on the staff front.

- Staff contracts – Here we go, lawyers going on about paperwork again! However, there is a good reason for that. Having recruited someone who you hope will be a great addition to the team, you don't want to get off on the wrong foot by issuing them with a deficient employment contract, or indeed not issuing one at all (which is a breach of employment legislation, with stringent penalties which apply). So make sure that you use a well-drafted contract from a reliable source.
- Tailor the contract – The fact that you are

given a style of contract doesn't mean that it fits the bill for all staff members. Before giving it to your new employee, read it through, make sure that it suits that particular position, and reflects the employment terms that you have agreed. You may be amazed at the number of occasions where we see contracts that don't reflect reality, sometimes with major discrepancies (such as working hours being wrong, holiday entitlement being unclear, etc).

- Record changes – Often the initial terms of an employee will change over time. We're not talking about salary reviews here, more changes such as someone going to part-time, changing their working hours, even changing role (for example, someone going from being a receptionist to practice manager). In such cases, the changes aren't always recorded. However, they should be for sake of clarity. If it is a small change, such as working hours, this can be recorded in a simple letter from the practice owner, which is acknowledged by the employee. In more major moves, such as job changes, it may be more suitable to issue a fresh contract. Either way, the new position should be recorded before the time that the change takes effect, so as to avoid any dubiety going forward.



For further information please contact:
Michael Royden
Partner for
Thornton's Solicitors
Tel: 01382 346222
mroyden@thorntons-law.co.uk

- Follow the terms – It may be an obvious point, but having put in place employment terms for each employee, you shouldn't allow people to drift away from those terms over time. As an example, we sometimes see situations where a specific employee has been allowed to leave early on a particular day to collect their children from school without their salary being changed. There is nothing wrong with that in practice, but if a shortened working week on the same salary becomes the norm over time, it can become contractual.
- Staff handbooks and policies – Again, a potential source of difficulty. Handbooks and policies are often procured from a third party, and in itself there is no difficulty with that. However, once again you should ensure that they actually reflect how you work in practice. Don't just assume that they will be fine because they are seen as a standard document. Details in handbooks and policies can come back to haunt an employer in the future if they aren't drawn up for the specific practice.

All of these pitfalls are avoidable, all you need is a organised system for your employment documents which is implemented for all staff, with advice being sought where necessary.

> CALCIVIS



A BETTER FUTURE

Dental professionals cannot see into the future but the CALCIVIS® imaging system enables them to gain valuable insight into what may lie ahead.

The CALCIVIS imaging system is a revolutionary device that uses bioluminescence to provide a visual map of active demineralisation at the chair side. Patients can now see potential 'hot spots' and with the advice and expertise of dental practitioners, effective preventive measures can be implemented to avoid invasive or complex intervention in the future.

Although it is impossible to see precisely what is on the horizon, CALCIVIS offers unique vision and supports the preventive dentistry approach.

To fast forward into the future, contact CALCIVIS today.

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> ORAL-B

PARTNERS IN PREVENTION

Oral-B is working with the British Society of Dental Hygiene and Therapy (BSDHT) to support its First Smiles programme.

Launched in June 2015 the key aim of the programme is to build relationships with nurseries, schools and their local dental practices, so that the fundamental aspects of good oral health can be disseminated to children. The Association recognises that this is a challenging task, which is why a multi-disciplinary approach is important, and is their rationale for working with select companies to optimise the programme's reach.

"Oral-B is a natural partner for First Smiles" commented Helen Minnery, President of the BSDHT. "Prevention is key to their ethos and it has the tools required to put this into practice. Investment in knowledge will pay the best interest, however, children need a good toothbrush to implement the oral hygiene advice given by our members. Oral-B has kindly agreed to donate kids' manual toothbrushes to this initiative. It will also provide a power toothbrush for BSDHT members to use as prizes for schools and nurseries who engage in the programme."

Each year £50.5 million is spent annually on dental extractions in 0-19 year olds in a disease that is nearly always preventable. To reduce this figure, sugar consumption must be controlled, and plaque removal techniques, mastered. Making a routine 'chore', such as tooth brushing, exciting and less mundane is challenging, but essential.

Oral-B uses play and technology to help parents/carers work with children to improve their oral health. Their Disney App, using Disney and Marvel character images, are revealed during two minutes of brushing time. Children can unlock 16 custom animations and 1,600 rewards, ensuring the app maintains its novelty and transforms the act of brushing into a game.

Making oral care interactive will increase brushing time. Such technology will help to positively influence children's oral health.



To get involved with First Smiles
Call 01788 575050 or email
enquiries@bsdht.org.uk.

> DENTASKY



WHY SKY?

We're all comforted by genuine customer feedback, which is why Dental Sky decided to introduce Trustpilot on their website.

Arguably behind every review is a valid customer experience; positive ones give reassurance that you are meeting customer expectations, as well as giving confidence to other customers that your business is built on honesty and transparency.

Negative reviews can also be beneficial, as they provide an opportunity to review, assess and if necessary, take steps to improve the overall customer experience.

Trustpilot makes it easy for customers to leave reviews and Dental Sky is delighted with its current score of 9.5 out of 10.

Joe Earl, Marketing Manager at Dental Sky, said: "We didn't want to rely on a 'gut feel' for how we were doing. Using Trustpilot allows us to solve issues before they become problems. It also tells us exactly what it is that our customers like about us.

"Ease of use of our website was a key motive, alongside good/transparent pricing and next day delivery with order tracking."

Work can be complicated, but one thing that shouldn't be is ordering your sundries.

If you want to simplify the process, then visit www.dentalsky.com

> ORAL-B



STRONG TEETH MAKE STRONG KIDS

Oral-B is working with dental professionals to help them support parents and carers in their efforts to achieve better oral health among children. Education and behavioural change go hand in hand.

Earlier this year the company launched its #StrongTeethMakeStrongKids campaign. Up to 20,000 educational packs are planned for distribution this year. These packs were developed in conjunction with the University of Leeds.

Combined with the right dental care products, the positive oral health messages contained in the material are intended to encourage parents to lead the way, so they can see that these oral health issues are mostly preventable with simple changes to their families' daily oral care routine.

Maintaining good oral health and establishing the right healthy habits early on will help children progress along the key 'Strong Teeth' milestones. They include the arrival of their first tooth or teeth, their first dental visit, and then the first time they use an electric power toothbrush (from age 3 onwards).

Having good oral health habits results in a healthy smile, which can drive confidence, usually a key contributor to a better future for children.

The materials include a dental professional flow chart (with guidance), oral healthcare leaflets and videos, a waiting room tent card and a motivational laminate.

To order your pack or find out more about the resources available to you, visit dentalcare.co.uk or speak with your local representative.

> TEPE

WHEN SUGAR IS GOOD FOR YOUR TEETH

How can sugar be good for your teeth? When it's used to make a TePe GOOD® toothbrush.

TePe has unveiled the UK's first sustainably produced, bio-based plastic toothbrush, made from sugar cane and castor oil and manufactured in Sweden using 100 per cent green energy.

The toothbrush is the first innovative new product in the TePe GOOD® range, offering more sustainable choices to consumers and the industry, without compromising on product quality, design or hygiene.

The use of renewable raw materials, such as sugar cane and castor oil, enables TePe to recirculate up to 95 per cent of the CO2 emissions during the product's life cycle. As with all TePe toothbrushes, the product is manufactured at TePe's Swedish Malmö factory, which has the largest solar power plant in the city.

The toothbrush is just the beginning of the TePe GOOD® story, which will expand to include more products in the future.

Elaine Tilling, Head of Clinical Education at TePe UK, said: "The TePe GOOD® product range marks a milestone in our continued journey towards a more sustainable future. The introduction of our bio-plastic toothbrush offers an environmentally-sensitive oral care solution that does not compromise on quality. This combined with our commitment to manufacture with 100 per cent green energy marks another important step for us as we explore opportunities to become a more sustainable business."

In addition to the sustainability benefits of this new product, the toothbrush has been developed in collaboration with dental experts. The toothbrush is efficient, durable and user-friendly with an ergonomic handle that enables maximum cleanliness.

The TePe GOOD® toothbrush, now on sale to dental practices and surgeries, has a suggested retail price £2.75.

For orders or more detail please contact your local dental wholesaler.

> DURR DENTAL



LOW INVESTMENT, HIGH PROTECTION

All equipment needs to be kept clean to function and prevent cross-infection.

Durr Dental has a full range of disinfection products manufactured to the highest industry standards. Their range doesn't just protect against bacteria and fungi, it is also fully virucidal, meaning it destroys all viruses, both enveloped and non-enveloped, such as polio and the Norovirus.

The company recently launched a Hygiene Starter Pack, so that those unfamiliar with the superior functionality of Durr's disinfection range, can try it at a substantially reduced price.

The pack contains their ID 212 Instrument Cleaner, MD 555 Special Cleaner for Suction Units, HD 410 Hand Disinfectant and FD 312 Surface Disinfectant Wipes. It retails at just £48, a saving of £50 off the normal price of £98.

These are just examples from Durr's comprehensive range. All are conveniently colour coded to identify each products application – blue for instruments, green for surfaces, pink for skin and hands, and yellow for special areas such as suction systems and amalgam separators.

For more information contact Durr Dental on 01536 526740.

> DENTASKY



SEE DENTISTRY IN A DIFFERENT LIGHT

Precision is key when it comes to excavating caries. However, improvements in restorative materials mean that it's often difficult to see the margin between healthy tooth structure and common restorative materials.

The Fluoresce HD Dual Wavelength Coupling makes caries detection and removal easier as well as minimising the risk of removing healthy tooth structure.

How? During caries removal the UV light causes porphyrins inside caries to fluoresce orange/red (and healthy tooth light green).

The UV light also causes restorative materials such as resins, cements etc. to appear a different colour. Since you can see everything as you're working, caries removal comes 'paint by numbers' simple – only remove what needs to be removed, leaving healthy structure intact.

This 2-in-1 handpiece coupling is compatible with Kavo MULTIflex turbines and is similar in price to a standard LED coupling. However, as well as performing the standard functions of an LED coupling, you'll also get a device that detects caries.

The user needs to wear a yellow filter to see the caries. These are available as yellow tint glasses or as a yellow tint loupe insert if the operator prefers to use loupes. The glasses are provided free with the coupling and a small charge is made for the loupe insert.

Fluoresce HD is distributed exclusively through Dental Sky. For more information visit www.dentalsky.com.

> ORAL-B

THE WORLD'S MOST INCREDIBLE FAMILY IS BACK!



It's been nearly 14 years since Disney Pixar introduced us to their Incredibles family, and now they're back on our screens. Incredibles 2 is sure to be a hit this Christmas, so why not use the motivational power of this crime-fighting family to get your younger patients focused on fighting plaque?

Oral-B has launched a NEW Power Kids Electric Toothbrush (suitable from age 3+) featuring fun and friendly Incredibles 2 Disney characters.

Kids can download the Disney Magic Timer App by Oral-B to help them brush for the recommended two minutes. Disney's NEW Incredibles 2 characters will keep them motivated and encourage proper oral care habits that will last a lifetime.

Benefits include the magical 'brush and discover' functionality. As children brush their teeth they can reveal a secret image. The longer they brush, the more is revealed. They can also unlock fun rewards gaining stickers. What's more fun than stickers? Children can fill their very own sticker album with stickers earned for brushing.

The new Oral-B Disney Incredibles 2 Power toothbrush puts the power of a great clean in little hands.

> DENTAL SKY



TREAT YOURSELF TO A FESTIVE HAMPER

You've worked hard all year so why not treat yourself to a wonderful connoisseur hamper from Dental Sky?

Containing two bottles of wine and an assortment of festive goodies, the hamper is bound to get you in the Christmas spirit. Valued at more than £70, it will be dispatched free to customers ordering £750 worth of goods from Dental Sky between 1-21 December. The offer is limited to one per practice, while stocks last.

Furthermore, you'll be able to top up your festive hamper with some treats from Dental Sky's loyalty programme, that rewards customers with one loyalty point for every £1 spent.

Placing a £750 order would automatically qualify you for a Cadbury's Treasure Box of chocolates, or for an additional £50 you'd have enough for a Green & Blacks Chocolate and Wine gift set.

If you've a large team to treat, then 1,000 points will qualify you for a pack of 20 Toblerone bars. There's a whole host of rewards to redeem irrespective of the size of your practice.

Visit www.dentalsky.com.

> CARESTREAM

IMAGING THAT MEETS YOUR NEEDS

The CS 8100 family of imaging units from Carestream Dental offers the ultimate flexibility for every practice.

Between the CS 8100, CS 8100 SC, CS 8100 3D and CS 8100 SC 3D, there is something to meet everyone's needs. You can select your preferred combination of panoramic, cephalometric and 3D imaging capabilities, without any compromise on quality. Each unit is compact for easy location and facilitates a smooth and simplified professional workflow. What's more, the CS 8100 family of imaging systems is compatible with CS Adapt, which enables you to view images in a filter of your choice for increased diagnostic confidence.



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

> DENTASKY

COLOURFULLY COVERED

Whatever type of dental examination glove you are looking for Dental Sky has the solution. The Medibase range of gloves includes the popular Powder Free Nitrile Gloves that allow great tactile sensitivity with a textured surface to ensure excellent grip. Being powder and latex free these gloves appeal to those with allergies or those who wear gloves for long periods.

All the Nitrile gloves within the Medibase range are high strength, tear resistant, and available in a wide range of sizes. And because Dental Sky like to bring a little more colour into everyone's lives they've now extended their range of Nitrile Gloves with several new vibrant colours.



To learn more or see the latest offers please visit <https://www.dentalsky.com/disposables/nitrile-gloves.html>

We would like to thank all of our
Colleagues for their continued support

Milngavie Orthodontics

We are primarily an NHS based Practice, but we also welcome Private Referrals for Patients who prefer to consider more cosmetic appliances such as "Clear" Appliances and Aligners.

We are happy to offer advice to Patients with a "Borderline" need for Orthodontic treatment.

Referrals accepted by

Telephone: 0141 955 0569
Email: milngavie.orthodontics@hotmail.co.uk
Post: Milngavie Orthodontics, Suite 1,
13 Main Street, Milngavie, Glasgow, G62 6BJ
SCI Gateway

We are delighted that Lauren Anderson won best
Young Dentist at the 2017 Scottish Dental Awards

