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HUMAN FACTORS

DECEMBER 2019



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CAN LEARN FROM PILOTS.



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Protect the patient, look after each other

At a conference in Glasgow last month, Niall Downey, a pilot with Aer Lingus, showed delegates a photograph of the lever which controls an aircraft's undercarriage. The handle is wheel shaped. To raise the undercarriage, you move the lever up towards the word 'Up'. To lower the undercarriage, you move the lever down towards the word 'Down'. Captain Downey's dry sense of humour was on display throughout his presentation. "We assume passengers are stupid too," he said, showing a picture of the approach to the passenger exit at Dublin airport where, on the floor, are printed the words: "Have you collected your luggage."

You may well laugh.

However, the apparently absurd simplicity of a control designed to be operated not by stupid people, but by highly qualified, highly skilled personnel has its roots in a series of crashes that blighted the US Air Force during the Second World War, when B-17 Flying Fortress pilots would, for no apparent reason, land their planes without lowering the undercarriage, or worse, pitch their craft into the ground, killing all on board. After the war, the USAF assigned a psychologist to investigate.

As an article in *Wired* magazine described last month, when he began looking at the aircraft, talking to pilots, and sitting in the cockpit, he did not see "pilot error", he saw "design error". Many of the critical controls felt, to the pilots' hand, exactly the same. The psychologist subsequently created a system of distinctively shaped knobs and levers that made it easy to distinguish all the controls of the plane merely by feel, so that there was no chance of confusion even if flying in the dark.

"By law, that ingenious bit of design – known as shape coding – still governs landing gear and wing flaps in every airplane today," noted

the article. "You couldn't assume humans to be perfectly rational sponges for training. You had to take them as they were: distracted, confused, irrational under duress. Only by imagining them at their most limited could you design machines that wouldn't fail them."

You would think that this approach to design and function would pervade high-risk environments today. Captain Downey went on to show a series of shocking photographs; including identically designed labels for diamorphine hydrochloride (except one dose was 35mg, the other 300mg) and a children's cough syrup bottle with virtually the same look as a bottle of hydrogen peroxide.

His exhortation to practitioners attending the Human Factors conference hosted last month by the Royal College of Physicians and Surgeons of Glasgow (see p20), was to approach every patient's treatment with two questions in mind; where could this go wrong, and what's plan B? Captain Downey also urged them to consider; what's in it for me? What's in it for practitioners is that by looking after themselves they don't make mistakes which harm their patients and result in professional censure and financial penalty.

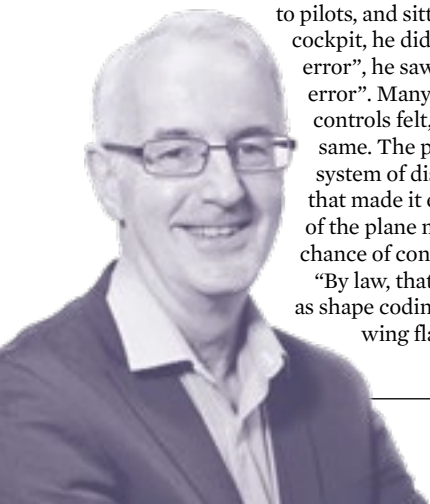
Also in this edition is a feature on the Safety Climate Survey which, in 2017, was piloted in 14 dental practices in three NHS boards and is now available to every dental team in Scotland. Health Improvement Scotland (HIS) is working closely with the Chief Dental Officer to support quality improvement activity in General Dental Services.

"Undertaking the survey may seem daunting, but it only takes 15 minutes

and I found it to be a valuable exercise," commented Irene Black, Clinical Lead for Dentistry at HIS (see p34). "It enabled us to learn more about the dynamics of our team and it provided the opportunity to discuss and share different perspectives."

Team working. Effective communication. Reducing hierarchy. Workload management. It's what practitioners can learn from pilots. As another speaker speak put it: "Protect the patient, look after each other."

**“
WHAT'S IN IT FOR
PRACTITIONERS IS
THAT BY LOOKING
AFTER THEMSELVES
THEY DON'T MAKE
MISTAKES WHICH
HARM THEIR PATIENTS”**



A changing of the guard

Or the new CDO is revolting? There are so many questions about rumoured plans for a new SDR, a new financial model, and – wait for it – a new IT system

It appears we have a new CDO. Congratulations to Tom Ferris on his secondment. I'm still waiting for my official email; you? It probably says a lot about the kind of distribution lists I'm on, but I get all the other ones from the Scottish Government about SDR updates. Maybe not the ideal start from a communications point of view but I think that's pretty much par for the course?

So, what can we expect from the new CDO? Well, it appears that we are about to enter into a short period of change. What do I mean, I hear you mutter as you read this on your way to something more interesting? Well, I am reliably informed that we are going to move into a new quality-driven model of delivery via a new SDR with a new financial model complemented by a newly designed clinical IT system which will integrate with PSD. And all this by winter 2021 or spring 2022.

Now, being that this is based on the OHIP and the previous CDO's mantra was "evolution not revolution" the above seems a lot like a revolution. To redesign a whole system, financial model and the SDR is quite an undertaking. I'm not necessarily suggesting it's a bad idea. I often think that putting a bomb under the system and starting again is the only way to effect real change. However, I'd prefer to take that philosophical stance from the sidelines when I'm not up to my neck in financial quicksand.

To put my business and the approximately 1,000 other dental practices in Scotland who interact with NHS dentistry at risk of wholesale change in terms of what they do, how they do it, and how and what they are paid to do it, is potentially catastrophic. Not to be the harbinger of doom and all but, in Scotland, we don't have the greatest record in terms of large-scale revisions and investments. I would offer the Scottish Parliament building, Edinburgh's tram network and, in healthcare, the massive overspend on the new Queen Elizabeth Hospital and Edinburgh Children's Hospital as evidence.

The other factor is the timescale for this. Ambitious is frankly a massive understatement; 24-30 months from now they want this to be up and running (possibly in early adopter practices). Two and half years to re-design and re-organise the whole of NHS dentistry in Scotland. I'd repeat that statement but I'm running out of 'rant room'. Really?

Let's move away from the emotive and difficult stuff like model of delivery, financial model, and the SDR. Did you notice I sneaked in a new clinical IT system designed and delivered by the Scottish Government? Now, God knows we all have issues with our IT systems. They don't

do all the clinical or financial stuff we'd like. They don't talk to PSD properly (anyone else having EDI problems?). They don't do the new prior approval thing very well. However, they are already designed, working, updating, supported and independently contracted to each and every practice.

Do we think that we can produce a new system from scratch in 24-30 months? Do we think it will be any better than the existing systems? Do we actually need the Scottish Government to spend time and money from the dental budget creating something that already exists, and they don't currently pay for? It's like Denpro; why create something which already exists and operates by the standard economic tensions of supply and demand and dentists have to fund it from their practice income regardless? I am not an economist, but it doesn't make much sense.

Maybe from the dentists' point of view we think we might get something for nothing and no longer have to pay software maintenance fees? That may be so but what are the tie-ins? If it's 'free' then surely, we are not the clients and would have great difficulty in complaining if it's not working? Will it deal with private work? Most practices are not 100 per cent NHS; if we need a different system to run our private work, what's the point? Is this a method of the SG finding out what private work we do? Maybe that's good for stats but I'm pretty sure most practitioners would be a bit cagey about that.

If it does operate like R4 or Exact, and so on, and charge fees, are they going to be competitive? Does it create a monopoly where you have to use their system to access NHS fees? Would the other suppliers make a legal challenge to this or would they just see Scotland as a lost leader and desert the sinking ship? If they do charge fees on a single system monopoly, what's to say they won't end up charging us a fortune?

So, as usual, I just ask questions and don't give any answers. I don't even claim to have all the questions. I'm pretty sure there are some really sharp operators out there with many more questions and concerns. And now here's the real concern: the groups who are consulting on these changes are announced and there are very few GPs involved. Those who are, come from the political fora. While I understand that's the usual conduit; surely a couple of random practice owners that do a lot of NHS work might be good to have in the mix? Expose some of the potential flaws early in the process. Give a real-life perspective. Maybe make the whole thing workable for those who actually operate the system? I am a cynic. I am also deeply concerned.





Show of strength promised in 2020

After breaking all previous records in 2019, the Scottish Dental Show is gearing up to be bigger and better next year

THE two-day event, at the Intu Braehead Arena on 24 and 25 April, brings people from far and wide to meet fellow professionals and find out about the sector's latest developments.

Voted a huge success in 2019 by visitors, exhibitors, as well as award nominees and winners, the show promises to be even bigger and better in 2020.

With more than 130 exhibitors demonstrating the latest technology and developments in dentistry, up to nine hours of CPD, and more than 60 lectures and workshops from professionals covering a multitude of topics, delegates will have plenty to see and do.

The show's Education Programme, validated by NHS Education for Scotland, will feature dedicated streams on eCPD, Clinical Skills, Business & Management, and Education & Training. Those eligible can also claim CPDA for any session where they attended two consecutive lectures.

2020 speakers include Professor Roger Currie, Consultant Oral and Maxillofacial Surgeon, Professor Stuart Clark, Consultant Oral and Maxillofacial Surgeon, and award-winning aesthetic dentist Dr Monik Vasant.

In an exciting development, the ever-popular Scottish Dental Awards will now

be a stand-alone celebration held in the autumn (11 September, at the Glasgow Hilton).

The decision will allow exhibitors and delegates to the show more time to meet and engage with their fellow professionals as well as providing the awards with a bigger platform to reflect the occasion's growing status.

Connect Managing Director Alan Ramsay said: "The number of delegates approached 3,000 in 2019 – it's clear that

we have become the must-attend dental event in Scotland.

"More than 60 per cent of exhibition stands are already booked for 2020, and we're gearing up for a fantastic two days of engagement and learning next April.

"Our awards have also grown to be the premier celebration for honouring the best in the Scottish dental profession, so establishing them as a stand-alone event in September gives the occasion the stature it deserves."



Study calls for more active prevention of child tooth decay

A STUDY comparing three different treatment options for tooth decay in children's teeth, led by dentists from the Universities of Dundee, Newcastle, Sheffield, Cardiff, Queen Mary University of London and Leeds, has found no evidence to suggest that conventional fillings are more effective than sealing decay into teeth, or using prevention techniques alone, in stopping pain and infection from tooth decay in primary teeth.

The three-year FiCTION (Fillings in Children's Teeth; Indicated or Not) trial, the largest of its kind to date, also found that 450 children who took part in the study experienced tooth decay and pain, regardless of which kind of dental treatment they received.

Professor Nicola Innes, Chair of Paediatric Dentistry at Dundee and lead author, published last month, said: "Each way of treating decay worked to a similar level but that children who get tooth decay at a young age have a high chance of experiencing toothache and abscesses regardless of the way the dentist manages the decay. What is absolutely clear from our trial is that the best way to manage tooth decay is not by drilling it out or sealing it in - it's by preventing it in the first place."

During the study, more than 1,140 children between the ages of three and seven with visible tooth decay were recruited by dentists working in one of 72 dental clinics throughout the country. One of three treatment

approaches was then chosen randomly for each child's dental care for the duration of the trial, which was up to three years.

The first approach avoided placing any fillings and aimed to prevent new decay by reducing sugar intake, ensuring twice daily brushing with fluoridated toothpaste, application of fluoride varnish and placing of fissure sealants on the first permanent molar (back) teeth.

The second option involved drilling out tooth decay, which was based upon what has been considered the standard 'drill and fill' practice for more than 50 years together with preventive treatments. The third treatment strategy was a minimally invasive approach where tooth decay was sealed in under a metal crown or a filling

to stop it progressing, together with preventive treatments.

Tom Ferris, Scotland's Chief Dental Officer, said: "FiCTION highlights the importance of preventing tooth decay in our youngest children. I believe the key to success in prevention lies within families and communities; for this reason, [the] Scottish Government launched the Oral Health Community Challenge Fund for third sector organisations working alongside families living in our most disadvantaged areas. The activities from these projects complements our mainstream 'Childsmile' work in education and health settings."

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More work needed to tackle oral health inequalities

The dental health of children in Scotland is improving but there is still a stark difference in the most deprived areas

NEW data from Scotland shows that children's dental health has improved, but more needs to be done to tackle persistent oral health inequalities, said the British Dental Association Scotland.

The latest report of the National Dental Inspection Programme shows that in 2019, 80 per cent of Primary 7 children are free from tooth decay – that's up 3 percentage points from the last report in 2017 and 27 percentage points since the first report published in 2005. These figures also show that the average number of decayed, missing or filled teeth per child reduced from 1.29 in 2005 to 0.42 in 2019.

Public Health Minister Joe FitzPatrick said: "These statistics show that the dental health of children across Scotland continues to improve, with no obvious signs decay in four out of five Primary 7 children – up from around half in 2005.

"This report also shows a narrowing in oral health inequalities, which is encouraging. To ensure we continue to tackle this, we have extended the Childsmile programme so that children living in our most deprived areas are entitled to receive fluoride varnish applications at nursery or school in addition to those at their dental practice."

However, the BDA



Public Health Minister Joe FitzPatrick

is concerned that stark oral health inequalities remain, with the percentage of P7 children free from dental decay in the most deprived areas almost 19 percentage points worse than those in the least deprived areas (69.5 per cent versus 88.1 per cent). The corresponding differences in 2015 and 2017 were 21.5 and 20.9 percentage points, respectively; while the gap has narrowed slightly, the difference remains substantial.

Children from the most deprived communities also experience more than three times the level of tooth decay compared to their counterparts in the least deprived areas (0.69 versus 0.20 decayed, missing or filled teeth per child).

While Scotland is making progress in the fight against tooth decay, the BDA has called

on the Scottish Government to renew its efforts to tackle deep inequalities by investing more on prevention and local resources.

BDA Scotland supports the innovative Childsmile programme, and awaits to see what impact the Scottish Government's three-year Community Challenge Fund has on reducing oral health inequalities.

Robert Donald, Chair of the BDA's Scottish Council, said: "It's good to see children's dental health improving, but there is absolutely no room for complacency. There has been a slight reduction in the inequalities gap, but the difference remains stark. Ministers need to ensure that not only is the overall improvement sustained, but also make every effort to tackle inequalities in the oral health of our children."

ndip.scottishdental.org/ndip-reports



Peter Ward to retire from BDA

PETER Ward, British Dental Association Chief Executive of 14 years, has announced his retirement from 31 March 2020.

Most recently Peter has overseen the development and roll-out of the new BDA Indemnity product. Ward will continue to work in that part of the business until his departure next year. Martin Woodrow will continue as Acting



Chief Executive until a permanent appointment is made.

"Serving as Chief Executive of my own profession's representative association has been the greatest honour of my working life," said Ward. "My passion for the wellbeing of hard-working conscientious dentists remains undiluted.

"It has been a great privilege to play an active part in supporting the UK dental profession. The pinnacle of that

has been the successful launch of BDA Indemnity – an industry best product, built solely around the needs of dentists.

"With Indemnity firmly established and growing fast, I'm confident that now is the time to make room for new blood to take the BDA to new heights."

BDA Chair Mick Armstrong commented: "Peter's contribution to the BDA has been immense. His in-depth, detailed, hands on knowledge of

the entire profession has been invested with personal passion into the work he has done for colleagues. He has been a respected and formidable advocate for the interests of all dentists and the importance of dentistry.

"Leaving the BDA with a legacy like Indemnity means that his input will be felt by many generations of dentists. We wish Peter a hugely fruitful and enjoyable retirement when the time comes."

Adopt an AED

Did you know only one in 12 people survive an out-of-hospital cardiac arrest?

SINCE 2015, it has become a legal requirement for automated external defibrillators (AEDs) to be placed in every dental clinic throughout the UK. The problem is, there are few, if any, AEDs registered correctly and some practices don't even have one.

Other practices don't even have the correct type of AED for the purpose they are required for. Dentists remain sceptical about AEDs due to the sheer lack of awareness and training offered when purchasing or the lack of accessories and after-care that comes with them.

Adopt An AED has been established to counter these problems. The initiative's aim is to help to reduce response times for out-of-hospital cardiac arrests, increasing the rate of survival for the patient. Adopt An AED helps the community become part of the first response process.

Adopt An AED is simple: Adopt, Register and Respond.

It is vital to ensure your AED is FDA approved, meaning the AED can deliver a shock in under 10 seconds. Not ensuring your AED is FDA approved could cost someone's life based on the recommendation by device maker Phillips that it is more beneficial to deliver a shock within three minutes of the person collapsing.

Adopt An AED only provides Phillips AEDs; the HSI which is the only AED in the world which requires no medical prescription. The HSI is also the world's first 'idiot-proof' AED and can be used by anyone, including children.



Become part of the process and help to save a life

Adopt An AED has created appropriate packages for local SME businesses, homes, organisations and the community that can be adapted to suit. Adopt An AED works closely with a first aid business called First2Train to provide SQA/OFQUAL accredited FAA First Aid, CPR and AED courses with every AED purchased.

So, for every AED purchased a free accredited CPR and AED course will be given to the owner. Adopt An AED has ensured that these courses comply with the requirements of CPD for dentists and offers assistance to register the device with the correct database that can use the AED in a time of need.

A spokesperson said: "Imagine if someone in your family had collapsed from a cardiac arrest. Would you want someone there quickly to start CPR and deliver a shock to help them survive? Wouldn't you want your loved one to have the greatest chance of survival?"

"When someone is in a cardiac arrest, for every minute that passes their chances of survival decreases by 10 per cent. Adopt An AED promotes building partnerships in the community to help one another. Become part of the process and help save a life."

Adopt an AED today by visiting www.adoptanaed.co.uk to see how you can help your community

GDC publishes three-year strategy

THE General Dental Council (GDC) has published its 2020-2022 strategy, 'Right time. Right place. Right-touch', setting out its programme of work for the next three years.

The regulator consulted on five strategic aims and its associated expenditure plans earlier this year. It said its approach is captured by the strategy's title, to

illustrate the GDC's continued focus on developing its approach to 'upstream regulation', 'Right place', to describe the continued work to support issues resolution by the correct organisation and to promote local complaint resolution wherever possible, and 'Right-touch', to highlight the regulator's commitment to ensuring its enforcement activity

is evidence-based and proportionate. GDC Chair, William Moyes, said: "The GDC [will] continue to improve its approach to achieving its responsibilities of protecting the public and maintaining public confidence in dental services. Key to this is ensuring that complaints are dealt with in the right place, which is often in the

surgery. The GDC has had increasing success cooperating with stakeholders to achieve its aims, and this strategy shows how we plan to further develop our approach over the next three years." It said it wants to make the relationship between its regulatory activity and the fees it charges "more visible, providing increased transparency".

Patients waiting two years for oral surgery

THE British Dental Association Scotland has said the Scottish Government must take responsibility and tackle waiting times of more than two years for oral surgery.

Freedom of Information requests undertaken by the Scottish Liberal Democrats have revealed waits of more than 120 weeks (2.3 years) for inpatient oral and maxillofacial treatment, covering diseases affecting the mouth, jaw, face and neck – with one patient in the NHS Grampian area having waited 243 weeks – 4.6 years – for an outpatient procedure.

The Scottish Government operates a 12-week target for surgery. These figures include procedures that can restore the functionality and appearance of a patient's mouth following oral cancer, which ranks among Scotland's fastest growing cancers.

BDA Scotland has pointed to huge problems filling consultant vacancies and continued underfunding of both primary and secondary dental services as key factors driving waiting times. Hospitals are facing an increasing number

of referrals for tooth extractions, adding to surgical waiting times, owing to the lack of support for senior clinicians in high street practice to supervise and train younger and less experienced dentists.

High street dentists are paid just £16.25 for a tooth extraction, and often struggle to cover staffing, equipment and facilities costs, adding to the volume of referrals for hospital treatment, which can cost as much as £600. Data published in June revealed over 5,000 people had been waiting for more than 12 weeks for extractions in hospitals.

David McColl, Chair of the BDA's Scottish Dental Practice Committee, said: "Patients shouldn't be waiting eons for life-changing surgery. These procedures can help restore both functionality and appearance to a patient's teeth and mouth after cancer or serious injuries. Years of under-investment and failure to support high street practice are heaping huge pressures on our hospitals. Ministers can't go on treating dentistry as an optional extra in Scotland's health service."

Standards in Dentistry now online

THE Faculty of General Dental Practice UK has made *Standards in Dentistry*, its flagship publication for general dental practitioners and their teams, available free of charge online.

Acting as a guide to personal or practice-based quality assessment, it sets out specific basic and aspirational standards covering consultation and diagnosis, paediatric dentistry, orthodontics, management of acute pain, periodontics, endodontics, removable partial dentures, complete dentures, minor oral surgery, implant dentistry, management of dental trauma, making and receiving referrals, oral medicine, direct, coronal and root surface restorations and indirect coronal restorations.



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Dr Carol Tait

Specialist in Endodontics
BDS Hons. MSc, MFDS RCS (Ed),
MRD RCS (Eng)
GDC No. 62862

After qualifying from University of Dundee in 1987 with Honours, Dr Tait spent several years in general practice developing her interest in endodontics before moving to Cape Town, South Africa in 1998 where she worked as a Lecturer in Restorative Dentistry teaching endodontics and gaining an MSc in endodontics.

Following her return to the UK, Dr Tait initially worked as a Clinical Lecturer and Specialist Registrar in Endodontics at the University of Dundee. She gained her post graduate specialist qualification, MRD RCS Eng in 2004 and has since been accepting specialist referrals at Edinburgh Dental Specialists. In addition, Dr Tait is presently a part time Senior Clinical Teacher in Endodontics at the University of Dundee where she teaches at both undergraduate and postgraduate level.

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Dr Robert Philpott

Specialist in Endodontics
GDC No. 82646

Bob qualified from University College Cork Dental School in 2003 and completed his three year specialist endodontic training at the Eastman Dental Hospital in London in 2009, graduating with distinction.

He then gained his MRD from the Royal College of Surgeons of Edinburgh (RCSEd) in 2009. He has worked as a specialist in endodontics in Ireland, England and Australia.

As well as providing specialist endodontic services here at the practice, his other role sees him as a Senior Clinical Lecturer/Honorary Consultant in Endodontics at the Edinburgh Dental Institute. He also acts as an examiner for the specialty exit examinations at the RCSEd and is a key opinion leader for Dentsply.

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Manifesto for oral health

BDA sets out key priorities with a call to all politicians for better treatment of 'Cinderella service'

THE British Dental Association has called on all political parties to stop treating oral health as the "missing piece in health policy".

Setting out its key priorities for the next UK parliament, the BDA said that it had built on work that has secured a Health Committee Enquiry into NHS dentistry, forced the UK Government to change tack on fines, and helped secure an extension of the Practitioner Health Programme to dentists.

In a call for a joined-up approach, the BDA has backed parallel action around three core priorities:

- A valued workforce – Provide support to attract and retain talent. Make NHS dentists part of the NHS family, through tried-and-tested initiatives that recognise and reward commitment.
- Remove barriers to care – Tackle the obstacles standing in the way of patient care, through a long-term funding settlement for NHS dentistry.

- Put prevention first – Invest to save, by tackling inequalities, and focusing on prevention – not just cure.
- The BDA said it was actively engaging with the major parties and is calling for support and workforce initiatives extended to other health professions to be applied consistently to dentists.

The latest BDA survey indicates that half of dentists (50.3 per cent) are actively considering reducing NHS hours to avoid exposure to pensions tax charges, and the BDA is pressing for the profession to be extended the same flexibilities offered to medics.

In a bid to stem the ongoing recruitment and retention crisis the BDA has said lessons must also be learned from successes such as the GP Targeted Enhanced Recruitment Scheme, alongside the restoration of commitment payments. Currently the lowest levels of morale are among practitioners with the highest NHS commitment.

Dentist leaders have called time on the decade-long freeze on the dental budget, an end to inflation busting charge increases, and extension and simplification of NHS charge exemptions.

BDA Chair Mick Armstrong said: "Our message to politicians of all parties is that oral health can no longer be the missing piece in health planning and budgets. We need a joined-up approach to prioritise the nation's oral health. Tooth decay and gum disease are the most prevalent – but preventable – diseases in Britain. Oral health is key to overall health, and dentistry cannot remain in a silo.

"This 'Cinderella service' continues to operate with less funding than it received in 2010 and thus, by default, private dentistry is growing to fill the void. The oral health gap between rich and poor isn't closing, patients are struggling to secure access, and the service faces a mounting recruitment and retention crisis."

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SHOP WHERE SERVICE AND VALUE COUNT

What is acceptable professional behaviour?

THE Faculty of General Dental Practice (FGDP(UK)) is encouraging dental professionals to help influence the regulatory standards to which the professional will be held in future.

The General Dental Council says there is a lack of a shared understanding of professionalism or what constitutes a breach of professional standards.

The GDC has asked the Association for Dental Education in Europe to undertake research that will be used to inform the next edition of Standards for the Dental Team as well as the development of Principles of Professionalism.

The research explores the boundaries of acceptable professional behaviour in dentistry, and UK-based dental professionals, dental students

and members of the public have been asked to complete an online survey run by Cardiff University to explore areas of agreement.

The researchers aim to identify:

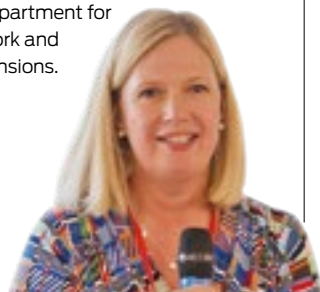
- What aspects of professionalism the public expects from dental professionals, and why these are perceived as important
- How aspects of professionalism may be categorised (e.g. moral, clinical, personal behaviour; in work, outside work)
- Whether expectations of professionalism in dentistry differ compared to other professions, or between dental professionals
- How the undergraduate curriculum prepares students to meet professionalism expectations, and how this is taught and evidenced.

PEOPLE
NEWSAnnual renewal
period open

The annual renewal period for UK-registered dentists is now open. To renew their registration, dentists need to make their annual or end-of-cycle CPD statement, declare they have, or will have, appropriate indemnity in place, and pay their annual retention fee. The £680 must be paid no later than 31 December for dentists to remain on the register and provides a non-refundable 12-month licence to practise in the UK. The ARF funds the system of dental regulation in the UK, which keeps patients safe and maintains public confidence in dentistry.

GDC appoints
new directors

The General Dental Council has announced Sarah Keyes (pictured) as its new Executive Director, Organisational Development, and Stefan Czerniawski, Executive Director, Strategy. Sarah joins the GDC with a strong human resources background, most recently as the Director of Organisations Change at Ofcom. Stefan has had senior leadership roles in the Civil Service across strategy, policy, regulatory oversight and change, including as Strategy Director at the Department for Work and Pensions.

Living with
dementia

Scottish dental group Clyde Munro has committed to training more than 160 dentists and 300 employees to become recognised as Dementia Friends. It has partnered with Alzheimer Scotland, which runs the initiative, to provide comprehensive access to bespoke information sessions for its teams, helping increase understanding and awareness of the condition across Scotland.

Recognition for
Aberdeen ortho

Dr Lisa Currie, Clinical Director of The Orthodontic Clinic in Aberdeen, has graduated as a Fellow of the Royal College of Physicians and Surgeons of Glasgow. Lisa gained her BDS with honours at Dundee Dental School in 1996. She joined the

Orthodontic Postgraduate Programme at Edinburgh Dental Institute and was awarded her MSc in orthodontics from the University of Edinburgh for research in sleep apnoea in 2002. Lisa became Consultant Orthodontist at Borders General Hospital/Edinburgh Dental Institute in 2006. Having lectured extensively, she continues to train Orthodontic Nurses and Orthodontic Therapists (see p91).

Neale Price

It is with great sadness that the Orthodontic Technicians Association announced the passing of council member Neale Price. Neale was a familiar face in the OTA, as a member and council member, serving as the OTA's educational officer and student awards coordinator. His achievements and endeavours included Chief and Advanced Technician to health boards.



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DATES FOR YOUR DIARY

5 DECEMBER

BDIA Midwinter Meeting

BDIA, London
bdia.org.uk/dental/events

5 DECEMBER

Dental Webinars – CoCr Partial Dentures

RCPSG, Glasgow
rcpsg.ac.uk/events/DentalWebinar

6 DECEMBER

FGDP (UK) Scotland Study Day

Glasgow
tinyurl.com/raswtcc

12 DECEMBER

Midwinter Meeting

BDIA, London
tinyurl.com/rdrn2j7

17 JANUARY

Scottish Orthodontic Conference

RCPSG, Glasgow
rcpsg.ac.uk/events/ortho

24 JANUARY

The Risk of Litigation

BDA, London
tinyurl.com/qvg6hvn

24-25 JANUARY

UK Dental Congress & Exhibition 2020

Olympia, London
professionaldentistry.co.uk/events/
uk-dental-congress

1 FEBRUARY

Predictable Multi Disciplinary Treatments: The Orthodontic/ Restorative Interface course

RCSEd, Birmingham
tinyurl.com/rswty3u

15 FEBRUARY

SmileFast Direct Activation Course

London
smilefast.com/course

17-18 FEBRUARY

Dental Cone Beam 2A&2B

RCPSG, Glasgow
https://tinyurl.com/rj4vyr9

3 MARCH

28th Euro Dentistry Congress

Edinburgh
dentistry.cmesociety.com

7 MARCH

24th Annual Conference for Dental Care Professionals

RCSEd, Edinburgh
tinyurl.com/sdqj5n4

13 MARCH

Preparing for Retirement

BDA, York
tinyurl.com/ts6543b

14 MARCH

SmileFast Direct Activation Course

Birmingham
smilefast.com/course

27 MARCH

Aesthetic Management of the Missing Dentition

BDA, London
tinyurl.com/uhzettll

25-27 MARCH

The 1st UK Restorative Dentistry & Prosthodontic Conference

BSSPD, Glasgow
tinyurl.com/t2e3vkj

4 APRIL

SmileFast Direct Activation Course

Edinburgh
smilefast.com/course

24-25 APRIL

Scottish Dental Show

Braehead Arena, Glasgow
sdshow.co.uk

30 JULY

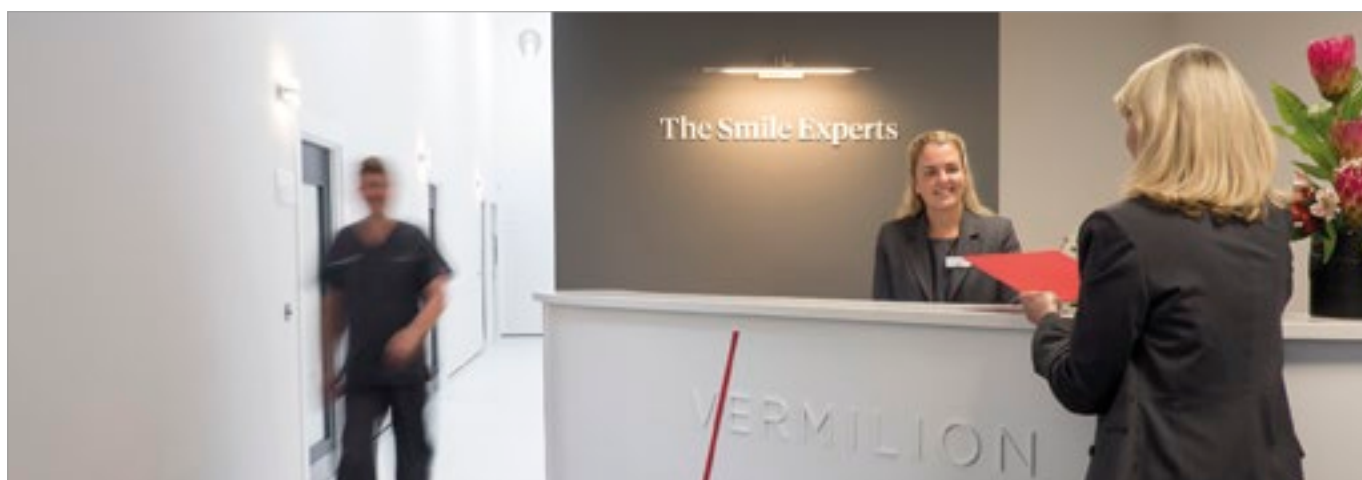
Career Yearnings, Earnings & Learnings

FGDP (UK), London
tinyurl.com/w3r978x

11 SEPTEMBER

Scottish Dental Awards

Hilton, William Street, Glasgow



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Flight time: what practitioners can learn from pilots

Lessons from the evolution of human factors in aviation can be applied in a healthcare setting

“**W**ould you behave differently if you shared the fate of your patient

arising from any error you made at work?” Professor Peter Brennan, consultant maxillofacial surgeon at Portsmouth Hospital NHS Trust and an Honorary Fellow of the Royal College of Physicians and Surgeons of Glasgow, posed the question recently, pointing out that this is the position pilots find themselves in as a matter of norm.

“If they make a mistake, everyone dies,” he said. “If I make a mistake, I walk away from the experience.”

Professor Brennan said that his eyes were opened to the phenomenon of ‘human factors in aviation’ – optimising the relationship between people and systems in order to improve safety and performance – around nine years ago. The friend of a patient he was treating happened to be a British Airways 747 Training Captain.

“I got chatting to him,” recalled Brennan, “and he came to theatre and really opened my eyes to better team working, effective communication, reducing hierarchy, and workload management.”

Professor Brennan was speaking last month at a conference on human factors, organised by Royal College of Physicians and Surgeons of Glasgow. He highlighted the importance of apparently simple things such as being properly hydrated and fed and

interpersonal relationships, as well as more challenging concepts such as “flattening hierarchies”, and how to ensure the adoption of a “no-blame culture”.

Taking a lead from other high-risk organisations, including aviation and air traffic services, the conference examined human factors and their relevance to errors in practice. In the run-up to the conference, Dr Richard Hull, the college’s Honorary Secretary, who co-organised the conference with Professor Brennan, outlined to *Scottish Dental* the thinking behind hosting the event.

“‘Never events’ are simply that; they should never occur. An audit of never events in Wessex showed that human factors were implicated in more than 80 per cent of cases reported. Since the Kegworth air disaster 30 years ago, where human factors occurred resulting in the deaths of 47 people, airlines and other high-risk organisations have embraced the relevance of human factors.

“[Since then] there has not been a single death due to human error on a UK registered airline in more than three billion passenger journeys. While the NHS environment is very different, we have much to learn to promote safe working, in a no-blame culture, to ultimately give better, safer, health care for our patients.”

The aim of the conference was to help people working in health care, dental professionals included, how to recognise the relevance of human factors in their day-to-day practice

and performance. It was important, said Professor Hull, for people to understand the specific features of errors and the scale of the problem. He added: “Errors are everyone’s problems and we need to do the maximum to prevent them.”

Medical errors are common and largely preventable, the conference heard. In the UK, one in 10 hospital admissions has some form of human error, ranging from relatively minor incidents, to never events and death estimated to be up to 5,000 patients per year. Analysis of so-called never events has found that human factors are responsible for the majority of these mistakes.

Professor Brennan underlined the view that healthcare cannot be compared exactly with aviation, “but we can use the many human factors that aviation and other high-risk organisations know so well; enhancing team working, effective communication, workload management, reducing hierarchy and professionalism among others.

“If our work on human factors prevents serious error for just one patient, then we have succeeded. We are gaining recognition internationally and helping to promote our specialty as a leader in this area.”

He said that most errors start at the organisational level and end with the unsafe act itself. “Most of my work has been looking at the preconditions; if you can block those conditions, you can almost certainly prevent the error from occurring.”

He added: “High-risk organisations – aviation, rail, nuclear energy, national air traffic services – they recognise the importance of human factors. The only way to embed human factors across healthcare is that top-down, bottom-up approach, so that we meet in the middle. There’s a wealth of evidence to show that senior management is core; not just in practice, but also the regulator, the Colleges.”

Professor Brennan showed a slide of a man he had operated on; the right side of his head had been penetrated by the blade of an angle saw he had been using to cut tiles in a shipyard. The preconditions, said Professor Brennan, were that he was new to the job, he was unsupervised, and he had been set a time limit to complete the task. The unsafe act – the error – was that he pressed down too hard. The blade sheared off, went through the visor he was wearing and sliced into his face below his eye socket.

“A simple mistake, that should never have happened,” recalled Professor Brennan, “It was a seven-hour operation, involving bone grafts to rebuild the orbit.” The outcome was positive, he said. “His vision was fine. I got that result because every two hours, I walked away for a 10- or 15-minute break. And actually, you finish quicker than if you work for seven or eight hours because your performance falls with time.”

Captain Niall Downey, a pilot with Aer Lingus, described himself as a “recovering thoracic surgeon”; he said he switched careers in the nineties, from medicine to aviation.

At the beginning of his presentation, he asked delegates: “Has anyone here ever made a mistake?” A delegate answered: “Every day.” Captain Downey responded: “So, we’re in the right room. In aviation, we assume we are going to make mistakes, and our whole mindset and system is based around that.” Looking back to his time in cardiac surgery, it was different: “We weren’t allowed to make mistakes. If you did make mistakes, you weren’t allowed to talk about it. I think there is a better way.”

To underline the urgency of his message, Captain Downey reviewed studies of deaths caused by human error in healthcare systems. Extrapolated, he said, while showing a slide of the passenger cabin of a 174-seat Airbus A320: “Each one of those seats is a funeral in the Scottish healthcare system due to human error. Every 10 days, we crash one of those. It doesn’t get covered by the

BBC and we don’t have to tell the CAA (Civil Aviation Authority). That’s your environment. We changed our environment, going back 40 years.” Charting accidents and incidents, and the number of deaths, in aviation from 1920, he said there was a steady climb to 1977, and then a descent to a point now where there are fewer than 1,000 deaths a year per year in commercial aviation worldwide, out of around four billion passenger movements. It was in 1977 that two Boeing 747 passenger jets collided on the runway at Tenerife airport, killing 583 people.

“That was a watershed moment in aviation,” said Captain Downey. “We decided as an industry, we needed to do things differently. It began as ‘cockpit resource management’, became ‘crew resource management’, and has evolved over the past 40 years into full-blown human factors.”

Captain Downey said that rather than a ‘no-blame culture’ – “We don’t have a no-blame culture. If I make a bollocks of something tomorrow, I will be blamed, I will be held responsible. But if I report it, I won’t be sacked for it– there is a ‘just culture’, which, he said, means “honest human mistakes, not deliberate error or gross negligence, but it means we can make mistakes and admit to them.”

In contrast, he said, in healthcare there existed a “name, shame, and reclaim” culture. In aviation, he said, when an error is admitted they look at the system to uncover the ‘tripwire’ that led to the error. “We then engineer the tripwire out of the system and replace it with a safety net.”

Aviation looks at crew resource management; communication, leadership, situational awareness, workload management. “A just culture. Systems. Crew resource management. That’s our basic three stage system,” said Captain Downey, “and that’s the system that we are trying to get across to you guys. You can’t just transplant it in, but the underlying DNA is good. We can genetically engineer it for your environment.”

That process of “genetically engineering” aviation’s three-stage system for a healthcare setting is something which Captain Graham Shaw, a senior First Officer Training Pilot for British Airways, and Captain Chris Holden, a flight instructor with British Airways, have undertaken within the NHS. Captain Holden looked back to the early days of NASA when it was found that high-

performing individuals did not work well together in teams. Tackling that problem has evolved today into what is termed an ‘integrated competency-based structure’ where there is no separation between technical and non-technical competencies.

“It is one skill set,” said Captain Holden. “You can use the competencies on a personal level, see your own strengths, and apply them to a team. There are technical skills – clinical knowledge and procedural conduct – and social skills – professionalism, communication, leadership, and teamwork. They should be evidence-based and observable. You can also track data. It’s about creating a bespoke version of competence for your own healthcare environment, but in principal they are broadly similar to any high-performing team.”

Captain Shaw said that the process of embedding this system in healthcare can face barriers. Systemic barriers include regulation, a lack of ring-fenced funding to support training, a perceived lack of relevance and a lack of an open culture. Individual barriers include a lack of clarity on how to implement and a lack of training.

“That’s where we come in; to help people recognise great behaviours, get teams to work together so that those behaviours spread throughout the organisation,” said Captain Shaw. “We can’t fix all those [barriers] while on the day job, but we can give ourselves the skills and knowledge to understand problems, to build an effective and empowered team, with everyone in the room working together to support each other, to use human factors as a final layer of defence when other protection layers in the system fail.” Captain Shaw stressed: “Protect the patient, look after each other. It’s the fundamental point.”



**“
IN AVIATION, WE ASSUME WE ARE
GOING TO MAKE MISTAKES, AND
OUR WHOLE MINDSET AND SYSTEM
IS BASED AROUND THAT”**

CAPTAIN NIALL DOWNEY, AER LINGUS PILOT



Personal factors that threaten safety

1. Lack of communication

Failure to transmit, receive, or provide enough information to complete a task. Never assume anything. Only 30 per cent of verbal communication is received and understood by either side in a conversation. Others usually remember the first and last part of what you say. Improve your communication:

- Say the most important things in the beginning and repeat them at the end
- Use checklists.

2. Complacency

Overconfidence from repeated experience performing a task. Avoid the tendency to see what you expect to see:

- Expect to find errors
- Don't sign it if you didn't do it
- Use checklists
- Learn from the mistakes of others.

3. Lack of knowledge

Shortage of the training, information, and/or ability to successfully perform. Don't guess, know:

- Use current manuals
- Ask when you don't know
- Participate in training.

4. Distractions

Anything that draws your attention away from the task at hand. Distractions are the number one cause of forgetting things, including what has or has not been done in a task.

Get back in the groove after a distraction:

- Use checklists
- Go back three steps when restarting the work.

5. Lack of teamwork

Failure to work together to complete a shared goal. Build solid teamwork:

- Discuss how a task should be done
- Make sure everyone understands and agrees
- Trust your teammates.

6. Fatigue

Physical or mental exhaustion threatening work performance. Eliminate fatigue-related performance issues:

- Watch for symptoms of fatigue in yourself and others
- Have others check your work.

7. Lack of resources

Not having enough people, equipment, documentation, time, parts, etc., to complete a task. Improve supply and support.

8. Pressure

Real or perceived forces demanding high-level job performance. Reduce the burden of physical or mental distress:

- Communicate concerns
- Ask for extra help
- Put safety first.

9. Lack of assertiveness

Failure to speak up or document

concerns about instructions, orders, or the actions of others. Express your feelings, opinions, beliefs, and needs in a positive, productive manner:

- Express concerns but offer positive solutions
- Resolve one issue before addressing another.

10. Stress

A physical, chemical, or emotional factor that causes physical or mental tension. Manage stress before it affects your work:

- Take a rational approach to problem solving
- Take a short break when needed
- Discuss the problem with someone who can help.

11. Lack of awareness

Failure to recognise a situation, understand what it is, and predict the possible results. See the whole picture:

- Make sure there are no conflicts with an existing procedure
- Fully understand the steps needed to complete a task.

12. Norms

Expected, yet unwritten, rules of behaviour. Help maintain a positive environment with your good attitude and work habits:

- Existing norms don't make procedures right
- Follow good safety procedures
- Identify and eliminate negative norms.

Source: Federal Aviation Administration (tinyurl.com/m5u6r5n)

RESOURCES

Brennan PA, Davidson M. Improving patient safety: we need to reduce hierarchy and empower junior doctors to speak up. *BMJ*. 2019; 366: l4461

Brennan PA, Oeppen R, Knighton J, Davidson M. Looking after ourselves at work: the importance of being hydrated and fed. *BMJ*. 2019; 364: l528



Toothboost: a new solution in oral care

A Scottish start-up has developed a technology to remineralise teeth 'on the go'

Novel and successful biotech products often spring from the laboratory; the result of groundbreaking research that is 'spun out' from a university and brought to market by a new company or through a licensing deal with an established firm.

"In developing Toothboost, I started with the consumer – my patients – in mind, and an unmet need in oral care products," said Carol Rafferty. "Since then we've been on a journey in reverse. It's coming up for five years now; from product concept to formulation, and then back out again through scientific testing, regulation, IP (intellectual property), consumer and dental professional market research, and now our route to market."

Carol, a dental hygienist with more than 30 years' experience, is the co-founder of Dentherapy, the latest addition to Scotland's dental research and development (R&D) eco-system, led by established companies such as Calcivis, and BioFilm, who are already marketing approved innovative dental technologies and devices, and Reminova, an established R&D company with products on the pre-clinical approval track.

Dentherapy is initially focused on the consumer market and its formulation can be delivered in a range of oral care products. Last month, the Aberdeen-based company's patent applications in the US and EU were published and it is now exploring partnerships with multinational consumer and oral health companies who have expressed interest in the technology and 'on the go' product concept.

WORDS
WILL
PEAKIN

The pocket size Oral Mist that the company has developed



Carol began her career in general dental practice and worked in the salaried dental service. In 2006, she led the establishment of NHS Education Scotland training schemes for dental nurses in Grampian and Tayside. In parallel, she completed a master's degree in health promotion at Robert Gordon University. "It was then I started thinking about what I could do next with my skills," she said.

"As a dental hygienist I was increasingly aware of the effect dietary choices and busy lifestyles were having on oral health. Snacking and grazing habits increase consumption of sugar and acidic foods and drinks, promoting an acidic environment. This results in frequent periods of demineralisation of the tooth structure, causing enamel erosion or carious lesions, leading to permanent tooth structure loss.

"Part of my role was to give dietary advice and recommend 'daily use' oral care products to support patients' dental health needs and concerns. This raised the question, what products can I advise patients to use directly after consuming sugar or acidic foods and drinks in order to boost remineralisation? Why were there no 'therapeutic' products that consumers could easily use on the go, to protect their teeth directly after eating and drinking?"

Carol added: "Toothpaste and mouthwash remineralising products tend to be restricted to daily home use, due to the inconvenience of finding a sink and the potential embarrassment of brushing your teeth in public. Consumer discovery confirmed people are keen to do more to protect and care for their teeth and are investing in cosmetic products and treatments to

improve their smile.

"The time seemed right for a product range that supplemented at-home oral care routines. The idea is to develop efficacious products that are convenient to use at any time and anywhere, with a great taste. The challenge was where to start!"

At that moment of realisation in 2014, Carol sat down with a friend Katherine Thom – today, her fellow director at Dentherapy – and the two began discussing the idea of developing a new oral health product and establishing Dentherapy Ltd. Their first point of contact was Dr Howard Marriage, Entrepreneur in Residence at the University of Edinburgh, and a family friend, whose wife she had met when they were studying for their MSc degree.

Howard provided initial guidance and encouraged them to seek support from Scottish Enterprise, which subsequently provided a grant to research the market and any existing intellectual property. Through Interface, the organisation connecting Scottish business with academia, Carol and Katherine put out a call to universities that might be interested in developing a novel remineralisation product.

The aim, she said, is to deliver a dose of calcium, phosphate, and fluoride at precisely the moment when the tooth surface is at its most vulnerable, post-acidic incident, to promote remineralisation. "We wanted to create a formulation that worked with the mouth's protective environment, boosting saliva's buffering action to neutralise acids and deliver bioavailable calcium, phosphate, and fluoride," said Carol.

Initial research highlighted a number of possible formulation ingredients including a multifunctional bioactive protein





INNOVATION



made by a multinational company and so Carol established contact. The manufacturer of the innovative ingredient continues to collaborate with Dentherapy on the project. The next step was to find experts to help with first-phase formulation development and in-vitro testing.

Carol alighted on a scientific paper co-authored by Dr Richard Willson, Director of Modus Laboratories. Richard was previously senior formulation specialist at GSK and part of the team that developed Sensodyne Pronamel toothpaste. He led Dentherapy's collaborative remineralisation study conducted with Calcivis, *Monitoring Erosive Lesion Treatment by Toothboost Technology*, the results of which were presented to the International Association of Dental Research (IADR) in 2018*. "Toothboost provides an effective alternative remineralising treatment for eroded enamel lesions," it concluded.

Dr Chris Longbottom, one of the team who developed the Calcivis imaging system, commented: "Toothboost technology bridges

the gap between at-home and professional remineralising agents, addressing an unmet need and opportunity in the global oral care market."

According to the published patent application, the formulation's inventors – Dr Willson and Edinburgh-based technical consultant Dr David Smillie – have created a liquid composition, comprising stabilised calcium, phosphate, and fluoride.

"On application the composition provides the active components... in a way that is efficacious in the repair of enamel and for the protection [against] damage to enamel when subjected to an acid challenge."

The patent is another milestone for Carol and her colleagues, and it is anticipated that additional patent applications will support further formulation development claims.

The formulation has exceeded the team's expectations, and includes inhibition of oral biofilm formation, stability and adherence; delivering bioavailable calcium phosphate and fluoride; remineralising erosive and

carious lesions; and supporting a healthy oral microbiome.

"Our initial on the go product, Toothboost Oral Mist, delivers frequent remineralisation allowing users to counteract acidic incidents throughout the day, immediately after eating and drinking. Our follow on product is Boostpaste, an SLS and surfactant-free toothpaste," said Carol.

She added: "We're a small, privately owned company currently focused on product R&D. We have received invaluable support from organisations such as Scottish Enterprise, Interface and, more recently, Opportunity North East's (ONE) Life Science Sector and BioCity." Dentherapy has also worked with Givaudan, the Swiss flavour specialist, to develop natural and long-lasting flavours.

"We hope to collaborate with an oral care company who share our vision for our innovative technology and product range development. We haven't discounted taking products to market ourselves and have global ambitions.

"We are looking for optimal routes to get the technology out there – to consumers, potentially to dental professionals for clinical use, and I believe there is scope for its application in public dental health settings."

www.toothboost.com

*<https://iadr2018.zerista.com/event/member/491824>



WE WANT TO ENABLE CONSUMERS TO DO MORE TO
PROTECT AND STRENGTHEN THEIR TEETH ON-THE-GO"

CAROL RAFFERTY

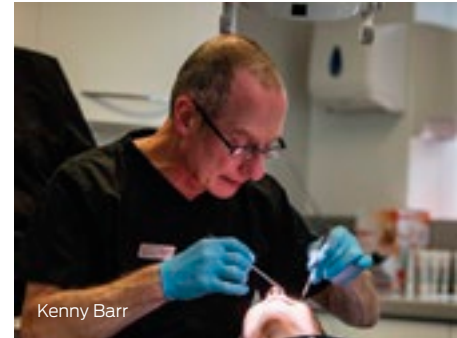


Dumfries Dental Centre, base for the Dumfries and Galloway Public Dental Service

RURAL DENTISTRY



For Ciara Baxter the region provides huge variety for her and her family



Kenny Barr

Think different about life in the country

WORDS
WILL
PEAKIN

You don't have to work in a city to flourish as a dentist – and your quality of life could be significantly better

Laura Kerr swore she was leaving, never to return. “I was going a long way away and would not be coming back,” she recalled, laughing. Looking out from her hometown, Laura eschewed Glasgow and Dundee dental schools (her siblings were at university in both cities), in favour of Cardiff. “I had a brilliant time. If someone had said ‘I would eventually be back working in Dumfries and Galloway, in Dalbeattie, I would have thought it was a ludicrous idea.’”

However, on graduating, a decision had to be made. Her boyfriend – now husband – was from Cornwall; would they move there, or Scotland? At the time, there were many significant financial incentives available for graduate dentists to move to rural areas in Scotland. Laura did her year's vocational training in Dumfries and then general professional training in Glasgow. “And that's when the penny dropped,” she said. “I wanted to be in a rural setting; the pace of life is so much better.”

Again, a financial incentive – available in 2007, and committing Laura to a rural practice for three years – was a factor. Returning to the practice in Dumfries where

she completed her vocational training, Laura also undertook a post-graduate diploma in sedation at Newcastle University. “I had developed an interest in working with anxious and phobic patients,” she said, “and worked part-time as a senior dental officer with the health board, treating those who had been referred.”

In 2010, aged 28, Laura decided to open her own practice, Birch Valley Dental Clinic, in Dalbeattie. “It was a huge step, so early in my career,” she reflected. “But the town I grew up in, there was no dental practice – for a population of 4,000. This meant that people either had to drive a significant distance to access NHS dentistry, or they just didn't bother – and their teeth became grossly neglected.”

She became a vocational trainer and was able to take on a trainee and then a qualified dentist. Approaching the two-year mark, the practice had registered 3,000 patients, triggering the first tranche of a grant which helped to pay off a loan taken out for the launch. It was also the year her daughter was born, presenting the additional challenge of finding maternity cover.

But, looking back, the decision to return to her hometown is one that she does not regret. “There is such a diverse range of patients

seeking a wide variety of treatment, which is great,” said Laura. “We also have a very close-knit dental community and there are a lot of events to support colleagues with audits, quality improvement projects and so on. The work-life balance is very good, with easy access to outdoor activities. We have really good local authority schools and housing is very affordable, especially if you are moving from the central belt of Scotland or the south of England.”

Nestled in the south west of Scotland, Dumfries and Galloway has a lot to offer in terms of career progression, work-life balance, and social activities. The area is famous for outdoor pursuits, a vibrant food and drink culture, as well as unique arts and entertainment offerings. With the average price of a detached home over 40 per cent less than Glasgow, and approximately 65 per cent less than Edinburgh, the housing market is great value for money. There are high-quality, new-build developments, classic family homes, and well-preserved historic buildings providing a variety of options for families and individuals.

As for education, there are nearly 100 primary schools serving age ranges 3 to 12 years old, with 17 secondary schools and a wide range of additional learning





opportunities throughout the region, including the newly established Bridge Educational Trust. The region is also home to Dumfries & Galloway College with sites in Dumfries and Stranraer; as well as campuses for University of Glasgow, University of the West of Scotland (UWS) and Scotland's Rural University College (SRUC).

Ciara Baxter graduated from Dundee nine years ago and undertook longitudinal foundation training in Glasgow, followed by work in practice, hospital, and community settings. "I really hadn't thought about coming home [to Annan]," said Ciara, "but my now business partner – we grew up next door to each other – was struggling to recruit a dentist and he persuaded me to come back part-time, and I stayed! It's great to feel part of a community and it's a privilege to serve it too. They are great in return; everyone tries to support each other. When I was pregnant with my son, my patients were more concerned that I was ok than whether I would be available to see them.

"The practice I now run has been established for 50 years, so it has a very loyal patient base. A few can even recall the days of lead aprons and gas and air! But I think people have this perception that you can't have a good job unless you work in Glasgow or Edinburgh. It's not true; you can have a really successful career here because the range and quality of dentistry is as wide and high as anywhere. The health board is really supportive also, and there are a lot of CPD events to keep ourselves up to date.

"We're an hour from the Lake District, we have the local hills, and sport is a big part of the community. I play for the local rugby team and it's great to get together with the girls – a lot of us are mums as well – for training during the week. As much as its beneficial to have the support of your colleagues in dentistry, it's also good to belong to something other than dentistry. It's a great lifestyle for our son as well; there are lots of clubs for him to be involved in. It does offer a less stressful pace of life. But, we're not cut off either; there's easy access to Glasgow, Edinburgh, Carlisle, Newcastle and Manchester [where Ciara's husband works]."

Kenny Barr has been practising in Stranraer for 26 years. After graduating from Glasgow in 1989, he worked at practices in Lanarkshire but his sister-in-law, who had married a farmer there, sent him copies of



Elaine Scullion, Deputy Manager Primary Care Development, Linda Bunney, Head of Primary Care Development, Valerie White, Interim Director of Dentistry, and Alison Milne, Public Dental Service Clinical Lead



Kenny Barr's practice in Stranraer registered 1,500 patients within two days of opening

the local paper which regularly bemoaned the lack of access to NHS dentistry for people in the area. "I set up a cold squat and in the first two days, we had 1,500 patients registered. And I liked it so much, I stayed," said Kenny. "I would struggle to find a better place to raise a family," he added. "It's safe, you have a wide choice of schools at both primary and secondary level, and there's so much to do here. Professionally, there is scope to develop a range of skills because we aim to treat our patients holistically rather than automatically refer them to a centre that might involve a round trip of 150 miles. Our VTs have a much more rounded training and our associates develop new skills."

Access to NHS Dental Services in Dumfries and Galloway has significantly improved in recent years, with 88 per cent of the population now registered with an NHS dentist and several practices across the region are accepting new NHS patients. Another

experience that Laura, Ciara, and Kenny have in common is the challenge of recruiting and retaining dental team members. It is a challenge that NHS Dumfries & Galloway is devoting considerable time and effort to meet, including publication of a recruitment and retention action plan.

"There are a number of opportunities at practices in the area and we are working hard to support those teams to find the best people," said Valerie White, Interim Director of Dentistry. "We're working closely with NHS Education Scotland to attract trainees and have seen some very positive results of that effort this year. The board is also very keen to make sure that dental professionals coming to the area are welcomed, that they feel engaged and are supported in their work and professional development."

There are also financial incentives available; dentists who complete vocational training or general professional training and meet certain conditions can claim £10,000 over two years and dentists from EEA countries can claim £5,000. Several practices in the area are also eligible for the Remote Areas Allowance; an annual payment of £9,000, subject to various conditions. Valerie added: "We pride ourselves on being an inclusive, welcoming and friendly region – and that goes for our health board as well. NHS Dumfries & Galloway provides a wide range of services from over 50 bases across the region. We are looking for people who share our values; people who want to be part of a community and team players who want to make an impact every day.

"We have people at our core and see ourselves as one team, with everyone playing their part to ensure the success of our services. We know that our region has a lot to offer, and we want to share that with others. We might be small in terms of population – with approximately 150,000 people spread out across nearly 2,500 square miles – but we are big in terms of ambition. We want everyone else to know what we know; that Dumfries and Galloway is an incredible place to work, live and play."



WE WANT EVERYONE ELSE TO KNOW WHAT WE KNOW;
THAT DUMFRIES AND GALLOWAY IS AN INCREDIBLE
PLACE TO WORK, LIVE AND PLAY"

VALERIE WHITE

Lessons from recent history

Improvements in oral health may not be impacted by Brexit, but the effects on the profession will be significant

It may be difficult to reliably forecast the future – but looking to events of the recent past can provide some pointers. Michael Donaldson, Consultant in Dental Public Health and Head of Dentistry at the Northern Ireland Health and Social Care Board, has spent time over the past few months trying to predict the likely effects of Brexit on dentistry – by comparing prospects for the UK's exit from the EU with what happened after the 2008 banking collapse.

Armed with economic forecasts for the UK and Irish economies post-Brexit, studies of the impact on oral health in the US and Europe of the global recession 10 years ago, evidence of trends in healthcare spending, and analysis of shifting dental workforce patterns, Donaldson found that the consequences for the UK and Ireland are likely to be significant – though not wholly negative.

“As we detach from the consolidated legislation of the EU, the healthcare system in the UK is going to become more bureaucratic, and therefore expensive,” he said. “In terms of our children's oral health, [decayed teeth] averages are likely to continue to decline with lower levels of decay in both the UK and Ireland.

“However, there will be ‘left behind’ areas in both jurisdictions. And we are going to see wider inter and intra-national variation in access to state-funded primary care dental services. In the Republic, this will very much depend on the funding

settlement for its new oral health policy.”

Speaking in a personal capacity at the Faculty of Dentistry, RCSI, annual scientific meeting in Dublin last month, Donaldson explored the impact of Brexit on the economy, oral health, healthcare spending, access to dentistry, the workforce, and the movement of drugs and medical devices.

The economy

With the exception of Patrick Minford, chair of Economists for Free Trade and professor of applied economics at Cardiff Business School, who has said that the UK's gross domestic product (GDP) will grow by 4 per cent as a result of Brexit, the majority of projections have it falling by 4 per cent by 2030; representing £100bn in that year alone, following an upward trend in the preceding years and continuing upward in the years that follow. It is a similar picture in Ireland, albeit its economy is smaller. Brexit is projected to reduce GDP in the Republic by 3 per cent by 2030; representing £10bn in that year alone.

Oral health

In the downturn that followed the 2008 banking collapse, oral health in the UK improved with the Decayed, Missing, Filled Teeth index (DMFT) showing a marked decline. In Ireland, there was a similar trend. In Iceland, whose economy was particularly hard hit, researchers studied the oral health of a 4,000-strong cohort in 2007 and again in 2009 and found that the collapse “did not have drastic negative effects on dental health behaviours of the population in

Iceland.” They added: “Our findings suggest that men may have opted for healthier dental health behaviours following the national economic collapse”⁽¹⁾. However, Donaldson pointed out that there was evidence of a negative effect on health inequalities and that there are areas of the UK and Ireland that are likely to be affected more than the average, along with specific population groups such as migrant families, travellers, and those in receipt of benefits.

Healthcare spending

Despite the UK and Irish economies displaying signs of recovery from 2010, healthcare spending in both countries declined in the years following, with the UK experiencing the largest reduction in spending as a percentage of GDP in its history. Despite Conservative leader Boris Johnston's election pledge to spend an additional £2.8bn on the NHS, Donaldson's view was that it was “very unlikely that healthcare spending will rise above trend”.

Access to dentistry

A US study published earlier this year⁽²⁾, showed that the 2008 recession resulted in a decrease in the demand for general oral health care and orthodontic care, the latter significantly. Medicaid spending, covering those on a low income, increased. In Northern Ireland, spending on private dentistry declined significantly in the years 2009 to 2012 as about 200,000 people – from a population of 1.8 million – switched to health service dentists. At the same time, the number of dentists entering the profession was increasing – by 18 per cent – supported by a 50 per cent increase in funding over a five-year period. In the Republic, the most recent available figures, from 2015, show

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spending on the Dental Treatment Services Scheme, Dental Treatment Benefit Scheme, and salaries to be around €150m.

Projected spending on Ireland's new oral health policy, Smile agus Sláinte, is around the same. Donaldson said that, in his view, with the demand-led contracts that exist in Northern Ireland and Scotland, the system could cope with a downturn in the economy. Not so in England and Wales, with their fixed-level contracts.

In Ireland, he said, "it is always going to hinge on the level of funding in this new oral health plan". The issue there would be whether the funding would be sufficient to support a trend away from private to public dentistry.

The workforce

Currently, UK and Irish graduates with a dental qualification from either country can register in one or the other. This will hold true until 30 June 2021. Beyond then, there is no clarity. If new arrangements are not put in place, then those graduates will be treated as 'third country' applicants – similar to someone from Australia or India, for example – in either jurisdiction. This would present a "significant" challenge for the UK's General Dental Council and the Dental Council of Ireland, said Donaldson.

There has been an increase in the number of dentists on the GDC register over the past decade, but that has levelled off. The number of graduates joining from the EU has dropped significantly; 500 fewer each year from 2011 to 2017. If subsequent UK immigration policy does not address this challenge, then dentistry, and the health service in general, will be under significant pressure.

Currently, about 17 per cent of dentists on the register are from the EU. If the pound continues to fall against the Euro, then many of those already practising here may leave. According to a report commissioned by the GDC and published last January, almost a third of those from the EU registered in the UK are considering leaving.

The issue is not as pressing in Ireland, where the common travel agreement will remain in place, and there is a good supply of dentists into the profession. A problem may occur with over-supply, however, if those opting out of the UK choose to register instead in the Republic.

“

AS WE DETACH FROM THE CONSOLIDATED LEGISLATION OF THE EU, THE HEALTHCARE SYSTEM IN THE UK IS GOING TO BECOME MORE BUREAUCRATIC, AND THEREFORE EXPENSIVE”

MICHAEL DONALDSON

Regulation of medicines

The European Medicines Agency (EMA) allows pharmaceutical companies to seek EU-wide approval for their drugs. Europe represents around 26 per cent of the global market; the UK, about 3 per cent. The consequence of the UK leaving the EU is that companies will seek approval in the US first, then Europe and, much further down the line, the UK. "The UK is going to be receiving new drugs considerably later," observed Donaldson. The UK is negotiating to remain part of the EMA, but no agreement has been reached. In terms of the current supply of drugs into the UK, 75 per cent come through Europe. If there is a no-deal Brexit, supply could be disrupted. There could also be a knock-on effect for Ireland, as 60 per cent of its drugs come through the UK. Realisation of this has caused Ireland to look to other suppliers.

In summary

- More bureaucratic and expensive dental systems.
- Most children will continue on a low caries trajectory.
- The numbers 'left behind' (i.e. high caries outliers) could increase.
- Wider inter and intra national variation in access to state-funded primary care dental services.

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How do you know if your dental practice is safe?

The Safety Climate Survey has been made available to every dental team in Scotland

We all know that safety is of utmost importance to everyone. It's what keeps us awake at night

if we feel we may have harmed our patients. You may think your current practice is safe, but that's not the same as knowing it is safe.

By completing the *Safety Climate Survey*, you will find out more about the safety culture within your dental practice and how you can make any improvements. Healthcare Improvement Scotland (HIS) is committed to supporting patient safety throughout all healthcare settings. It has led and delivered the unique national initiative Scottish Patient Safety Programme since 2008. HIS has worked across a wide range of healthcare settings to support patient safety in primary care to make care safer across all areas of health and social care, including dentistry. In 2017 the Safety Climate Survey was piloted in 14 dental practices in three NHS boards, and now, working in partnership with NHS Education for Scotland, it has been made available to every dental team in Scotland.

HIS is working closely in collaboration with the Chief Dental Officer to support quality improvement activity in General Dental Services with the implementation of the Safety Climate Survey in dentistry, as the first phase of the QI activity in the current three-year quality improvement cycle. Completing the Safety Climate Survey and developing an action plan for improvement meets the criteria for your allocated QI hours and allowance for year one of the three-year improvement cycle.

HIS will also be working with the Chief Dental Officer to consider other mechanisms to support QI in dentistry in the second phase of the quality improvement cycle. If you haven't heard of the Safety Climate Survey yet, Healthcare Improvement Scotland's Clinical Lead for Dentistry, Irene Black, shares her experience as she has previously completed the survey about her own dental practice.

What is the Safety Climate Survey?

The Safety Climate Survey is a tool that enables practices to consider a snapshot of the safety culture in their practice and to better understand the impact on safety in their practice. It has been developed specifically for

Dentists and Practice Managers v Other Staff



Figure 1 This is a sample bar chart from a safety climate report, showing how staff can be grouped (dentists and practice managers versus all other dental team members) and showing anonymisation of staff. Differences in responses between the two groups would provide a foundation for meaningful conversations within and across teams.

general dental services and public dental services.

Can I do the survey now?

Yes! The Safety Climate Survey opened on 1 August 2019 and is due to close on 31 March 2020. But don't leave it till the last minute, as every member of your dental practice should take part and you will need to allow them time to complete the survey before it closes.

Why should I complete the survey?

Completing it will help your dental practice have a conversation about the domains within the survey, how this might impact on safety and identify where you can make improvements. When all staff members have completed it, you can download your report from the website. Remember it contributes towards your QI hours and allowance for this year too.

What do we do with the report?

In my practice, we followed the guidance developed by Healthcare Improvement Scotland and held a team meeting to discuss the results. This allowed us to talk about making positive changes to improve the safety

culture and in turn improve the service we deliver.

Who sees the answers?

Don't worry, all answers are anonymised, and the individual report is not seen by anyone else out with your team.



What next?

After the meeting you should create an action plan, highlighting three things you do well and three areas for improvement. There is a template available from HIS which will guide you in this process. Your completed plan should be uploaded to the NHS Education for Scotland Portal. Irene added: "Undertaking the survey may seem daunting, but it only takes 15 minutes and I found it to be a valuable exercise. It enabled us to learn more about the dynamics of our team and it provided the opportunity to discuss and share different perspectives."

More info here: www.ihub.scot/spsp-dentistry

Young dentists Snowflake generation r future leaders?

Rather than lamenting how students and trainees are “not what they used to be”, the profession needs to adapt, engage, and lead

Professor Wendy Turner is keen to point out that she is not a psychologist. “I’m a restorative dentist,” she said. She has, however, taught dentists at all levels, from undergraduate through to speciality registrars and doctorate students. A graduate of London Hospital Medical College in 1992, she worked for 25 years in the city, mainly at Barts and the London School of Medicine and Dentistry as a clinical academic consultant. In 2018, Turner moved to Queens University, Belfast, to take up the post of Professor and Consultant in Restorative Dentistry. She adds, with a smile, her experience comes both from working with dental students and being a parent.

Turner has studied the so-called snowflake generation, those who became adults in the 2010s, and questions whether the default view of them as less resilient and “prone to melting” is helpful. “We have three distinct generations in the workplace – baby boomers, Generation X, and Generation Y – who are now being joined by a fourth, Generation Z – the ‘digital natives,’” she told the Faculty of Dentists, RCSI, annual scientific meeting in Dublin last month. Turner has mapped how the generations’ different upbringings, experiences and expectations combine to create a learning environment which could be better understood by the profession.

“Recent generations, although remaining career motivated, are far

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more demanding of flexibility and a work-life balance than previous generations, who are broadly seen as being hard working but possibly to the point of excess. Yet to understand our modern-day trainee or student, we need to not only appreciate the emerging cultural differences between generations, but also the changes that have happened to both medicine itself and our training over the same time frame.”

Generations are defined, biologically and sociologically, by shared life experiences; September 11, for example, the global financial crash, or Brexit. Generation X – born between 1965 and 1979 and aged between 40 and 50 today – balances a strong work ethic with a laid-back attitude; many grew up in homes with two working parents and learned from their example to work hard, as well as fend for themselves. Generation Y – born between 1980 and 1994 and aged between 25 and 39 today – are confident, have high expectations of their employers and are not afraid to question authority. Their over-protective parenting style, however, can mean that their children struggle as students to thrive.

This current cohort, Generation Z – born between 1995 and 2015 and aged between four and 24 today – are fluent in technology, crave information on demand and have never lived without connectivity. “They are entering the workforce with a generally more liberal set of beliefs and an openness to emerging social trends,” said Turner. “They

multi-task, are altruistic, and value diversity.” They have been shaped by *I’m A Celebrity*, Netflix, Instagram, and climate change. Turner contrasted the ‘comfort zone’ of their lecturers’ and mentors’ – the lecture theatre, printouts, written notes, quiet study, and acceptance of professional authority – with the *modus operandi* of today’s learners – always open laptops, YouTube as a learning tool, wanting to feel empowered.

For the dental student of today, there are financial and academic pressures amid intense competition in an assessment-driven climate. Graduates are entering the profession in a difficult environment, where patient complaints, litigation and referrals to the regulator are commonplace creating a “climate of fear”.

Turner cited a recent article in the *British Dental Journal* by Kathryn Fox, Senior Clinical Lecturer at Liverpool University’s School of Dentistry*.

“In order to understand the pressures facing our new graduates, we must first understand how recent changes in society have affected the way in which this generation has been raised,” wrote Fox. “We should also accept the role of individuals, and the profession as a whole, in changing the current climate and promoting graduates’ professional development through appropriate risk management, coaching and mentoring. Dental students and newly qualified graduates will mirror the response of their senior colleagues, so until dentists are comfortable



owning up to their mistakes and doing the right thing without fear of prosecution, the next generation will continue to struggle further in this climate of fear, rather than developing the resilience and clinical confidence required to become the competent clinicians that our patients require.”

Turner added: “They emerge from dental school as fledgling professionals, expected to navigate a scary terrain. The treatment options for most conditions have evolved massively and, consequently, so too has the potential to get it wrong. Decision-making is more complex now than it’s ever been – simultaneously requiring greater knowledge and increasing the chance of errors. We have moved nationally towards a training system that is highly regulated and closely assessed, but this places heavy demands on trainees and students.”

A 2018 study** of the wellbeing of medical, dentistry and veterinary students by Dr Duleeka Knipe, a mental health epidemiologist at Bristol University, revealed a higher proportion of dentistry students, compared with medical students, who had moderate depression, higher levels of anxiety and lower wellbeing scores. In this context, Turner mentioned “the R word”; resilience. “[It] is defined as the ability to adapt well in the face of significant stress and adversity.

“Our students have progressed through tests, GCSEs, AS levels, university clinical aptitude tests, dental school interviews. Any un-



WE SHOULD UNDERSTAND THAT THEIR EXPECTATIONS HAVEN'T REALLY CHANGED; TO SEE PATIENTS REGULARLY, TO DIAGNOSE, TO TREAT, AND TO LEARN FROM THOSE EXPERIENCES”

PROFESSOR WENDY TURNER

resilient ones would have fallen by the wayside! Being resilient doesn't necessarily mean you have good mental health.”

Turner said it was important to understand the approach of students today to learning; online resources have proliferated, and they want to be taught things they can't Google.

“The ideal boss of a Gen Y is equal parts mentor and leader,” she said. What this means for lecturers and mentors is the need for practical scenarios and teaching that is relevant. It should be focused on improving learners' ability to deal with the “ambiguities and complex decision-making of clinical practice, while at the same time nurturing their capacity to be the leaders and innovators of the future”.

There are multiple generations in the workplace today, and with an ageing population this phenomenon will only become more pronounced. “Rather than people being better or worse,” said Turner, “we are just different in different generations. A lot

of the problem is poor communication leading to misunderstood attitudes and relationships. Our younger colleagues with different values and expectations turn to us for mentorship – are we prepared?

“The bottom line is rather than lament how students and trainees are not what they used to be, we should understand that their expectations haven't really changed; to see patients regularly, to diagnose, to treat, and to learn from those experiences. Wishing people were more like you is not a strategy – we need to adapt. Respect work-life balance and know how that might differ to each person. Don't try to manage the 'generation' – instead, lead and engage the individual. When it comes to work, they are actually looking for a lot of the same things; job security, work-life balance, an employer that will treat them with respect.”

*www.nature.com/articles/s41415-019-0673-0

**www.doi.org/10.1192/bjpo.2018.61

Body image

No filter

In the era of social media-driven perfectionism, dental teams should be conscious of a patient's mental health when asked about cosmetic treatment

Natasha Devon MBE, the writer and activist on mental health and body image issues, once went undercover to investigate a Harley Street cosmetic surgeon. Under an assumed identity, her chosen procedure was liposuction of the stomach. In the waiting room, she filled out an eight-page questionnaire on the medical history of herself and her family. "Not one question was to do with mental health," recalled Devon.

The consultant said she didn't need liposuction, but instead a tummy tuck – which was twice the price. As she was about to leave, he asked her to look in the mirror at her "flank" – a word she had only previously heard used in the context of a cow – and said she was carrying excess fat there; if she booked in for the tummy tuck, he would lipo her flank for free. "Not only was I getting a buy-one-get-one-free offer," she said, "but a new neurosis as well."

Devon tours schools and colleges throughout the UK, delivering talks – an average of three a week – as well as conducting research on mental health, body image, gender and social equality. "I ask 14 to 18 year olds about their school experience, any challenges to their wellbeing, any changes they would like to see in their community," she said.

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"But I always begin with the same question; if you could have a PSHE (personal, social, health and economic) lesson on anything, what would you choose? And they are absolutely related to mental health ... exam anxiety, bullying, consent ... but, in the 12 years that I have been doing this, the one that comes up consistently is body image."

More than half of 11 to 14 year-old girls avoid normal school activities because of poor body image, according to the organisation Girlguiding. Not just sport, drama, or public speaking – 11 per cent said it prevented them from raising their hand in class. The organisation's research also found that girls as young as seven feel that society judges them more on their looks than their ability. According to the Mental Health Foundation, one in eight adults in the UK has experienced suicidal thoughts because of

concerns about body image.

Almost a third of men have felt anxious because of their body image and a tenth have felt suicidal, according to a study published last month. The research, by Mental Health Foundation Scotland, found that 28 per cent of Scottish men said they had experienced anxiety due to body image while more than a third said it had a negative impact on their self-esteem in the past year. Almost a quarter said that they had avoided taking part in social activities that would require them to show their body, such as sports or beach holidays.

Surgery, said Devon, is a common response – but it does not address the underlying issue. Only 2 per cent of people with body dysmorphic disorder (BDD) who underwent surgery found their psychological health was improved and the severity of their BDD reduced (*Annals of Plastic Surgery*, 2010). A 13-year study of 1,500 teenage girls found that 78 per cent of those who underwent plastic surgery were more likely to be depressed and/or anxious in later life (*Psychology Today*, 2012). The desire for surgery can be a symptom of poor mental health, said Devon, and any subsequent procedure will not assuage the underlying psychological problem.

A study published in 2017* by Thomas Curran, of the Centre for Motivation and Health Behaviour

“

NOT ONLY WAS I GETTING A BUY-ONE-GET-ONE-FREE OFFER, BUT A NEW NEUROSIS AS WELL”

NATASHA DEVON



Change, at Bath University, and Andrew P. Hill, of the School of Sport at York St John University, was the first to examine generational differences in perfectionism at a cohort level. Its findings suggested that “self-oriented perfectionism, socially prescribed perfectionism, and other-oriented perfectionism” have increased over the last 27 years.

“We speculate that this may be because, generally, American, Canadian, and British cultures have become more individualistic, materialistic, and socially antagonistic over this period,” said the authors, “with young people now facing more competitive environments, more unrealistic expectations, and more anxious and controlling parents than generations before.”

Devon said that the higher someone scores on this measure, the more vulnerable they are to a mental health issue. The era of smartphones and social media has seen young people being sold two narratives, she said; never be content with what you have and consume constantly in order to prove yourself. In researching her forthcoming book, *Yes You Can: Ace Your Exams Without Losing Your Mind*, Devon asked teachers who they thought created stress among people over

exams. They blamed parents. The parents blamed teachers. But when she spoke to young people, they blamed neither; it came from within themselves and “from an early age they have internalised this idea that they have to measure their value through exam results. The other way this phenomenon manifests itself is through body image; they believe their body is something that can be sculptured to their will”.

It is a public health issue, said Devon, and as practitioners dentists are in a position to help change the cultural and social environment in which young people develop. “If

young people constantly chase an ideal,” she said, “they will never find the solution to any underlying psychological problem. I hope that practitioners can play a part in understanding how body image impacts mental health and provide the appropriate care for people who might be vulnerable.”

www.natashadevon.com/advice-support

*Curran, T., & Hill, A. P. (2019).

Perfectionism is increasing over time:

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Pivotal learning experience

From initial examination to maintenance and recall

Robbie McLeish, BDS (Glas)

Introduction

My vocational training year served as an excellent opportunity for honing my clinical, communication and team working skills, as well as providing my first real insight and experience of working in a system that sometimes presents challenges to providing the best available care. The case I am about to recall was by far the most memorable and rewarding one that I've had the opportunity to work on in my, currently, short career spent in general practice.

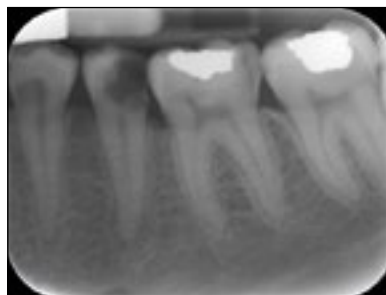
Background and reasons for selecting the case

As a newly qualified and fresh-faced dentist, this patient presented early in my vocational training year and had struck a certain resonance with me, as they had attended university during the same time period as myself, having also moved there from a small town. As well as this they presented with one of the worst maintained dentitions – particularly for their age – I had seen, which would require a multidisciplinary approach to restore. For these reasons, I thought this patient would be an excellent example to discuss for my vocational training year case presentation, as well as providing an insight into what could be achieved and the limitations of supplying dental treatment on the NHS.

Presenting complaint and examination

The 23-year-old male presented in August 2018 for an emergency appointment as a new patient to the practice. His chief complaint was of pain from a tooth on the lower left. Pain had developed two weeks prior, occurred when food or the tongue was pushed into the tooth, no spontaneous pain, no associated tenderness to pressure and resulted in no disturbance of sleep. Medically, he suffered from migraines; taking Pizotifen and Sumatriptan when required. He was otherwise fit and well and a non-smoker. Clinical and radiographic (*Figure 1*) examination revealed tooth 35 had deep caries in close proximity to the pulp with no associated peri-radicular pathology. A diagnosis of caries and reversible pulpitis was established, gross caries were hand-excavated and a Kalzinol dressing was placed, with a plan for the patient to return for a full examination and appropriate special investigations.

Figure 1



He returned several weeks later – with pain from 35 having settled – when a full examination, bitewings, anterior periapicals (*Figure 2*), clinical photography (*Figure 3*), sensibility testing and plaque and gingival indices were completed, giving the following findings:

- Fully dentate with mesially impacted 38 and 48
- Gross caries, affecting all teeth with the exception of 31, 41, 42
- All teeth positive to ethyl chloride sensibility testing
- Generalised plaque deposits and bleeding on probing; Bleeding Score: 100 per cent Plaque Score: 76 per cent
- BPE: 1, 2, 3 / 1, 2, 3
- Class 3 edge to edge incisal relation with moderate lower arch crowding and 12 and 22 in crossbite

Figure 2

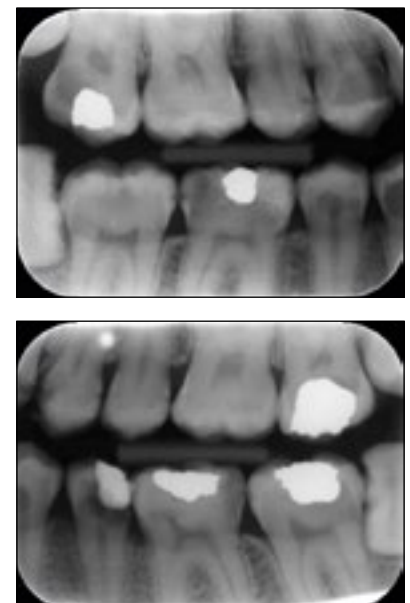




Figure 3: pre-operative



The dental and social history revealed that during his five years spent at university the patient almost never brushed his teeth and consumed one to two litres of full sugar carbonated drinks per day. Since moving back home and starting work in the family business, his reported hygiene and diet habits had improved, brushing usually once daily and drinking less than one litre of fizzy drinks per day. From all these findings, diagnoses were established and a treatment plan was formulated.





These findings lead to the following diagnoses:

- Caries: 18 - 11, 21 - 28, 38 - 32 43 - 48
- Generalised gingivitis
- Generalised chronic periodontitis (Stage I, Grade A, currently unstable, no risk factors).

Treatment options discussed and plan agreed

Clinical and radiographic examination showed that all teeth – excluding the 8s – were restorable, although some to a greater degree than others. Because of this we agreed upon a restorative approach including surgical removal of all 8s under a general anaesthetic. The general anaesthetic was chosen by the patient to minimise time off work. The plan included:

- Oral hygiene instruction and diet advice
- Periodontal Treatment: Supra and subgingival scaling
- Caries Management: 17 - 11, 21 - 27, 37 - 32, 43 - 47
- Root Canal Treatment: 12, 13, 22, 33, 35, 43, 44
- Cast Post/core: 22
- Metal Ceramic Crowns: 22, 24, 35, 12, 13.

On discussion with the patient, it was decided all treatment would be provided on the NHS and the plan was submitted for prior approval. All anterior and buccal lesions were to be restored with composite resin, but with the option of using a resin modified glass ionomer should moisture control not be amenable to composite placement. The root canal treatments were charted on teeth where caries removal was likely to result in pulpal exposure and/or loss of vitality. The crowns were charted with the plan to use direct restorations if there was sufficient tooth tissue remaining after caries removal.

This being the first large case I had ever sent for prior approval, it served as

a steep learning curve in understanding the inner workings of the SDR and prior approval system, made even steeper by the change to a computerised approval system midway through. Because of this change and the extensive nature of the treatment plan, the time between initial submission and first approval was around four months.

Treatment carried out

The first phase of treatment included caries management, periodontal treatment, and oral hygiene and diet advice. The latter was also covered at the examination appointment and a marked improvement in gingival health and plaque control could be noted on the patient's return for treatment. Caries management represented the bulk of the treatment required, this included: the use of glass ionomer as an intermediate restoration in multiple buccal lesions where composite wasn't viable as an immediate restorative material, two pulpal exposures on teeth 24 and 46 – both rinsed with chlorhexidine and dressed with direct pulp caps of calcium hydroxide and resin modified glass ionomer cores – and most notably, no teeth showing indication for root canal treatment.

Once caries management was complete and all intermediate glass ionomer restorations were changed for composites, the treatment plan was reassessed. Ethyl chloride sensibility testing was repeated on teeth that had been approved for pre-emptive root canal treatments; all of which were found to be positive. From this the following changes were made to the treatment plan and re-approval was applied for:

- All RCTs and 22 cast post/core were removed
- 46 amalgam restoration changes to a metal shell crown due to more extensive caries than anticipated
- 12 and 13 metal ceramic crowns were changes to direct composite restorations

- 47mo amalgam changed to 47mob amalgam
- 27do amalgam changed to 26dob amalgam.

Then began phase two of the treatment, which included crown preparation and cementation for teeth: 22, 24, 35, and 46. For 24 and 46, after pulpal exposures, there was three month waiting period to ensure neither became symptomatic or non-vital.

The final phase of treatment included periodontal re-evaluation, clinical photographs (*Figure 4*) and consideration of long-term maintenance. Post-treatment plaque and gingival indices showed a plaque score of 24 per cent and bleeding of 35 per cent, with only one pocket greater than 4mm in the six-point pocket chart. The patient showed great motivation from the start which made for ideal conditions for placement of composite restorations close to the gingival margin at the caries management phase. His motivation wavered past this initial phase; however, the need for long term maintenance was enforced throughout the treatment. This resulted in a marked improvement which can be observed in the final clinical photographs. There were still some areas of marginal gingival inflammation that can be noted; this was partly due to some rough eqi-gingival restoration margins that were corrected. The patient's fizzy drink consumption had also dropped dramatically, reporting only drinking two glasses per week, having changed to mostly water. He was placed on a three-month recall interval to ensure periodontal health was being maintained, with the plan of being moved to a six-month recall once stable.

Benefits to the patient

The patient noted a considerable aesthetic improvement to his smile as well as a functional benefit, feeling

Figure 4: Post-operative





confident to eat without risk of damage to decayed teeth. He also described feeling less lethargic with much more energy since cutting down his high sugar diet, as well as a cleaner feeling mouth through brushing two times per day and use of interdental brushes almost every day.

Conclusions and learning from the case

This case proved to be an invaluable learning experience for me, both in improving my clinical skills, as well as gaining a more complete understanding of providing dental care within NHS Scotland.

The latter included learning to work within the SDR, the prior approval process and the limitations of treatment that can be provided on the NHS. It was also very rewarding to see the patient's change in attitude to oral hygiene have a positive effect on his life as a whole, not just limited to the mouth.

It helped me realise the importance of treating every patient with a holistic approach, to ensure they can achieve the maximum benefit from the treatment you provide.

There were some areas that on reflection of the case could have been improved upon. I feel these can be broken down quite well into limitations of my own ability/knowledge and limitations of treatment provided on the NHS.

Limitations of my own treatment:

- Upper left posterior periapical more appropriate radiograph than left bitewing
- 35 shade not great match; patient not concerned or interested in remake



- Periodontal health; ultimately patient driven but hoped to see better resolution by end of treatment
- Consider veneer technique for more seamless margins on anterior composites
- A longer waiting period of six to twelve months may have been more appropriate before reassessing vitality of 24 and 46 pulp exposure and placing crowns.

Limitations of NHS:

- Direct composite less destructive method than metal shell crown for 46
- Four months wait between applying for prior approval and it being passed
- Intermediate glass ionomer restorations not financially feasible if working as an associate

- Large anterior direct composite restorations time consuming and not remunerated well; likely to result in placement of crowns when less destructive option available.

Overall, I thoroughly enjoyed working on this case and found it a pivotal learning experience in my vocational training year, showing what could be achieved on the NHS and that my initial scepticism wasn't completely founded.

It was also rewarding to be able to see the treatment all the way through, from initial examination to maintenance and recall; giving the opportunity to thoroughly reflect on the treatment as a whole, a luxury not always afforded at an undergraduate level.

HOW TO DEAL WITH STRESS IN THE WORKPLACE

Some lessons, hints and tips for up-and-coming managers, principals, associates and nurses

[WORDS: SUSIE ANDERSON SHARKEY]

A FEW WEEKS AGO, AS I WAS browsing on one of the online dental forums, a desperate practice manager asked for any tips on how to deal with stress in the workplace. As someone who has had almost 30 years in the dental industry and most definitely have more days behind me than in front of me (many of which have been off-the-scale stressful), I felt qualified to offer some sage words that I hope may have helped her in the coming months and years of her career.

Stress in the workplace, any workplace is very real and can (and does) impact our personal lives, some to such an extent they need to seek medical intervention. As I look back over my many years in dentistry, I realise I have learned a little of how to live, both inside and outside the workplace, although at times in the past I'd be the first to admit that the lines have been blurred. But I blame myself for that and I know that given life to live over again, there are some things I would definitely do differently.

So, here are some lessons, hints, and tips that I've learned along the way, and hopefully it will be of help to up-and-coming managers, principals, associates, and nurses along the way.

1. AGREE GROUND RULES REGARDING HOME LIFE AND WORK LIFE AND STICK TO THEM

Just a couple of days ago, a practice manager posted on the forum that she was off sick but was being contacted by everyone at work and was expected to work from home even though she was ill. It can depend on what type of illness, how ill, how long will you be off for, but ask yourself the question: "Would you contact a nurse at home if she/he was sick?" A manager is an employee like any other member of staff, can be ill like any other member of staff, and may need some time to recover like any other member of staff. There's something wrong if the practice falls apart if the manager isn't available for a few days.

2. REMEMBER YOUR WORK IS WHAT YOU DO, NOT WHO YOU ARE, IT SHOULDN'T DEFINE YOU

So many people in so many spheres of life are defined by what they do for a living. I could write a whole article about this. We all know that when we meet someone, one of the first things we or they ask is: "So what do you do for a living?". Depending on your answer they either suddenly develop a keen interest in you or notice a friend across the room whom they have to see immediately! Okay, so maybe I'm being a bit harsh, but I have definitely met people who clearly tried to define me because of my job and had no idea what kind of a person I really am. A job is what you do, it's not (or shouldn't be) intrinsically who you are.

3. REALISE EARLY ON THAT YOU'RE NOT ALWAYS GOING TO GET IT RIGHT

Yup, we've all been there, and it feels awful and can even dent our pride. We want to believe that we're infallible and we find it difficult to accept that we're human, just like the rest of humanity. When you make a mistake: a) admit it; b) see what you can do to make things right; c) learn from it and move on.

4. YOU'LL NEVER PLEASE EVERYONE SO DON'T TRY

If you try to please everyone then at some time or other everyone is going to be disappointed, annoyed, or have a go at you. Generally speaking, I've lived out my working life in trying to be fair in every

circumstance and do my very best to find a good outcome in any situation. But I've had to be realistic and admit that sometimes it's just not possible. Don't lose sleep over it, don't take it personally. Do what is the right thing to do in the situation and that's the very best anyone should expect.

5. BUILD IN REGULAR BREAKS

Do NOT take your phone on holiday or answer emails, tempting as this may be.

Holidays are for you to recharge, have down time, reflect, spend time with family and friends and basically be 'out of the office' in every sense of the word. These times are vital for mind, body and soul and you will come back refreshed, with great new ideas and motivation to move forward.

6. ENJOY WHAT YOU DO AND IF THERE COMES A TIME YOU DON'T THEN MOVE ON

Don't be afraid of change. Embrace it. Circumstances change throughout life, businesses change as staff come and go, and what was right for you ten years ago is possibly not right for you now. It's so important that you are happy and fulfilled in whatever you do otherwise you will become resentful and definitely unable to give of your best.

7. AND LAST BUT MOST DEFINITELY NOT LEAST: DON'T TAKE YOURSELF TOO SERIOUSLY

Have the ability to laugh at yourself as others laugh with you and admit that sometimes you're just a nummy! Keep a sense of perspective and a sense of humour! The job will be there long after you have moved on and it's so important that you keep a perspective on what is really important in life.



DO NOT TAKE YOUR PHONE ON HOLIDAY OR ANSWER EMAILS, TEMPTING AS THIS MAY BE"

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

CHALLENGES RAISED BY RISE OF TELEDENTISTRY

THE ANNOUNCEMENT THAT THE

“teledentistry pioneer” SmileDirectClub is opening ‘SmileShops’ in locations in the UK and Ireland cannot have bypassed any thinking dentist.

A slick, well-written press release made it easy for sub-editors to cut and paste. The tone and content shifts the focus from those boring places where people can obtain specialised dental advice and treatment, commonly known as dental practices. That these businesses comply with regulations and educational standards is neither here nor there.

The release states that SmileDirectClub’s mission is “to democratise access to safe, affordable and convenient teeth straightening solutions through doctor-directed remote clear aligner therapy”.

“We believe everyone deserves a smile they love,” says Alex Fenkell, co-founder of SmileDirectClub. Of course every dental health professional has been struggling for years wondering how they should help their patients.

The evangelising feel continues: “Our mission is to help people unleash the power of their smile and positively impact their place in the world. The confidence that comes from having a great smile is transformative to every aspect of your life. The time is right to expand our mission to the UK to give more Britons the confidence that comes from a straighter, brighter smile.”

So, another company helping the dentally challenged

general public to get just the treatment they need to improve their appearance on Instagram...and all for just £1499...

“...licensed dentists and orthodontists customise each patient’s treatment plan and manage their patients’ care from initial diagnosis through [to] the conclusion of treatment, monitoring care along the way with remote check-ins every 90 days to allow patients to avoid the hassle of scheduling frequent visits to a doctor’s office...”

Heaven forbid that people might have to visit a trained and registered dentist to ensure no harm was being done.

WHAT SHOULD YOU DO IN THE FACE OF THIS CHALLENGE?

Be aware. This is a logical extension of the spread of aligner therapy which has removed the near monopoly for “tooth straightening” from control of specialists and into general practice. If you have a practice which depends upon a regular throughput of aligner patients not only for jam, but also bread and butter, then be prepared to fight back. Take a long hard look at your marketing and ensure that you are perceived as an expert, who is going to be around in another decade, is experienced and can offer a broad range of skills.

Focus on relationships. SmileDirectClub appeals to transactional customers. Success in dentistry, as in all good businesses, is built on relationships. Ensure that you understand the difference between the two.

Transactional patients are primarily interested in price; if they can find something cheaper, they will move. They exhibit little or no loyalty, and believe that the internet or a catalogue will give them all the information they need. Easy marketing hits appeal to them.

They provide little profit, so be prepared to pile high and sell cheaply if you go into this market. Always seeking a deal, they will watch your business go bust because you weren’t cheap enough.

Relationship patients seek trust, they become lifetime patients and supporters. They want the familiar and the reliable in people and products. They will pay more because they value the relationship, they find it emotionally tiring to shop around. Long and medium term, they are highly profitable and are the core of a professional business.

[WORDS: ALUN K REES]

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.

www.thedentalbusinesscoach.com





Know your patients. Those three little words are the difference between success and failure, and between happiness and misery in dentistry. Ensure that they wouldn't dream of going anywhere else by knowing not only what they need but also what they want. The market has changed profoundly – if it hadn't, we wouldn't be talking about SmileDirectClub. For generations dentists

“

**HEAVEN FORBID THAT PEOPLE MIGHT HAVE
TO VISIT A TRAINED AND REGISTERED DENTIST
TO ENSURE NO HARM WAS BEING DONE”**

reacted to disease. Bad tooth? Fill or remove. Too many gaps? Fill the spaces. Over a generation we have become more proactive. Dentists and their teams help their patients to keep their teeth, to maintain them and to have greater expectations. By raising our patients' 'dental IQ' we encourage them to have and to share their aspirations.

It can be very easy to presume what your patient wants; like any relationship it needs work.

Know yourself. The phrase “low-hanging fruit” when applied to business means those goals that are easier to achieve than others. However, it has been used to encourage dentists to get involved in ‘easy sales’. It doesn't necessarily apply to treatments that are relatively expensive but can be very profitable.

Quality of care cannot be measured on a spreadsheet and most dentists, no matter how closely they watch their Key Performance Indicators, will always want to be able to look themselves in the mirror at the end of the day.

FEEL 'STUCK' AND DON'T KNOW WHAT TO DO? HAVE NO-ONE TO DISCUSS CHALLENGES WITH?



Should you use a business consultant at your practice? If you decide to, here are some suggestions on how to get real benefit

[WORDS: RICHARD PEARCE]

“
**BUSINESS CONSULTANCY IN DENTISTRY
IS COMMONPLACE, BUT LIKE ALL THE
SERVICES YOU BUY, HAVE A CLEAR IDEA
OF THE OUTCOMES YOU ARE AIMING FOR
AND IN WHAT TIME FRAME”**

IT HAS OFTEN BEEN SAID THAT

management consultants just use your watch to tell you the time, and then charge you for the privilege! There may be some truth in this so, therefore, the buyer – i.e. practice owner – needs to be clear on the short/long-term benefits which they want from any consultancy engagement.

This article will look at the history of consulting, the position of management consultants in business generally, consultants in dentistry and how you as an owner might work with a consultant.

Management consultancy really began in the late 19th century as an interest in the process of management developed. It slowly developed with industrialisation and really expanded in the 1960s and 70s as larger companies looked for process improvements and to quickly get an outside perspective from consultants who had global exposure to the problems which they faced. Today, it is a multi-billion-pound industry, so you are definitely not alone when you hire a consultant.

It was only as dental practices began to increase in size and complexity and owners realised the need to market their services, that a very few individuals noticed an opportunity to provide advice. Historically, the main source of advice for a practice owner was their accountant. If the accountant had a few dental clients they could quite easily compare these practices,



by looking at the Profit & Loss statements they were creating and extract some useful benchmarks. Notably on costs – accountants haven't picked up the slightly derogatory moniker 'bean counters', for nothing.

Clearly, the practice owner should ensure that their accountant provides the desired level of commentary on the performance of their business in a timely way, and furthermore advises on the funding (for growth), tax planning, compliance and exiting (selling) assistance, that is also needed. So, why seek the services of a dental business consultant? The reasons will probably fall into the following categories:

- Want to grow (want more profitability) but not sure how
- Feel 'stuck' and don't know what to do
- Feel lonely/have no-one to discuss the challenges with, within the practice
- Have a 'difficult' manager who is an obstacle to development but don't know what to do about it (and so want someone to help 'remove' them without contravening employment law).

If any of the above apply to you, or even if you have a different reason, try to write down what you want a consultant to help you achieve and how long you think it might take. Ideally, make your objectives SMART (Specific, Measurable, Achievable, Realistic, Time-bound). So often, a consultant engagement becomes open-ended and the initial objectives get forgotten and never

referred to. You should be very clear on the costs involved and how long the engagement will last. There are dental practice owners paying many thousands of euros a month for a consultant's input yet the amount of time they work 'for you' can be hugely variable. Duration-wise, it's difficult to make real change in less than a year, three years should be more than enough time to make fundamental changes.

Some owners become totally dependent on their consultant and they assume every word they utter or write is business 'gold'! Unfortunately, not every initiative they suggest will be right for you or will work in the context of your practice. It is possible that the implementation may not deliver as expected; perhaps a key staff member (who is part of the implementation) might leave, or you might not invest appropriately.

It always surprises me that an owner doesn't ask for a six-month or a one-year 'break' in the consultancy engagement while they consolidate. It is natural, if a consultant is paid by the month that they will keep pushing the pace. It is very easy for them to keep suggesting/insisting what needs to happen next, because they feel they are justifying their fee. Often what is needed is stability, consolidation and consistent growth. Take control and say what you believe is right for you.

When meeting your consultant, put aside the appropriate time: have the meeting at

an appropriate location and don't let it be shortened/interrupted. This is a constant bugbear for business consultants and can be an indicator of the importance you attribute to business development. (Once, I was in a client meeting in an office which was too small for two staff and yet there were four of us in there. Seriously, go to Starbucks or pay the £100-£200 for a hotel meeting room, for the morning/day.

Business consultancy in dentistry is now commonplace, but like all the services you buy, you should have a clear idea of the outcomes you are aiming for and in what time frame. Every business situation is unique, but it can be useful to look at trends and developments across the industry: ultimately the right course of action for your practice can only be decided by you.

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:

ENSURE PATIENTS KNOW WHAT TO EXPECT

Good record-keeping is invaluable in defending against negligence claims

[WORDS: AUBREY CRAIG]

MR P, 52, ATTENDS HIS DENTIST, DR N, with pain in the upper right quadrant. Clinical and radiographic examinations reveal tenderness to percussion and widening of the periodontal ligament space (indicating formation of an abscess) associated with UR8. Dr N diagnoses irreversible pulpitis and suggests root canal treatment (RCT) or extraction. Mr P is further advised that the root canals of UR8 look sclerosed on the radiographs and may be difficult to locate. Dr N explains that the success rate for RCT is around 80 per cent. The patient agrees to the procedure as UR8 is the only standing molar and retains Mr P's partial upper denture.

WEEK FIVE

Mr P attends the surgery for the first stage of RCT to UR8, which is carried out using rubber dam and rotary instruments and is irrigated with sodium hypochlorite. Dr N has difficulty locating one of the root canals and asks for help from a colleague. It is eventually located and the rest of the treatment is carried out as planned. The tooth is temporarily restored and Mr P is advised of possible post-operative soreness over the next few days and is asked to contact the practice if the discomfort does not resolve.

WEEK SIX

Dr N completes the RCT treatment using a local anaesthetic under rubber dam. A post-operative radiograph is taken and this shows a good quality root filling present. Mr P had reported some tenderness over UR8 for the previous few days and is again advised of possible post-operative tenderness and told to contact the practice if the symptoms persist.

WEEK EIGHT

Mr P returns to the surgery complaining of pain associated with UR8 and also UR2. Clinical examination reveals tenderness to pressure on UR8 but no occlusal disharmony (i.e. disturbance to his bite) and Dr N advises the patient that the

tooth should settle given time. UR2 is found to be tender with palatal pressure but there are no other clinical signs. Dr N suggests two possible causes for the pain: a recurrent infection due to a failing root filling (present for 15 years although with no previous problems) or a root fracture. The dentist advises that in either case the prognosis for the tooth is poor. A radiograph is taken but there is no obvious root fracture – just evidence of a badly aligned post and early abscess formation around the root. This is the last time Mr P attends the practice.

SUBSEQUENT ACTION

A letter of claim is sent to Dr N alleging clinical negligence in his treatment of Mr P. It claims that Dr N failed to clean/fill the patient's root canals at UR8 to an appropriate standard and had to ask for help during the treatment. It is also alleged that Dr N put pressure on UR2 while undertaking the second part of RCT on UR8, causing a root fracture which he later failed to diagnose. MDDUS instructs an endodontic specialist to provide an expert opinion. Subsequent disclosure of the full dental records reveals that Mr P attended a different dentist after the treatment by Dr N. This dentist advised the patient that

the RCT of UR8 was substandard and the procedure was redone – and it is further claimed that the previous gutta percha (GP) root fillings were easily removed with tweezers.

The endodontic specialist examines Dr N's treatment records which record in detail the treatment plan and consent discussions with the patient. The post-RCT radiograph taken by Dr N shows well-condensed root fillings present and the expert questions the second dentist's claim that they could be removed by tweezers. The expert states that in carrying out the RCT over two appointments Dr N was following best practice. Requesting

assistance from a colleague does not suggest the treatment fell below a reasonable standard of care, and it is noted that Mr P was warned that the root canals looked sclerosed and might prove troublesome.

The expert also reasons that it would be highly unlikely that Dr N exerted pressure on UR2 while carrying out RCT on UR8, given the dentist is left-handed and would not have used UR2 as a stabilising point. The radiograph taken by Dr N of UR2 shows no sign of a root fracture but rather evidence of abscess formation, which was the likely cause of the pain. MDDUS sends a letter of response denying negligence and nothing further is heard from Mr P's solicitors. The case is eventually closed on expiry of the legal limitation period.

KEY POINTS

- Good record-keeping is invaluable in defending against negligence claims.
- Do not neglect to make and record BPE assessments.
- Ensure patients understand what can be reasonably expected from treatment.

Aubrey Craig is head of dental division at MDDUS



“**DR N'S RECORDS DETAIL THE TREATMENT PLAN AND CONSENT DISCUSSIONS WITH THE PATIENT**”

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AN AMBITION FULFILLED

An Edinburgh practice has doubled in size and in 2020 will become a major educational resource for Scotland

It has been busy 18 months for Leanne Branton, founder and practice principal at Southside Dental Care in Edinburgh. Her practice has doubled in size, involving the acquisition and integration of an adjoining four-storey, formerly residential building, new team members joining, and the adoption of a digital workflow.

"Southside Dental Care is an independently owned practice set up as a squat almost 12 years ago," explained Leanne. "The building itself had been a general practice for the previous 25 years. We were a three-surgery practice, but this year have undertaken a significant expansion to become a six-surgery practice with state-of-the-art equipment including a training suite and a dental laboratory.

"At the time I established Southside Dental my aim was to create a centre where patients

(Above) Leanne Branton (fourth from left) and the Southside Dental Care team

Dr Josh Rowley who is heading up the NHS and private orthodontic clinic



could get access to the treatments and services they require within the convenience of one site. With the ever-changing nature of dentistry this will always be a work in progress, but I am very proud of the way Southside Dental is moving forward.

"We provide a full range of both NHS and private services including orthodontics, implant dentistry, sedation and facial aesthetics. As well as six chairs, we have the full Dentsply Sirona digital workflow from the Orthophos SL imaging unit, CBCT, to our CEREC MC XL and SpeedFire.

"Introduction of the digital workflow is entirely focused on making our patient journey more convenient and stress free.

By utilising the digital workflow we achieve higher accuracy and patients ultimately spend less time in the chair which they always love.

"We have always believed in

providing a first-class patient journey for everyone whether they are receiving NHS or private treatment. This journey is only made possible by my amazing team. Southside Dental has a team of 26, including six dentists, three hygiene therapists, one orthodontist, one dentist with a special interest in implant dentistry, one facial aesthetic clinician, and a whole team of support staff without whom the practice could not function.

"It is their drive and passion which pushes my practice forward and so my desire is to support their development in whichever way I can. Sometimes team members need or want to change their career focus and it is my responsibility to aid this whilst hopefully finding a new role for them within our practice.

"A big focus of our expansion has been on staff facilities, including creating a training





suite which we will use not only to enhance our own staff's skills but to provide learning for other local dentists and dental professionals. The expansion has also allowed us to create Southside Orthodontic Clinic and we are very excited to bring in the talent of Dr Josh Rowley who heads up this clinic.

"Over the last few years we have really noticed a shift whereby the general public are more aware of the importance of prevention in oral disease. The key to prevention is early diagnosis, and the introduction of Calvis technology has given us a communication tool to better educate our patients."

Leanne graduated in Glasgow in 2003, but Southside is where she grew up. Her professional interests are focused on implant dentistry and she has recently finished her FGDP Diploma in Implant Dentistry course and is waiting to sit her exam next year to gain her qualification. Her practice has been managed throughout by her sister Aimi Bouglas who has been invaluable to its growth and development.

"These last two years were made challenging by the fact that I had already chosen to undertake the FGDP Diploma at the Royal College of Surgeons in London



Leanne with practice manager Aimi Bouglas



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- Dr Josh Rowley (BDS, MFDS RCSEd, DCLinDent Orth, MOrth RCSEd, MRACDS Orth).



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when the opportunity for the expansion arose. Juggling this while continuing to run the practice and enjoy a family life has been a difficult balance, made only possible by the support of my family, friends and team.

"This next year is all about us settling into this new enlarged team and encouraging everyone to take on their new roles within the practice.

"I am really looking forward to becoming ever increasingly involved in education within dentistry with the practice hosting world-class courses for local dentists. The

support of Dentsply Sirona in this new project has been invaluable."

It was at the Scottish Dental Awards evening a couple of years ago that Leanne met Michael Davidson, Clinical Lead at Dentsply Sirona, which led to him delivering a CPD event at the practice, sparking a deeper interest in the power of continuous professional development for the dental team.

At the awards, Leanne mentioned to Michael her ambitious plans for expansion which have now been realised and which have now also led to a significant education partnership between Dentsply Sirona and Southside Dental Care.

It is envisaged that the new facility at Southside will become an educational resource and live teaching centre for dentists in Scotland and the north of England.

Dentsply Sirona currently has one training facility, at Weybridge in Surrey, and

it runs around 300 educational events a year. Planning for a full programme of events in Edinburgh for 2020 is well under way.

"Dentsply Sirona invests around \$125m a year in research and development, developing new technologies" said Michael, "But we also have an obligation to support education within the profession and we take that very seriously." Leanne added: "A huge focus of ours over the last 12 years has been to provide a supportive internal development programme, designed to push our staff to achieve the best they can.

"Recruitment has become increasingly difficult within dentistry and our ethos has been to focus on developing and encouraging new talent. The provision of a training facility which is linked to our primary surgery is of huge benefit to patients who will be cared for by staff at the cutting edge of clinical education within dentistry."



THE PROVISION OF A TRAINING FACILITY WHICH IS LINKED TO OUR PRIMARY SURGERY IS OF HUGE BENEFIT TO BOTH STAFF AND PATIENTS"

The project

LEANNE and her architect applied for provisional planning permission before buying the building. "I knew that asking to separate a four-storey town house and change its use in such a prominent part of Edinburgh was a big ask."

"When planning was accepted, we then had to finance the project – and without the support of our accountants and the bank. We eventually purchased the property in December 2018, after a year of planning, and we opened to patients in August this year. It was a tight schedule driven by our desire to return to vocational training – and we are delighted to be able to support three vocational trainees within the practice now."

The main contractor was Laurence Macintosh. Subcontractors were Nevin Decorators, Latent Heat Gas specialists, and McCrone Electrical Services. The project was planned with Neil Dall Architect, and Leanne received guidance on equipment from Dentsply Sirona and Wrights Cottrell. The project was a huge undertaking, said Leanne (pictured below, with Associates Eleri Strachan and Lucy Sinclair), "but it has left us with a stunning practice throughout".



Leanne with associates Eleri Strachan and Lucy Sinclair



Business Banking

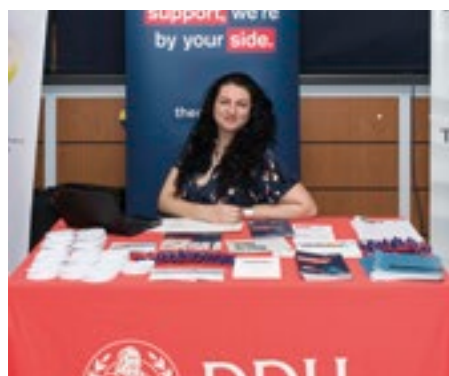
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BLACKHILLS SYMPOSIUM 2019

Top speakers share insights



Now in its eighth year, the Blackhills Symposium mixes clinical learning with sessions on business planning, employment law, leadership, and team building.

More than 120 dentists, dental nurses, hygienists, and therapists gathered at the Perth Racecourse conference venue last month for the annual symposium.

Delegates from 37 practices heard from a wide range of top speakers sharing their insights into better business planning, staff wellbeing, and clinical skills. Between sessions attendees networked and engaged with representatives staffing 24 trade stands.

The free-to-attend all-day symposium is for all dental practices referring to Blackhills and is open to all members of the team. It offers a full day of verifiable CPD with a wide variety of speakers and parallel sessions for different groups.

"It's a way to say 'thank you' to the dental practices who refer to us and trust us to deliver the best possible treatments for their patients," said Paul Stone, Clinical Director, "and provide exhibition space to the many different companies who work with us."

Set in the picturesque grounds of

the historic Scone Place and skirting the banks of the River Tay, the racecourse is a wonderful venue with the lecture hall directly above the exhibition and coffee/lunch area.

"The staff are great and go the extra mile to deliver a good experience for the attendees," said Paul.

He added: "We try to construct a programme which is a little different from the usual all-clinical format seen at most other small meetings – mixing other aspects together, such as business, law, leadership, and team building.

"Along with this, Blackhills Clinic specialists also lecture every year, focusing on topics that are relevant to general dentists and their teams.

"We often find our suppliers and supporting companies are very keen to provide speakers for the symposium and we have seen that our delegates appreciate this varied programme by the comments they make on their feedback forms over the years."

Paul said that this year's symposium yielded another great set of forms. "The attendees seemed to love Andy McDougall from Spot On Business Planning, even though he's an accountant!

"They also gave great comments

about our two specialists Graeme Lillywhite, who spoke on occlusal considerations in restorative dentistry, and Marilou Ciantar, who covered aesthetic periodontics."

Commenting on the content of his presentation, Andy said: "Running a healthy business requires firstly strategic focus, only then can the tactics be determined. So, a strategic plan is derived.

"The planned achievement is spread over the year so we can measure progress via performance management, monthly management accounts and KPIs. In delivering the target performance we need to deliver

change. This is a function of leadership. It cannot be delivered without getting the team on board. This most often requires a cultural change."

One of the many highlights of the day was the presentation by Peter Mossey, Professor of Craniofacial Development at the University of Dundee, who spoke on issues affecting the cleft and craniofacial communities.

His presentation focused on the inequalities in access to care for cleft lip and palate patients in the developing world and illustrated the projected role of dentists as health professionals in the future.

“

WE TRY TO CONSTRUCT A PROGRAMME WHICH IS A LITTLE DIFFERENT FROM THE USUAL ALL-CLINICAL FORMAT SEEN AT MOST OTHER SMALL MEETINGS”

PAUL STONE

> COLTENE



A CUT ABOVE THE REST

Shahram Mirtorabi is principal dentist at Hindley Dental Practice, Wigan.

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"PerFect™ TCS II allows me to manage soft tissue with accuracy and efficiency, with less bleeding and a faster healing time. In periodontics, it is invaluable for reducing pocket depth.

"It is also useful in orthodontics, by removing excess soft tissues in order to attach brackets easily; also, in restorative dentistry, by controlling bleeding in the gingival sulcus prior to impression taking, or fitting the restoration."



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> ORAL B

BRITAIN IN STATE OF DECAY

Parents in the UK are being pushed to the brink as they try to get their kids to take dental hygiene seriously. Research from Oral-B has shown that 70% of parents say ensuring their children regularly pick-up a toothbrush is the most stressful element of modern parenting.

On average, parents will spend nine minutes nagging their kids to brush their teeth and when the little ones finally get brushing, they only last an average of just 76 seconds, well short of the two minutes recommended by dentists.

Despite frustrated parents' best efforts, British kids are brushing their teeth on average just nine times a week, skipping on at least 20 occasions every month. The research was conducted by Oral-B, in conjunction with their #strongteethstrongkids campaign, which is encouraging parents to take part in a #BedtimeBrushChallenge. The campaign aims to raise awareness of the importance of oral health and support parents in the UK to ensure children have access to better oral health care from home.

View Oral-B's top tips to make brushing fun, alongside helpful information for parents on maintaining oral health for kids here: <https://www.oralb.co.uk/en-gb/oral-health/life-stages/kids/how-to-encourage-brushing-for-kids>



Get involved in the campaign on Instagram via @oralb_uk #strongteethstrongkids

> INVISALIGN



INVISALIGN OPENS A NEW POP-UP

Consumer trends are changing fast. They are increasingly becoming digital-savvy, informed and want to stay in control of their choices. They are also busy, and want their experiences to be fast and convenient. The Invisalign Connect Pop-Up taps into these trends by offering an interactive brand activation, which takes them on the exciting digital journey to a new smile.

By bringing the Invisalign brand closer to consumers – and showcasing Invisalign technology in an engaging, non-clinical environment – visitors to the Invisalign Connect Pop-Up can explore the potential of clear aligner therapy, learn what to expect during treatment and how to get started with an Invisalign trained doctor. The Pop-Up team will also be on hand to guide visitors and answer their questions about the Invisalign system.

A new Pop-Up has recently opened at Westfield Stratford Shopping Centre in London, where visitors can try on a new smile in 60 seconds. Thanks to the latest SmileView technology, developed by Align, consumers can take a selfie and see a non-clinical visualisation of what their new smile could look like in their own photo. If they like what they see, they can be connected to an Invisalign doctor of their choice for a free initial consultation to determine if they are a good candidate for Invisalign treatment.

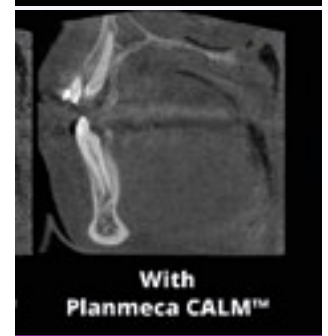
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To learn more about Planmeca ProMax® 3D and the new Planmeca CALM™ algorithm, contact our Planmeca team or visit www.plandemo.co.uk to book your free mobile showroom visit and we can bring the latest in 3D imaging to you.



NSK GIVES CHARITY A HELPING HANDPIECE

It turns out that the dental industry is full of kind-hearted souls. So say Andrea Johnson, dental technician and co-founder of charity Den-Tech, and oral surgeon Sami Stagnell who have a lot to thank their fellow dental clinicians, technicians and dental companies for

ANDREA, COULD YOU TELL US WHAT DEN-TECH DOES AND HOW IT CAME INTO BEING?

Andrea: I founded Den-Tech with my fellow dental technician, Andrew Sinclair in 2017. We were spurred into action after we had been on a charity volunteer mission in Uganda. There are many charities that provide essential 'dental pain clinics', but we noticed that there was no subsequent provision for the restoration of the dentition thereafter.

While in Uganda we noticed that patients who had undergone extractions as part of their acute dental treatment were left with large gaps which restricted their ability to eat and speak and had a huge impact on how they looked and felt. We felt very passionately that this shouldn't be allowed to continue and set up Den-Tech in response.

Den-Tech's aim is to relieve poverty by the provision of affordable dental appliances to those patients who are in need and unable to afford them.

We also provide training, mentoring and education for dental technicians in developing countries to enable them to supply the appropriate quality dental appliances.

HOW DOES THIS WORK OUT IN THE FIELD?

Andrea: We are working with two universities and a charity-run health centre in Uganda to supply Den-Tech-supported dental labs, which will provide much-needed high-quality laboratory services as well as training for local people in dental technology. We are also working with a university in Cambodia to set up a crown and bridge laboratory and provide additional support and training for their students and to help facilitate them to provide a service for free to the very poorest communities. We are also now heavily involved in providing dental laboratory services to homeless people in the UK.

Sami: In the past I've been fortunate to work with Crisis, a national charity fighting to end homelessness, where I was lucky to be involved in treating patients at the dental drop-in centre which forms part of the Crisis for Christmas service over the Christmas period. Over the last two years, Den-Tech has got involved with the dental service at Crisis to set up an on-site field laboratory to support simple, same-day procedures. It's made such a difference.



Andrea Johnson,
Co-founder and
Chair of
Den-Tech

To donate, volunteer or find out more information about Den-Tech, visit www.den-tech.org.
 Facebook: @Dentech1
 Twitter: @DenTech_charity

To find out more about NSK, visit www.uk.nsk-dental.com
 Facebook: NSK UK Ltd
 Twitter: @NSK_UK
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Andrea: We also help out with other charities such as Dentaaid, by supporting their mobile vans which travel around the country to patients in more stable situations, such as hostels or half-way houses. We have a host of volunteer laboratories around the country who accept these cases on our behalf and complete the patient cases they take on for free, including funding the materials and postage.

IT SOUNDS LIKE YOU HAVE A LOT OF SUPPORT FROM THE DENTAL COMMUNITY?

Andrea: The response has been absolutely fantastic. We have received many offers of help from dental technicians across the country and we now have a database of laboratories who are willing to take on cases for us. We also have technicians who have volunteered their time to being on site at Crisis and other field operations. We've also had a great response from dental companies, such as NSK, who have recently made an incredible donation.

HOW DID THE DONATION FROM NSK COME ABOUT?

Sami: I have worked with NSK and their surgical products for several years and have built up an excellent professional relationship with them. I was aware that they also produce laboratory equipment and that they had already generously donated to Crisis, so I approached them about also lending a helping hand to Den-Tech. Their response was so far above and beyond what we expected two NSK Ultimate XL laboratory micromotors!

Andrea: Yes absolutely. All of our trustees know how excited I am about these micromotors as I couldn't hide it during our last meeting. No matter what other equipment a laboratory uses, if it does not have decent quality handpieces, it cannot do its job. The Ultimate XL is an amazing piece of kit; it is very powerful, reliable and sturdy. It is also perfect for our work as it is light and easy to transport to our field laboratories. We couldn't have asked for better handpieces.

Equipment and materials donations are absolutely crucial to Den-Tech, particularly for our on-site laboratories. We rely heavily on donations from dental company partners like NSK to equip and support our activities.

WHAT DOES THE FUTURE LOOK LIKE FOR DEN-TECH?

Andrea: Excitingly for us, Sami has just agreed to come on board as a trustee at Den-Tech, and to have a clinician's perspective and insight will be invaluable.

Sami: I'm really excited about having recently become a trustee too. Being able to bring the clinical perspective to Den-Tech will be very rewarding and together we can concentrate our efforts on the real goal, which is to help those people in need of dental help and advice. One of my first projects with Den-Tech is setting up a dental service at the Southampton Veterans' Drop-in Centre, a place for Armed Forces Veterans to get advice, support and a hot meal. We are helping them set up a dental clinic and laboratory which will deliver much-needed treatment, hygiene advice and education. It will also be a base from which we can refer on those in need, to other services within the NHS system.

Andrea: Yes, it's going to be a real challenge, but very worthwhile. Another one of Den-Tech's other projects is putting together field kits for producing simple appliances, adjustments and repairs for our teams that work alongside mobile clinicians around the UK and abroad.

We are always so grateful for any help or donations and it makes a massive difference, we just couldn't do what we do without it.

Sami: Yes any help is fantastic. What I find so rewarding is that our goal is not to do heroic dentistry – but rather to do simple things that make a difference and help people get back on their feet.

Andrea Johnson is an experienced orthodontic technician. She is currently the orthodontic and maxillofacial laboratory manager, deputy lead for quality and clinical governance-OMFS and quality improvement coach at Montagu Hospital, Doncaster, and chair and publicity coordinator of the Orthodontic Technicians Association

Sami Stagnell is a specialist in the field of oral surgery and currently works across both NHS and private sectors and has a special interest in implantology. He works regularly with techniques such as hypnosis, cognitive behavioural therapy and sedation and has an MSc in aesthetic dentistry. He represents the profession within the BDA and FGDP

PRIVATE DENTISTRY IN DEMAND AS BUYERS GO FOR GROWTH

Paul Graham analyses the market trends to explain the increasing interest in buying into private dentistry

The private dentistry market is on the move, with increasing demand for quality practices across the board.

WHAT IS DRIVING DEMAND?

Many multiple operators are turning to fully private practices to balance their portfolio risk. In addition, they are beginning to identify that added value comes through the development of private revenue. This can be achieved through upskilling associates to sell private treatments ethically and introducing hygiene services that, when done correctly, can be a highly profitable element within a practice. Many practice owners assume they are restricted from introducing private revenue streams, particularly if their practice is located within an NHS landscape and has less favourable demographics; however, this train of thought is flawed. Some of the best private practices in the country are not in the

salubrious addresses you would expect.

WHO IS BUYING?

Demand is mainly driven by independent partnerships, multiple practice owners and corporates. Corporates account for only about 15 per cent of the UK dental market, so there is undoubtedly consolidation happening at the top tier of the market, particularly when there is a premium price point for certain profile of practices. As a result, you naturally home in on who is financially capable to deliver on that level of purchase; understandably it is often a corporate operator. However, the buyer profile that currently dominates the Scottish market is the emerging private multiple practice owner.

WHAT'S IN DEMAND?

While there are many more buyers willing to consider a private practice, the stigma or



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sensitivity around the transition of ownership is starting to ease slightly. Typically, this is often mitigated by deferring part of the consideration and linking this deferred consideration to the retained principal's 'tie-in' period. We completed on a number of these types of sales where the price achieved was not only well in excess of market value, but terms that favoured the seller were also delivered. Too often we see sellers who have been dealing directly with a buyer receiving unfavourable and unrealistic conditions attached to a mediocre offer. Increasing enquiries from private equity and other investors is another interesting trend of the current market looking for larger, associated practices and they have a similar appetite to the acquisitive private multiple practice owners. The scalability of a practice comes high on their list of priorities, with four or more surgeries and the principal staying on post-sale being of particular interest.

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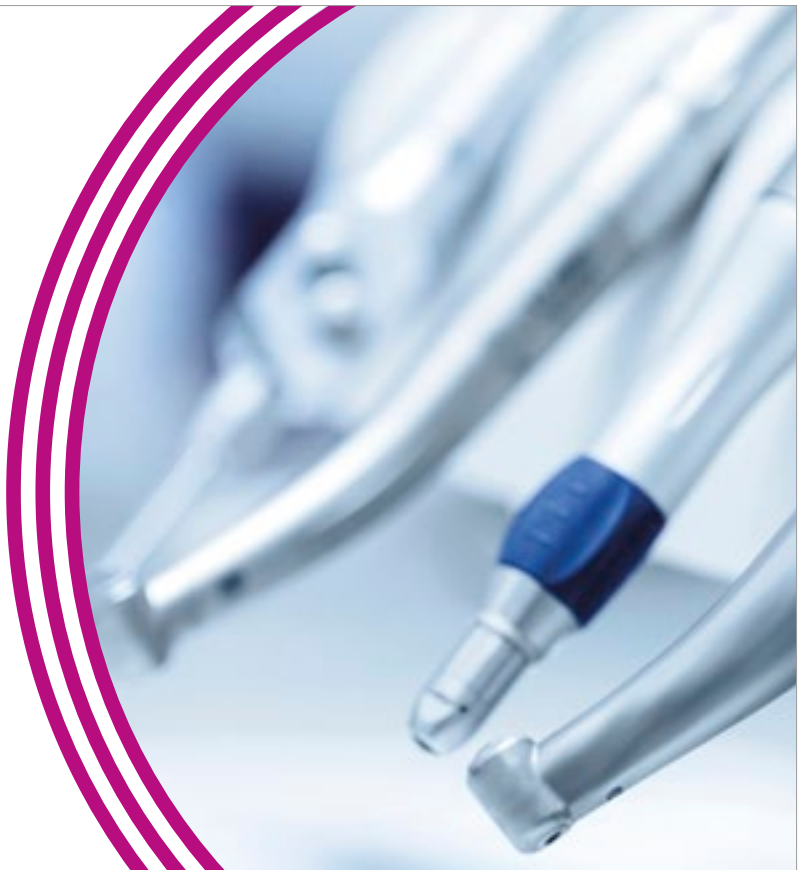
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NEW DAWN FOR AMBITIOUS COUPLE

Dentist Duncan Smith and his wife Maritza Logan, who is a dental therapist, describe how Strictly Confidential helped them to realise their dream of owning their own practice

Our journey to practice ownership began in the summer of 2019. The result of a wonderful holiday in Bali and the South Pacific. Over some glasses of champagne and some exquisite haute cuisine watching a spectacular Balinese sunset, my wife and I inevitably broached the subject of dental practice ownership – as one does.

After a spell of a few years on the East Coast working in long-established and well-run dental practices the time had come for us to stand on our own two feet and become owners and rulers of our own destiny.

Upon our return to an equally balmy Scottish summer we set out to find a practice. Our first port of call was Strictly Confidential who had won our attention through reputation as well as a well-stocked stall of Ferrero Raffaello at the Scottish Dental Show the previous April.

After a short phone call to Trisha we arranged a meeting to discuss our needs and exactly what we were looking for. This allowed us to get to know Trisha and Gillian and to see if we would put our trust in them – I am delighted to say that we did.

Taking an extensive list of what we required from any dental practice that we would be looking to

purchase they immediately told us that they had somewhere in mind that would suit us perfectly. Subsequently, a visit to said practice was arranged for the following week. It was a perfect fit, a practice with all the things we were looking for – great potential and great bones for us to flesh out.

After two visits to the practice in Alexandria we took the decision to press ahead with the purchase. Strictly have a wonderful team of contacts in the fields of law, accountancy, banking and real estate who were able to assist in setting up everything that was required for us to proceed.

The whirlwind that followed was certainly made

easier by our own organisation and preparedness and this allowed the sale to proceed as smoothly as possible with us working in tandem with Strictly and the rest of the team.

When the final handover and purchase was completed, we were the two owners of a fantastic dental practice and new bosses to a wonderful group of staff. We have never regretted our decision for a moment and would happily endorse Strictly Confidential as they allowed us to fulfil our ambition and take the first step into the next chapter of our lives.

Thank you Trisha and Gillian!



IT WAS A PERFECT FIT, A PRACTICE WITH ALL THE THINGS WE WERE LOOKING FOR – GREAT POTENTIAL AND GREAT BONES FOR US TO FLESH OUT”



SELLING TO A BODY CORPORATE

Martyn Bradshaw explains how to get the best deal

A sale to a body corporate does not appeal to everyone but there is no doubt they have their place in the market. Body corporates are not limited in the number of practices they purchase and funding is rarely an issue – therefore they can often be an attractive option when selling a larger practice, which may be out of reach for the majority of private buyers. They can also appeal to the principal who still enjoys dentistry but has lost the enjoyment of running the business and the extra legislation and red tape that comes with it.

While it is possible to contact a body corporate directly and arrange for them to view and make an offer on your practice, this will often not lead to the best price. Here, I discuss the considerations when looking at this type of sale.

WHAT IS EBITDA?

When selling a practice, whether to a body corporate or individual, it is important to understand the way in which the practice is valued (or at least have your practice valued by an independent expert). Nowadays practices are valued on a multiple of EBITDA (earnings before interest, tax, depreciation and amortisation). Amortisation (a depreciation of the goodwill) only applies to limited companies.

The importance of the calculation of EBITDA should not be underestimated and this is where I suggest you seek professional guidance from a valuer. Certain items need to be removed, such as personal costs running through the business and items such as BDA subscriptions and personal indemnity insurance. I also look at any one-off expenditure from the previous year such as a roof repair – which would not be a regular expense. As multiples can typically be around 6.5 under an associate-led EBITDA model, getting this wrong by just £10,000 could lead to a £65,000 reduction

in value. The multiple will also change depending on the location of the practice, types of treatment offered and its practice. Understanding the market allows the correct multiple to be applied.

ARE THERE WAYS TO ENHANCE THE EBITDA?

When valuing dental practices, I look at ways in which the EBITDA can be enhanced. This can often lead to thousands if not tens of thousands of pounds being added to the EBITDA and then a multiple of this is used to value the practice. An example of this could be how you re-charge the hygienist/therapist back to the associate. In one practice PFM Dental sold, the practice did not make a charge at all, as they assumed that the practice taking 50 per cent of the gross fees covered the cost of the hygienist. However, I changed this so that the cost of the hygienist was cost neutral to the practice, with a charge made to the associate. In this practice I managed to increase the profit/EBITDA by £65,000 and on a 6.5 multiple this led to an increased value of £422,500.

RETENTIONS

Each corporate will have different requirements as to the retention (money held back) that it requires and possible future targets that the retention monies would be conditional upon. This is also likely to be different for each type of practice. For example, a fully private practice with a principal generating a high level of personal gross fees is deemed to be more of a financial risk to the corporate than an NHS dentist generating an average level of gross fees. As such, the first is more likely to have higher levels of retention.

TARGETS

Some corporates (generally the larger more widely recognised corporates) will also require targets either on the principal's



Martyn Bradshaw is a Director of PFM Dental, one of the UK's leading dental practice sales agents. Martyn is a specialist in dealing with body corporate sales
Go to: www.pfmdental.co.uk

income or the total practice turnover. The retention amount would then be payable on the basis that the principal remains at the practice as agreed at the outset and the annual income is also met. Where there is a shortfall of income, there would be a mechanism to calculate the loss of the retention, with each corporate having a slightly different stance on this.

DENTAL PRACTICE AGENTS

To ensure that you are getting the best price and terms for your practice, I recommend speaking with a dental agent who is active in the market. New body corporates are entering the market all the time and often because they are less well known or run by dentists with a handful of practices, they can offer different terms than the bigger corporates. An agent will be able to identify the right types of corporates for you and bring many suitable buyers to the table. What may be right for you, may not be for someone else; some people will be more concerned about any retention and will prefer to accept a lesser price without one, while others will be happy to take a higher notional price, only achieving this after meeting the targets.

An experienced agent that deals with body corporates on a regular basis will also know what each will require as retentions and targets and know what can be negotiated to give you better terms.

I advise anyone seeking to sell their practice to, at the very least, get a valuation of the practice. Agents, such as ourselves, provide valuations as a separate service and do not require clients to use us for the sale. However, we tend to find that those clients who do wish to sell have seen our experience and knowledge demonstrated and normally instruct us to act on their behalf. While it may seem cost-effective to try to negotiate the sale yourself, it often proves a false economy and you could lose £100,000s in sale price.

ARE YOU CLAIMING TAX RELIEF ON YOUR DENTAL PRACTICE RESOURCES?

Capital allowances can provide substantial tax savings to businesses, and it is therefore important that these are maximised where possible. By claiming capital allowances on plant and machinery, in most cases, the full cost of an item can be deducted from the final tax bill by using Annual Investment Allowance (AIA).

It was announced in the 2018 Autumn Budget that there would be a temporary increase in the AIA limit from £200,000 to £1m. This increase took effect from 1 January 2019 and will remain until 31 December 2020, meaning businesses have a two-year window to take advantage of this limit.

Although "plant and machinery" may sound like something more likely to be found

in a factory rather than a dental practice, there is likely to be substantial expenditure on items used in the running of your dental practice that would qualify for capital allowances.

Here are some areas where capital allowances can be claimed, and examples of specific items found in dental practices:

- patient chairs, dental operator lights, X-ray imaging equipment
- security e.g. alarms and secure doors
- waiting area facilities such as television, chairs, coffee machine
- catering facilities – kitchen appliances
- storage facilities – open shelves and bookcases
- office areas – computers and filing cabinets.



With the new AIA limit being the highest since it was introduced in 2008, there has never been a better time to invest in your practices' assets.

While this is a welcome change, businesses with a year end that straddles 1 January 2019 should be aware of the transitional rules that apply, meaning the timing of capital expenditure should be carefully planned to ensure the AIA is maximised.

If you are looking for advice, support or further information about capital allowances and the amounts that can be claimed, please email Anna Coff on anna.coff@eqaccountants.co.uk or call 01307 474274.

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For further information please contact:

Louise Grant 01382 312100 louise.grant@eqaccountants.co.uk

Anna Coff 01307 474274 anna.coff@eqaccountants.co.uk



RESTRICTIVE COVENANTS – A POINTLESS EXERCISE OR NOT?

We are regularly asked to provide advice on restrictive covenants, either in putting them into place or advising on their enforceability. In doing so, we often find that people have preconceptions about them, many of which are incorrect or are based upon a very black and white view of the legal position. In many cases the advice which we provide is not at all what our clients expect to hear.

So, what are restrictive covenants?

In the context of a dental practice, restrictive covenants are a set of provisions which are designed to prevent someone connected with the practice from taking certain steps which might damage the practice in some way.

The covenants are most likely to apply for a period after someone leaves the practice, and are most likely to be seen in the following situations:

- When an associate or employee leaves a practice (in which case the principal will have the benefit of the covenant)
- When a principal leaves, either on sale (in which case the buyer can enforce the covenants) or on retirement from a partnership (the other partners will be the beneficiaries of the covenants in this situation).

WHAT WILL THE COVENANTS COVER?

Every covenant differs, but commonly they will prevent one or more of the following:

- Soliciting patients from leaving the practice
- Practising dentistry within a radius of the practice premises
- Soliciting employees or dentists from leaving the practice
- Practising under the same or a confusingly similar practice name

DO RESTRICTIVE COVENANTS REQUIRE TO BE IN WRITING?

Absolutely. The law doesn't imply any covenants when someone leaves a practice, and in the absence of specific restrictions being agreed, they would have free rein to do whatever they like.

BUT RESTRICTIVE COVENANTS AREN'T



ENFORCEABLE ARE THEY?

This is a very common misconception which isn't correct. Covenants are enforceable, it being recognised by the courts that a business owner has a legitimate interest in protecting the value in their business. Practice principals are no different. They own their goodwill and are entitled to take steps to maintain it.

SO AS A PRINCIPAL I SHOULD ENSURE THAT WE HAVE VERY WIDE COVENANTS IN OUR ASSOCIATE AGREEMENTS, ETC?

Again this is an area where there is a lot of misunderstanding. Often our principal clients want to provide for very strong restrictions, e.g. that an associate can't move to a practice within a broad radius, or for a significant period of time (say five years) they can't treat patients of their original practice. However, this is where enforceability does become an issue. The courts take the view that a covenant shouldn't go further than is reasonably necessary to protect the goodwill of the practice. Going beyond that risks the covenant being viewed as unreasonable, and therefore unenforceable. So, however counter-intuitive this may seem, our general advice is to keep covenants as narrow as possible, as that improves the likelihood of them being capable of being enforced.

The extent to which a covenant is seen as reasonable will also vary from one case to



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another. Generally, there is more interest in enforcing a covenant against the seller of a practice rather than when an associate leaves, and in turn a covenant for an employee is likely to be less restrictive.

It is also worth noting that generally a court won't interfere with the terms of a covenant if it is viewed as going too far. As an example, a restriction that applies to someone for a period of 10 years after leaving a practice will clearly be unenforceable. A court won't see it as its place to decide what period would have been reasonable and to substitute such a restriction. It will most likely simply say that 10 years is too much, with the result that in practice there will be no restriction at all.

SO WHAT PRACTICAL STEPS CAN I TAKE TO ASSIST WITH ENFORCING COVENANTS?

- First of all, think carefully about the specific circumstance you are trying to cover and what is reasonable. Don't blindly copy terms from another practice – they may not work for you.
- Make sure that you actually set out the restrictions – we often see BDA template associate agreements where the detailed restrictions are blank – if there is no detail, then there is nothing to enforce.
- Finally, be prepared to enforce if someone does breach a covenant – apart from anything else, not doing so sends the wrong message to the rest of the practice.

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> ZENFLORE

STRESSING THE ALTERNATIVES

Researchers from the BDA found high levels of stress and burnout among a survey of more than 2,000 UK dentists. More than half (54.9%) reported experiencing high job stress. Dentists are not alone. According to the World Health Organisation, "Stress is the health epidemic of the 21st century".

Now there is a new way to tackle stress which doesn't involve taking drugs. It works through the 'second brain', altering the bacteria in the gut, now recognised for the profound effects it can have on our stress management. A daily probiotic called Zenflore contains a bacterial strain called 1714-Serenitas®, which has been shown to help alleviate stress, and activate the coping centres of the brain as well, by reducing the levels of stress hormone in the body. Clinical studies demonstrate it can directly help brain function in healthy people: improving their ability to process stress; moderating their brain processes linked with negative emotions and enhancing vitality and reducing mental fatigue.

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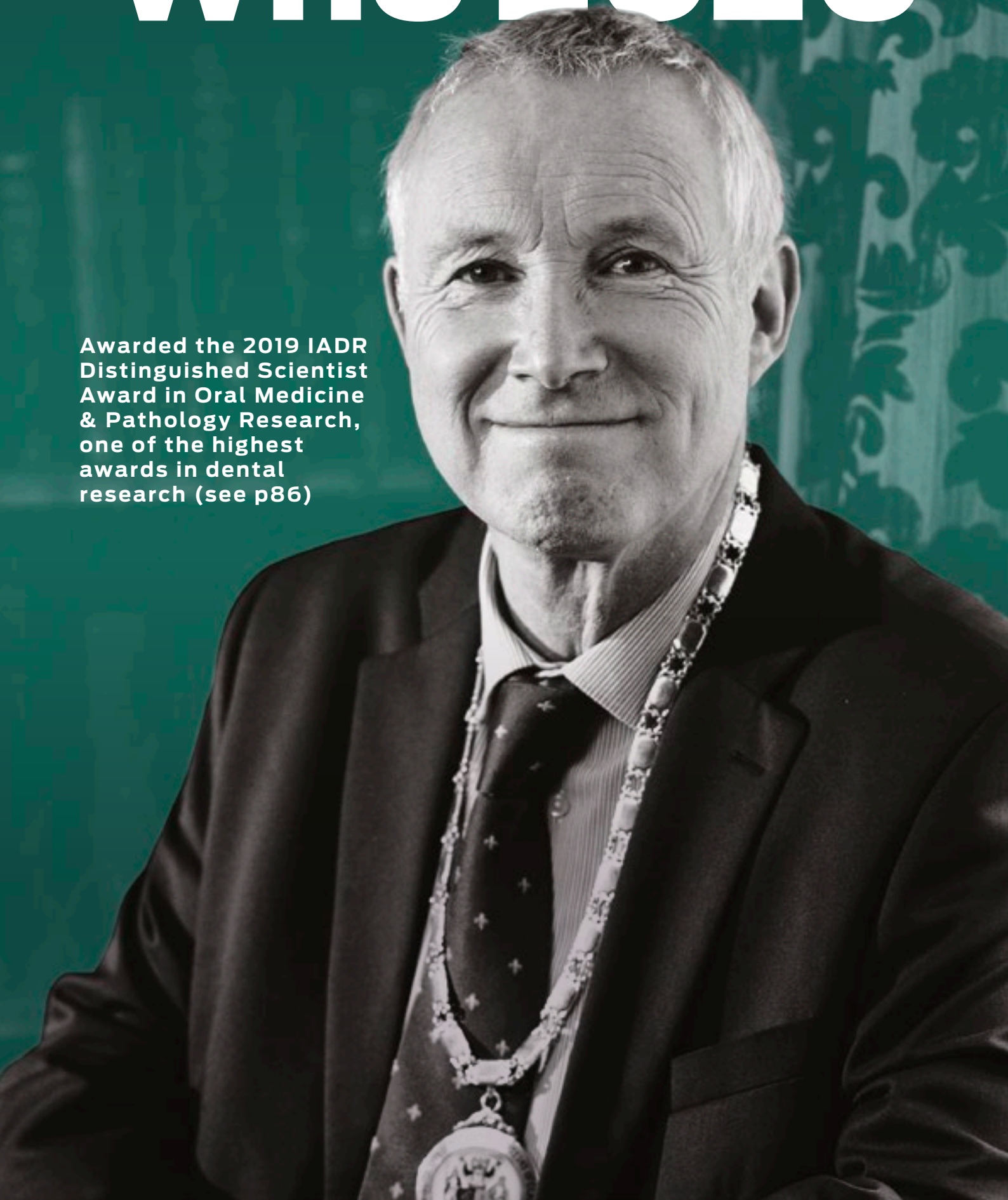
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PROFESSOR GRAHAM OGDEN

Who's **Who 2020**

**Awarded the 2019 IADR
Distinguished Scientist
Award in Oral Medicine
& Pathology Research,
one of the highest
awards in dental
research (see p86)**





A GUIDE TO EXCELLENCE

Welcome to the 2020 Scottish Dental magazine Who's Who; the fifth issue of this guide to the profession and associated industries, featuring a selection of leading dental and oral health professionals working in public and private dentistry across Scotland.

The past 18 months has been overshadowed by politics and Brexit, making it a challenging time to put health – and specifically oral health – at the heart of policymaking and innovation. It is to be hoped that 2020 will provide greater clarity and stability, so that the progress that has been made in Scotland in public health, in leading-edge treatment, and in disease prevention can be consolidated and taken to the next stage.

The year ahead should be an exciting time for the profession, with the nation's world-leading dentistry providing inspiration to the next generation of practitioners. It will also be a time for important

discussions in Scotland to be held around the potential for a new model of care.

As highlighted in News (p9), a three-year study comparing three different treatment options for tooth decay “found no evidence to suggest that conventional fillings are more effective than sealing decay into teeth, or using prevention techniques alone, in stopping pain and infection from tooth decay in primary teeth”.

As Professor Nicola Innes, Chair of Paediatric Dentistry at the University of Dundee and lead author on the paper, noted: “What is absolutely clear from our trial is that the best way to manage tooth decay is not by drilling it out or sealing it in – it's by preventing it in the first place.”

In response, the BDA has called on all political parties to resource a UK programme to prevent child tooth decay, based on existing efforts in both Wales and Scotland. It has long advocated the Scottish programme Childsmile as a potential model for England, a national effort in nurseries and schools with both

universal and targeted components that has already reduced the bill for dental treatment costs by £5m a year.

While Scotland has led the way, the proposed new model of care in Scotland – which has at its core a system of remuneration that rewards prevention rather than “drill and fill” – will not be without challenges in implementation and implications in division of resources. These are topics that Scottish Dental magazine looks forward to covering in forthcoming editions.

Meantime, the following pages feature some of those representing the best in Scottish practice and business. Space does not allow the list to be comprehensive – many of those deserving of inclusion may not find their names mentioned and we will endeavour to publish a more complete guide in the next edition – so it is, by definition, representative.

However, through those who are included it is a way of showcasing wider excellence in practice, in teaching, in research, and in the supply sector.



Tony Anderson

Tony Anderson has worked in general dental practice for more than 20 years, becoming increasingly involved in postgraduate education and training before taking up post as a Director of Postgraduate GDP Education with NHS Education for Scotland in 2002. He is currently Associate Postgraduate Dental Dean and lead for the Continuing Professional Development (CPD) workstream, which includes national responsibility for CPD for all dentists and dental care professionals in Scotland, Clinical Audit/Quality Improvement Activity, Remediation and Return to Work support for dental registrants and Mandatory Training.



Professor Jeremy Bagg

Jeremy Bagg is Professor of Clinical Microbiology and Head of Glasgow Dental School. He also holds the position of Deputy Head of the School of Medicine, Dentistry & Nursing. He is currently Chair of the Steering Group of the Scottish Dental Clinical Effectiveness Programme and a member of the UK Advisory Panel for Health Care Workers Infected with Blood-borne Viruses.

In 2004, he was awarded the Fellowship of the Faculty of Public Health for his contribution to public health microbiology. From 1983 to 1991 he was Lecturer in Oral Medicine & Oral Pathology at Cardiff Dental School.

In 1991, he moved to the University of Glasgow as Lecturer in Oral Microbiology and was awarded a Personal Professorship in Clinical Microbiology in 1999. He received an OBE for Services to Dental Education in 2018.



Dr M Tariq Bashir

Tariq Bashir graduated from University of Glasgow Dental School in 2005. After this he held SHO positions in hospitals throughout Scotland before settling at the Visage Cosmetic Dental Clinic in Glasgow. He has been practicing there for over 10 years and his main interests lie in minimally invasive dentistry and endodontics. He has travelled extensively and learnt from renowned clinicians from around the world. He recently became the first graduate from Scotland at the prestigious Kois Center in Seattle in the US under the guidance of Dr John Kois. He is currently in the process of completing his masters dissertation in endodontology. In the past he has held a visiting GDP role in the Restorative Dentistry Department of Glasgow Dental School teaching undergraduate students. In 2018 he co-founded the popular Scottish Dental Study Club, which aims to bring the best dental teachers to Scotland from around the UK and also internationally.



Professor Jan Clarkson

Jan Clarkson is a Director of the Scottish Dental Clinical Effectiveness Programme (SDCEP) and, with Professor Ruth Freeman, is Co-Director of the Dental Health Services Research Unit at the University of Dundee. Her remit is to conduct high-quality research and promote the implementation of research evidence in dental primary care. Professor Clarkson is a founding member of the Cochrane Oral Health Group and is Joint Coordinating Editor. She is also Director of the Scottish Dental Practice Based Research Network and NES lead at Dundee Dental Education Centre.

As well as being a Fellow of the Royal College of Physicians and Surgeons, Glasgow and the Royal

College of Surgeons Edinburgh, she is a Member of the Institute for Learning and Teaching.



Stuart Clark

Stuart Clark graduated in dentistry from Edinburgh in 1985 before oral and maxillofacial posts in Edinburgh, Liverpool and Aberdeen. He qualified in medicine from Aberdeen in 1994 and completed basic surgical training in Aberdeen and Edinburgh and higher surgical training in Newcastle, Sunderland and Middlesbrough. He was appointed Consultant Oral and Maxillofacial Surgeon to Central Manchester and Manchester NHS Trust and WWL in August 2002.

Stuart is a member of the European Academy of Facial Plastic Surgery and the Association of Facial Plastic Surgeons. He regularly teaches on Advanced Trauma Life Support and Critical Care of the Surgical Patient courses. Stuart examines for the Royal College of Surgeons of Edinburgh for MFDS, MRCS and the Exit Specialty FRCS exam in oral and maxillo-facial surgery. Elected to the Council of the Royal College of Surgeons of Edinburgh in 2016, Stuart is also currently a Specialty Advisor for the North West for the Royal College of Surgeons. He has over 50 publications covering all aspects of oral and maxillo-facial surgery.



Professor David Conway

David Conway graduated from University of Glasgow BDS in 1996. Following brief periods in general dental practice, hospital dentistry in Bristol and Edinburgh, and SHO posts in oral and maxillofacial surgery at St John's in Livingston, he attained FDS RCS (England) in 1999.

He returned to Glasgow in 2000 for a clinical lectureship in dental public health combined with a





specialist registrar training post based in NHS Lanarkshire and NHS Argyll & Clyde Health Boards. He completed the MPH at University of Glasgow in 2002 and completed specialist training in dental public health in 2005 (FDS DPH RCS, and FFPH); and was awarded a PhD in 2008 for research on the epidemiology of oral cancer from a socioeconomic perspective.

Since 2005 he has held the position of Honorary Consultant in Dental Public Health – Information Services Division, NHS National Services Scotland. David was appointed Professor of Dental Public Health in 2015 in the School of Medicine, Dentistry and Nursing, where he is the current Director of Dental Research, and he is a Co-Lead for the Oral & Dental Specialty Group in NHS Research Scotland.

David's research interests focus on health inequalities, cancer epidemiology, and child oral health; involving multiple methods including: cohort studies, big data/data-linkage, community trials, and systematic reviews/meta-analyses. Ongoing work includes: evaluating the Childsmile programme and participating in several international studies: International Head And Neck Cancer Epidemiology (INHANCE) consortium; WHO IARC Inequalities in Cancer; CRUK – price policy research; and the HEADSpAcE – EU funded multicentre cohort investigating factors associated with late stage presentation of head & neck cancer.



Roger Currie

Roger Currie is a Consultant Oral and Maxillofacial Surgeon in NHS Ayrshire and Arran with sessions at QEUH, Glasgow. He is an Honorary Senior Clinical Lecturer at the University of Glasgow and an elected member of Council of the Royal College of Surgeons of Edinburgh. He qualified in dentistry from Leeds in 1989 and medicine in Glasgow in 1996, he holds Dental and Surgical Fellowships from both Glasgow and Edinburgh, is a Fellow of the Faculty of Surgical Trainers, and an Intercollegiate FRCS examiner.

He was appointed a consultant in 2003 and has been Chairman of the Medical Advisory Committee at BMI Carrick Glen since 2012. He was on the development group for the Scottish Government Referral Guidelines for Head and Neck Cancer in 2014, he is the current lead clinician for skin cancer in the West of Scotland, sitting on the Regional Cancer Leads group, and immediate past Chairman of the Scottish Oral and Maxillofacial Society.



Paul Cushley

Having worked in the hospital service, public dental service and in general dental practice as an associate, partner and principal Paul Cushley is NHS National Services Scotland Director of Dentistry. Paul's more than 20 years' experience as a dental officer included work in HMP Barlinnie, Shotts, and Greenock, and laterally as the visiting dentist at HMP Zeist in Holland during the Lockerbie trial.

After a period of working in the Public Dental Service in a variety of roles, including Dental Director in NHS Forth Valley, Paul was appointed to his current role in 2015. He also retains a role as an NHS NES Vocational Training Adviser and as one of the Royal College of Surgeons of England Fellowship tutors.

Paul was instrumental in partnering with 400 NHS dental practices to establish the biggest ever dental buying collaborative – Denpro – in 2016.



Ulpee Darbar

Ulpee Darbar is a Consultant in Restorative Dentistry and is the Director of Dental Education for the Eastman Dental Hospital. She is also the Training Programme Director for Dental Core Trainees. Ulpee graduated from the University of Wales College of Medicine in 1986

and after a brief period in general dental practice started her hospital career in 1987. She successfully completed her training in restorative dentistry in 1996 and took up her consultant position in 1997. Since her appointment, she has held several leadership positions at the Eastman while maintaining an active clinical practice.

Ulpee lectures and teaches widely in topics of soft tissue management, augmentation in the field of implant dentistry and periodontology and management of failures and treatment planning.

She also holds a number of external positions for the Royal Colleges and specialist societies and is currently the Chair of the Advisory Board in Implant Dentistry for the Royal College of Surgeons of Edinburgh.



Dr Michael Davidson

Michael Davidson is Senior Manager at Dentsply Sirona, looking after Clinical Affairs Commercial Development for the Global Endodontics and Restoratives business.

He received his Bachelor of Dental Surgery from the University of Dundee Dental School in 2000. His background includes 18 years in general dental practice, as both an associate and practice owner.

Michael's role is to ensure that dental care professionals worldwide, have access to high-quality education and innovation that helps improve clinical efficiency and advance patient care.



Robert Donald

Robert Donald is Chair of the British Dental Association Scottish Council and a non-executive Director of MDDUS. A GDP based in Nairn, he qualified from Edinburgh with honours in 1983, before spending 18 months in a training position

at Edinburgh Dental Hospital. He entered general practice in 1985, gaining the diploma in general dental practice in 1992.

He is a past chairman of Independent Care Plans UK and director of Highland Dental Plan

Robert was previously Chairman of the Scottish Dental Practice Committee, Vice-Chairman of the Scottish Dental Vocational Training Committee and Vice-Chairman of the Scottish Association of Local Dental Committees.



Andrew Edwards

Andrew Edwards is Dean of the Dental Faculty, Royal College of Physicians and Surgeons of Glasgow.

Andrew was born in Dundee where he qualified in dentistry in 1987. A period of junior positions in oral and maxillofacial surgery followed and he then gained FDS from the Royal College of Surgeons and Physicians of Glasgow in 1993.

He went to medical school qualifying MBChB from the University of Aberdeen in 1998. Basic surgical training was in the West of Scotland, gaining FRCS in general surgery of the Royal College of Physicians and Surgeons of Glasgow in 2001.

He went on to his higher surgical training in oral and maxillofacial surgery in the North West of England, gaining the Intercollegiate Fellowship in Oral and Maxillofacial surgery in 2006.

Within the Royal College of Physicians and Surgeons of Glasgow he was Director of Dental Examinations from 2016-19.

He has also been Associate Director for International Affairs developing overseas links in India and East Asia.

His is currently Consultant Oral & Maxillofacial Surgeon at The Royal Preston Hospital, specialising in the surgical correction of facial deformity and facial trauma.



Dr David H Felix

David Felix graduated in dentistry in 1978 from the University of Glasgow and after completing a number of training grade posts within the Hospital Dental Service returned to study medicine, graduating from the University of Edinburgh in 1988.

Following completion of higher specialist training in oral medicine he was appointed to the post of Consultant and Honorary Senior Lecturer at Glasgow Dental Hospital and School in 1992. In 1995 he took on the role of Postgraduate Tutor for the West of Scotland. He was appointed to the post of Associate Dean for Postgraduate Dental Education NHS Education for Scotland in 2002 and subsequently Postgraduate Dental Dean in 2011. He has contributed to the peer reviewed literature in dentistry and education.

Over the years he has gained extensive experience of the structure of postgraduate education within the UK and overseas and has held a number of key UK wide roles – President, British Society for Oral Medicine (2003 – 2005), Chair of the Specialist Advisory Committee for the Additional Dental Specialties (2007 – 2010), Dean of the Faculty of Dental Surgery in the Royal College of Surgeons of Edinburgh (2008 – 2011) and Chair of the Joint Committee for Postgraduate Training in Dentistry (2013 – 2017).

In addition to his current role in Scotland he is also Chair of the Committee of Postgraduate Dental Deans.



Tom Ferris

Tom Ferris is Chief Dental Officer for Scotland and was appointed in October 2019. He qualified from Glasgow in 1982 and has worked in general practice, hospital service, the salaried service in Scotland and in the hospital service in Malta.

He has a Masters in Public Health (Glasgow) and a Masters in Business Administration (Stirling) and has awarded an honorary Fellowship in Dental Surgery from both the Royal College of Physicians and Surgeons of Glasgow and the Royal College of Surgeons of Edinburgh and Fellowship of the Faculty of Public Health.

Tom is currently undertaking a Bachelor of Arts in classical studies with the Open University. He was seconded to Scottish Government as Deputy Chief Dental Officer from his substantive posts with NHS Forth Valley and NHS Education for Scotland in 2010. In December 2018 he was appointed interim Chief Dental Officer before the post was made permanent 10 months later.



Professor John Gibson

John Gibson graduated in both medicine and dentistry from the University of Glasgow, where he also completed his PhD on the condition known as orofacial granulomatosis and undertook his specialist clinical training in oral medicine. He has held posts at the Edinburgh Dental Institute, NHS Education for Scotland, Dundee Dental Hospital and School, and most recently, as Chair of Medicine in relation to Dentistry at Glasgow Dental School and Hospital. In 2018, John was appointed Director of Dentistry at the Institute of Dentistry in Aberdeen.



Toby Gillgrass

Toby Gillgrass is a Consultant and Honorary Senior Clinical Lecturer in Orthodontics at Glasgow Dental Hospital. He was formerly clinical lead for Cleft Care Scotland and is chair of the Specialty Advisory Board in Orthodontics. He is a former recipient of the Deans Medal and a Fellow of the Faculty of Dental Trainers.





Professor Mark Hector

Mark Hector was appointed Dean and Professor of Oral Health of Children at the University of Dundee in 2011 and conferred as The Boyd Chair in Dental Surgery in 2015. He first graduated in Physiology, then in Dentistry in 1981 at Guy's Hospital London. There followed three years at the University of Bristol and Kings College, London, after which he received his PhD. Following three years in oral medicine and pathology at Guy's Hospital Dental School he was recruited to The London Hospital Medical College as a lecturer in Child Dental Health. He gained his Readership in 2001 and in 2002 became Professor of Oral Health of Children at Barts and The London School of Medicine and Dentistry. Between 2009-11 he was President of the International Association of Paediatric Dentistry.



Professor Richard Ibbetson

Richard Ibbetson graduated from Guy's Hospital Dental School, University of London in 1974.

He spent some time in general dental practice in the West Country and then worked in Northern Canada. He undertook his postgraduate training at the Eastman in London and joined the staff there initially as a lecturer. He was at the Eastman for 20 years, becoming Senior Lecturer and Consultant. During this time developed his major interest in the teaching and clinical practice of conservative dentistry and fixed prosthodontics.

In 1999, he was appointed Professor of Primary Dental Care and the Director of the Edinburgh Dental Institute at the University of Edinburgh. During this period, Edinburgh established the first Honours BSc in Oral Health Sciences for those wishing to register as dental hygienists and therapists.

Richard was Dean of the Dental

Faculty of The Royal College of Surgeons of Edinburgh from 2011-14. In 2015, he was appointed Professor of Restorative Dentistry and Director of Dentistry at the University of Aberdeen.

He has taught professional groups extensively both within the United Kingdom and internationally. He has also acted as an external examiner both within the UK and internationally for both universities and Royal Colleges.



Dr Sarah Manton

Sarah Manton is Director of the Faculty of Dental Trainers and the former Vice-Dean of the Faculty of Dental Surgery at The Royal College of Surgeons in Edinburgh.

She is a specialist in restorative, periodontics and special care dentistry and is currently working in specialist practice.

She was Consultant (Honorary Senior lecturer) in Restorative and Special Care Dentistry at Dundee Dental School, where she led the sedation and special care teaching and clinical services. Previous posts have been held in university, hospital and primary care settings, including positions as Clinical Dental Director of a community dental service and as a Lecturer in Oral Medicine and Periodontics.

She is currently the Chair of the British National Formulary Dental Advisory Group.



Gordon Morson

Gordon Morson has worked in general practice ever since qualifying from the University of Glasgow in 1998.

He works in Alloa and has been a partner in a large NHS practice there for 14 years. He is currently a member of Forth Valley Local and Area Dental Committees and has been involved in dental politics for over 15 years. He also

has a significant interest in dental education, having organised Forth Valley's educational programme for dentists and DCPs for more than 10 years.



Dr Eimear O'Connell

Eimear O'Connell graduated from Edinburgh University in 1992, subsequently undertaking a year as a house officer in conservative dentist/casualty/oral surgery.

She worked as an associate in an NHS practice in Edinburgh until 1995, when she set up her own practice in the city, Bite Dentistry.

Eimear received her MFGDP from the Royal College of Surgeons in London in 2007 and completed her Diploma of Implant Dentistry from the Royal College of Surgeons in Edinburgh in 2014 and her FFGDP from the Royal College of Surgeons, London in 2015. She is currently President of the Association of Dental Implantology, having previously been the ADI representative for Scotland.

Eimear has lectured extensively in the UK and Ireland for the past five years.



Professor Graham Ogden

Graham Ogden is Chair in Oral Surgery at the University of Dundee and is also Dean of the Dental Faculty in the Royal College of Physicians & Surgeons in Glasgow. He completed his PhD on cytoskeletal and nuclear morphology of normal and malignant oral epithelium at Dundee and his postdoctoral research focused on the effect of alcohol on cell function and morphology.

For raising public awareness and contributions to professional education on oral cancer, he received the 2012 Ian Stevenson Award for Public Engagement with Research. He won the Senior Colgate Prize in 1992, awarded by the British Society for Dental Research, and represented

the United Kingdom as participant at the IADR Hatton Awards in 1993. Earlier this year, he was awarded the IADR Distinguished Scientist Award in Oral Medicine & Pathology Research, one of the highest awards in dental research.



Peter Ommer

Peter spent the first 15 years of his career as a GDP, becoming Practice Principal with two practices. He then worked directly for Health Boards and was appointed Clinical Dental Director of the PDS, Ayrshire and Arran, in 2009. Appointed Clinical Director of Primary Care Dental Services, Ayrshire, in 2016 he was recently appointed Director of Dentistry. He is an FDS, Royal College of Physicians and Surgeons, and an MJDF, Royal College of Surgeons of England. He was as a member of the Scottish Dental Practice Board (2007-2013), and panellist/Chair for the GDC Fitness to Practise committee since 2013. Engaged as a professional adviser to the Scottish Public Services Ombudsman in 2017, he was appointed a dental member of the Scottish NHS Tribunal Service in 2018.



Andrew Paterson

Andrew Paterson graduated from the University of Edinburgh in 1987 and practised in a specialist referral based restorative practice in Glasgow for 22 years in Glasgow.

He has been an NHS Consultant at Glasgow Dental Hospital and Crosshouse Hospital, Kilmarnock and a dento-legal adviser for a dental defence organisation. Andrew was brought up in Uganda, Kenya and Malawi and has always had an interest in developing world dentistry. He undertook a masters degree in medical law and ethics where his dissertation was on the ethics of international healthcare volunteering, which is now also the

subject of a part-time PhD.

Andrew is a volunteer, clinical lead, and trustee of the UK dental development charity Bridge2Aid which trains non-dentists in emergency dentistry and oral health education in rural Tanzania and is involved in the project to introduce a similar model to Malawi. He is also Senior Clinical Lecturer/Honorary Consultant in Restorative Dentistry at the University of Dundee/NHS Tayside.



Professor William Saunders

William Saunders is Emeritus Professor of Endodontology at the University of Dundee. He was appointed in 2000 having previously been in the Royal Air Force (1970-75), general dental practice (1975-1981) and a lecturer in Conservative Dentistry at the University of Dundee Dental School (1981-88).

William was the first clinical academic to undertake formal higher training in restorative dentistry. He was appointed to a senior lectureship in the University of Glasgow Dental School in 1988 and promoted to a Personal Chair in Clinical Dental Practice in 1993. He was appointed to the first Chair in Endodontology in the United Kingdom in 1995. He was appointed Dean of the Dundee Dental School in 2000 and served three terms until 2011.

He was Chair of the Dental Schools Council (2008-2011) having been President of the British Endodontic Society (1997-8) and Chair of the Association of Consultants and Specialists in Restorative Dentistry (1999-2002).

He chaired NHS Education for Scotland Dental Committee (2014-19). He sat on Dental Council of the Royal College of Surgeons of Edinburgh for three terms and chaired the Speciality Advisory Board in Restorative Dentistry for six years.

He also served as Dean of the Dental Faculty (2014-17) and was awarded the Faculty Medal in 2018 and an Honorary Fellowship of the Royal College of Surgeons of Edinburgh in 2017.

As a consultant William devoted the majority of clinical practice to

endodontics and was one of the first clinicians to use an operating microscope in this discipline. William was the recipient of the inaugural Scottish Dental Lifetime Achievement Award in 2012.



Kenneth Scoular

Ken Scoular is the recipient of the 2019 Scottish Dental Lifetime Achievement Award.

From running his own practice, a year out of university, and overseeing the multimillion-pound development of three dental centres in Scotland, Ken has combined a working life with a myriad of other activities including rescuing people from mountains (28 years' service with Lochaber Mountain Rescue) and taking on the Cresta toboggan run in Switzerland.

After beginning his career as a dentist in Kettering, Northamptonshire, in 1976, Ken moved to Fort William, taking over a practice established in the 1920s with a large and geographically spread patient. He started a study group for dentists in Fort William and Oban and subsequently sat his MFGDP at the Royal College of Surgeons in London in 1998. After merging his practice with another, to form M&S Dental Care, Ken also became a CPD tutor for NHS Education for Scotland in Inverness.

In 2002 he took up the role of Dental Practice Advisor (DPA) for NHS Highland, and then in 2005 he was appointed Director of Dental Postgraduate Education. Ken was involved in the design and the project management of the Stornoway Dental Centre, Dumfries Dental Centre, and the Centre of Health Science in Inverness.

Subsequently, as Dental Director at NHS Education for Scotland, as well as managing CPD, Dental Nurse Education and several VT schemes, he contributed substantially to the development of the Practice Manager scheme, dental therapist education, remote and rural education and developed and managed the TRaMS (Training, Revision and Mentoring Support) scheme, providing remediation training for dental professionals.





Susie Sharkey

Susie Sharkey has worked in the dental industry for almost 30 years. She used her original qualification in hotel management to start her career in a practice in the West of Glasgow where she qualified as a dental nurse and oral health educator as well as managing the practice.

She briefly worked for Isoplan before taking up the post as Practice Manager at Dental Fx in 2006. During that time, she graduated top of her year from the University of Highlands and Islands with a Professional Development Award in Dental Practice Management. For this she won the Louisa Fraser Memorial Award.

She also gained an award in Training and Education which has enabled her to write a course for nurses aspiring to learn more regarding dental implants and she is also a regular columnist for *Scottish Dental* magazine.

Currently, Susie is working as a Treatment Co-ordinator for Dental Fx and is active on several different dental forums where she is committed to helping out young professionals starting out on their career in dentistry.



Dr Donald J Thomson

Donald J Thomson has worked in paediatric, dental emergency, oral medicine and oral surgery posts in dental hospitals in Bristol, Edinburgh and Glasgow before beginning specialist training in DMFR in Dundee and Glasgow.

Since 2016 he has been a part-time consultant in dental and maxillofacial radiology in NHS Lothian, having previously been a consultant in Tayside. His primary role is CBCT and salivary gland imaging. He also works for NES, where he is the Associate Dean with responsibility for Core and Specialty Training in Scotland. Donald additionally reports CBCT scans

privately. He is a Member of Dental Council RCSEd and an examiner for MFDS, and for DDMFR at the Royal College of Radiologists.



Professor Angus Walls

Angus Walls is the Director of Edinburgh Dental Institute, an Honorary Consultant in Restorative Dentistry to NHS Lothian, and Director of NHS Lothian Oral Health Services.

Angus's research interests focus on the oral health status and care needs of older people.

He served as President of the British Society for Gerodontology, the British Society for Restorative Dentistry the British Society for Oral and Dental Research, the European College of Gerodontology and the International Association for Dental Research.

Professor Walls was a member of the RAE panel in 2008 and the REF in 2014.



Lezley Ann Walker

Lezley Ann's career began when she studied Dental Nursing at Glasgow Dental Hospital and School, graduating in 1987 after being awarded the Oral B Cup for academic excellence. She developed her skills in general practice in Ayr. Continual professional development led to Lezley Ann completing the NEBDN exam which she attained a distinction and was awarded the prestigious Claudius Ash academic prize. Lezley Ann has accumulated extensive experience in general practice, private practice and specialist hospital dentistry including surgery.

In 1993 she returned to Glasgow Dental Hospital and School working within the Orthodontic Department. In 1997 Lezley Ann was then promoted to the post of team leader within the Periodontal Department

and the School of Dental Hygiene.

In 2005 Lezley Ann followed her passion for teaching and learning by studying in Edinburgh achieving the F.A.E.T.C. This represented a turning point in her career development, and she immediately accepted an additional role as a distance learning tutor for trainee dental nurses with Reid Kerr College.

In 2008 a new post of dental team tutor was created to teach undergraduate dental students. Lezley Ann was appointed, providing her with the opportunity to shape and influence the course a position that she has developed and promoted since its inception. Lezley Ann remains in this role, which encompasses wide and varied subject matter across dentistry, including the Basic Life Support Programme, training for DCPs and CPD training for Glasgow University staff and MSc students.

Since the inception of Restart a Heart Day initiative in 2014, Lezley Ann has promoted and supported the event. She takes dental students and pupils of Chryston High School to Glasgow Science Centre to deliver CPR training to the public in an interactive and enjoyable way. In 2018 Lezley Ann expanded the event with colleagues in Dundee Dental School and Edinburgh Dental Institute, which provided CPR training.



Alan Whittet

Alan Whittet was appointed Senior Dental Adviser at NHS Scotland in April 2017.

He qualified from Edinburgh Dental School in 1984. He went straight into general dental practice and worked in three different practices over the course of 27 years.

The majority of that time was spent in the NHS. He was an associate at a practice in Stirling for two years before moving to another in the west end of Edinburgh.

After five years he headed to East Lothian and a practice in Longniddry.

During his 20 years there he bought into the practice and helped introduce a series of changes. He first became a practice adviser in 1994.

MEDICAL PROTECTION

Helen Kaney, Head of Dental Services, Scotland at Dental Protection

HELEN is dually qualified as both a dentist and a solicitor and completed an MBA in 2013. She is a Fellow of the Faculty of General Dental Practice (UK) and in 2019 was elected to the Faculty Board in a national seat. She has also been awarded foundation Fellowship status of the Faculty of Forensic and Legal Medicine. Helen works for Dental Protection as a full-time Lead Dento-legal Consultant and is Head of Dental Services, Scotland based in the Edinburgh office.

Helen qualified in dentistry from the University of Glasgow in 1987 and worked for several years in general dental practice. She has also worked as a clinical assistant in restorative dentistry at Guy's Hospital and at Glasgow Dental Hospital.

She studied law at the University of Strathclyde and initially worked as a dento-legal adviser in England before returning to Scotland and training as a solicitor. She then spent several years in legal practice, where she specialised in defending clinical negligence claims against doctors and dentists, appearing at fatal accident inquiries and advising and acting for dentists in relation to NHS tribunals and the General Dental Council, acting for medical and dental defence organisations (including Dental Protection) on behalf of their members.

Helen leads the Scotland-based team for Dental Protection, which is part of the Medical Protection Society (MPS). MPS is the world's leading protection organisation for doctors, dentists and healthcare professionals and supports the professional interests of more than 300,000 members around the world.

Dental Protection's in-house experts assist with a wide range of legal and ethical problems that arise from professional

practice. This can include clinical negligence claims, complaints, legal and ethical dilemmas, disciplinary procedure and GDC referrals. Dental Protection's philosophy is to support safe practice by helping members to avert problems in the first place. We do this by promoting risk management through our workshops, E-learning, publications, conferences, lectures and presentations.

Dental Protection's Edinburgh-based team had another very successful year in 2019, helping numerous members in relation to complaints, claims and regulatory cases in the UK and Ireland and in other international jurisdictions.



Helen Kaney

BDS LLB Dip LP MBA FFGDP (UK) FFFLM

Lead Dento-legal Consultant and Head of Dental Services, Scotland

GDC: 62428



SPECIALIST PRACTICE

Dr Lisa Currie, of the award-winning Orthodontic Clinic

Lisa Currie

BDS (Hons) MFDS RCSEd MSc MOrth RCSEd FDS (Orth) RCS FDS(Orth) RCPSGlasg
GDC: 72073

DR Lisa Currie is the Clinical Director of The Orthodontic Clinic, a multi award-winning specialist practice in Aberdeen.

The practice was named Most Improved Practice in the Dentistry Scotland Awards 2016 and was highly commended in the category of Best Employer in the Dentistry Scotland Awards 2017. The clinic also won the Best Dental Team Award at the Scottish Dental Awards 2017.

The practice won Best Dental Team and Best Employer at the Dentistry Scotland Awards 2018 and were winners of the Best Dental Team (Scotland) at the Dentistry Awards UK 2018. In the same year, the clinic won a local Aberdeen business award, the Elevator Awards, for Best Employer.

In 2019 the clinic won the prestigious Specialist/ Referral Practice of the Year and Leadership Award, all at the Scottish Dental Awards.

The practice was highly commended in the categories of Best New Practice and Best Private Practice in the Dentistry Scotland Awards 2019, as well as in the Best Practice category in the Dentistry Awards UK. They won the Best Patient Care (Scotland) award in the Dentistry Awards UK in 2019.

Lisa gained her BDS with honours at Dundee

Dental School in 1996. She joined the Orthodontic Postgraduate Programme at Edinburgh Dental Institute and was awarded her MSc in orthodontics from the University of Edinburgh for her research in sleep apnoea in 2002. She gained her MOrth from the Royal College of Surgeons of Edinburgh in 2003.

After working as an FTTA at Birmingham Dental Hospital and University of North Staffordshire Hospital, she gained accreditation as a consultant orthodontist, gaining her FDS(Orth) from the Royal College of Surgeons of Edinburgh in 2006.

Lisa became Consultant Orthodontist at Borders General Hospital/ Edinburgh Dental Institute in 2006. Having lectured extensively to general dentists, undergraduate and postgraduate dental students and dental care professionals, she continues to train orthodontic nurses and orthodontic therapists. She was appointed as Honorary Senior Lecturer at Aberdeen Dental Hospital and School in 2015.

This year, she was elected as a Fellow of the Faculty of Dental Surgery in Orthodontics, FDS(Orth), from the Royal College of Physicians and Surgeons of Glasgow; a real acknowledgement of her significant contribution to the specialty.

For more information visit
www.theorthodonticclinic.co.uk/



IMPLANTOLOGY

Dr Bruce Strickland of Care Dental Implant Clinic

Care Dental Implant
Clinic, 16-22 Comrie
Street, Crieff,
Perthshire
For more
information on
Care Dental, call
01764 655745 or visit
www.care-dental-implants.co.uk

OVER the years Dr Bruce Strickland has placed more than 6,000 implants and worked closely with referring dentists from all over Scotland. His aim is to partner with other clinicians as an extension of their team and to provide a referral service that enhances their treatment portfolio offered to patients.

To some, this partnership is the delivery of a completed case, without any involvement in the surgical or restorative phase. To others it is a journey of clinical development through Care Dental's mentoring and training programmes, which equip our referring dentists with the skills to be involved in implant restorations, supported by our dedicated implant laboratory, to guide you in the planning

and delivery phase.

Here is what one of our partners, Dr J Lang, had to say: "Bruce's approach to educating his referring practitioners is second to none. He is dedicated to providing the absolute best level of patient care and equipping you with the knowledge and skills to do the same."

"The courses and study club evenings not only increase my knowledge and understanding of implants, but they have also enabled me to confidently undertake advanced restorative dentistry on my own patients, during the restorative phase."

If you would like to join our study club evenings, accompany your patient, or visit our clinic and laboratory please contact us.



Bruce Strickland
BDS DiplImpDent RCS (Eng)
GDC: 66125



DIGITAL ORTHODONTICS

Andrew McGregor of Park Orthodontics

**Park Orthodontics,
14 Royal Terrace,
Glasgow G3 7NY**

ANDREW McGregor is a specialist in orthodontics and owner of Park Orthodontics in Glasgow's West End.

He qualified from Glasgow Dental School in 2002 and gained his MOrth qualification in 2010 at Newcastle Dental Hospital.

He bought into Park Orthodontics in 2012, then an exclusively NHS practice. Since then it has been transformed into a successful mixed practice offering the full range of cosmetic appliances.

His main area of interest is in digital orthodontic techniques.

Using the iTero scanner and software systems, Insignia, Invisalign and Wired, the clinic is able to design and fit a full range of custom-made appliances.

This has opened up new opportunities in precision tooth and root alignment that has made working with referring dentists at the orthodontic-restorative interface much more efficient as well as producing superior results.



Andrew McGregor
BDS MSc BSc MFDS RCS
MOrth RCS
GDC: 80505

FACIAL AESTHETICS

AISLING Hanly, who qualified in Dundee in 1997, is a partner in multi-award-winning Kirriemuir Dental Practice and clinical director of Enhance Facial Aesthetics, which she set up in 2012.

She is also clinical trainer in facial aesthetics at ReNu training academy in Dundee, which was the 2017 winner of Best Training Academy at the Herald's Look Awards.

One of the first dentists in Scotland to be awarded the quality assurance mark from the regulatory body IHAS, Aisling was also the winner of Dentist Practising Facial Aesthetics at the first Scottish Medical Cosmetic awards in 2015.

She regularly attends master-classes given by industry leaders. She is currently involved in the creation of a facial aesthetic support group in Tayside and development of the ReNu training

academy in the east of Scotland, with nurse practitioner Kristeen Geddes RGN NIP.

Aisling completed advanced training in anatomy and dealing with complications of non-surgical treatments at the Royal College of Surgeons in London with multi-award winning team of renowned plastic surgeon Dr Dalvi Humzah and specialist nurse Anna Baker.



Aisling Hanly
BDS
Partner, Kirriemuir Dental Practice
GDC: 73486

IMPLANT DENTISTRY

SAM Elassar graduated from the University of Dundee in 1997. He went on to establish his implant training with the Royal College of Surgeons in London, and in 2007 he set up City Quay Dental Clinic and Implant Centre. The practice acts as a referral centre for implant dentistry in Dundee.

Sam is full-time implant dentist and works very closely with referring dentists, and hosts regular study clubs, and implant restorative courses. Sam was also vocational trainer from 2003 till 2017, but he now concentrates his dentistry solely on implants.

He has lectured nationally and internationally on the field of implantology. His main area of interest is digital dentistry and full arch rehabilitations workflow, from planning to restoration. In 2017 he was awarded the Best Digital Practice in Scotland award.

City Quay Dental Clinic's experienced implant team includes three treatment co-ordinators to support Sam, who has so far accepted referrals from more than 50 dentists in Dundee and beyond. He uses Straumann and Southern implants mainly, but would place other implants if the referring dentists are comfortable restoring other brands.



Sam Elassar
BDS MJDF RCS Dip ImpDent
RCS Eng
MFDS RCPS Glas
GDC: 73357

MEDICAL INDEMNITY

MDDUS's expert team of dento-legal advisers understand the challenges faced by members and can help them to avoid risk and respond efficiently and sensitively to any professional difficulties

Head of division



Aubrey Craig

BDS FDS RCPS (Glasg) MPhil MBA

Aubrey qualified at the University of Dundee in 1987 (BDS) and has worked in hospital posts and as a principal in general dental practice. He gained an FDS from the RCPS Glasgow in 1991, an MPhil in Medical Law in 2001 and an MBA in 2009. He joined MDDUS in 2006 and became Head of Dental Division in 2009.

Dental advisers

Rachael Bell

BDS MPhil PGCert MFGDP (UK) MJDF

Rachael qualified at the University of Glasgow in 1991 (BDS) and gained an MPhil in medical law and ethics in 1997. She worked as a general practitioner in mixed NHS/private vocational training practices for 22 years before joining MDDUS in 2009. Rachael was also a clinical audit facilitator for Argyll and Clyde Health board.

Douglas Hamilton

(TBC) BDS LLM MJDF RCS (Eng)

Doug graduated BDS from the University of Glasgow in 1989. His clinical career was primarily in general dental practice. He was awarded an LLM in healthcare law by the University of Dundee in 2009 and joined MDDUS the same year.

Stephen Henderson

BDS LLM FFGDP

Stephen qualified in London in 1984 and obtained an LLM in 2005. After working in hospital practice, he went into practice in Oxford where he still works as a visiting specialist in oral surgery. Before joining MDDUS, he worked for another indemnifier for 17 years. He was recently awarded an honorary fellowship by the FGDP.

Susan Willatt

BDS MBA LLM

Susan qualified in London in 1983 (BDS) and gained an MBA in 2000 and an LLM in 2004. She worked in general practice before moving to a clinical and management post in a dental corporate. In 2000 she took up a part-time post in the community dental service and worked for another indemnifier for 17 years before joining MDDUS.

Mike Williams

BDS LLM DGDP MGDS RCS (Eng) FFGDP (UK)

Mike qualified at the University of Dundee in 1979 (BDS), obtained MGDS in 1993, and is a fellow of the FGDP. In 2009 he gained a master's degree from the University of Cardiff, and he is on the GDC specialist list for oral surgery. He joined MDDUS in 2012.

Sarah Harford

BDS LLM

Sarah qualified in Newcastle-upon-Tyne in 2001 and obtained an LLM in Cardiff in 2017. She has worked as a GDP in NHS, mixed and private practices, in both independent and corporate settings. Before joining MDDUS in 2018 Sarah worked for another indemnifier for four years.

Laura McCormick

BDS MJDF RCS(Eng)

Laura qualified from the University of Dundee in 1996 and works as a partner in a dental practice in Glasgow. She obtained her MJDF in 2009, and has been a vocational training adviser since 2008. Laura has also been involved with remediation and mentoring through TRaMs and served on the Scottish Dental Practice Board. She joined MDDUS in 2016 as early practitioner adviser, offering free career advice to new dentists.



AESTHETIC IMPLANTOLOGY

Michael Tang of Kalyani Dental Lounge

MICHAEL TANG

BDS MFGDP (UK), RCS PGDIP (IMPDET)

MSC (IMPDET)

GDC: 80508

MICHAEL Tang has a special interest in aesthetic dental implantology, including the "teeth in a day" technique. He receives referrals from other dentists for implant surgery as well as CBCT scans, bone grafting, soft tissue/connective tissue grafting and sinus lifting at his boutique clinic, Kalyani Dental Lounge.

His interest in dental implantology stemmed from a course held in Harley Street in 2005. In the same year he decided to complete an intensive implantology course in the influential Medical Faculty in Boston, USA. He has since attended hundreds of related courses, trained with world-renowned clinicians and lectured by influential speakers. Michael holds both the Diploma and Masters qualifications in dental implantology. In recent years, he has mastered the digital workflow to improve predictability for patients and now all intra oral scanning, digital implant planning and 3D printing is

carried out in-house. He runs implant courses at the Kalyani Dental Lounge, and many dentists have already benefited from his implant experience. He also mentors less experienced dentists both at his own clinics and at the mentees clinics. He finds mentoring to be the most effective way of learning the complex skill. Many colleagues also frequently discuss their cases with Michael informally and he finds the discussions stimulating and educational for all parties.

Although most of his clinical time is dedicated to dental implantology, he has managed to maintain his commitment to inspecting other dental practices on behalf of the NHS Forth Valley Health Board since being appointed Dental Practice Inspector in 2007. Michael is also a partner and Clinical Director in 5 other clinics.

Michael is keen to work with new referring dentists/clinics or mentor less experienced dentists in the field of dental implants. Feel free to get in touch.

For referrals visit www.dentalpractice.com



DENTAL IMPLANTS

*Meet the New Life Teeth team who provide the highest quality
with a range of cosmetic dentistry options*



Dr John Clydesdale

BDS (Belf), MJDF RCSEng, MFDS RCSEd, DiplImpDent RCSEng, FFGDP(UK)

Dental Surgeon

John graduated from Queens University of Belfast, with a distinction in the practice of dentistry in 2001. John then moved to Edinburgh to continue his career and has worked in the Edinburgh area since 2001. Over the years John has pursued an intensive postgraduate education, completing and passing the required examinations and coursework for the Royal College of Surgeons of Edinburgh and England as well as the implant diploma and fellowship.

John's main area of interest is implant dentistry and he works with a network of referral dentists in and around the Lothians and Fife. John also organises a free study club that meets twice a year, covering various topics including core CPD. Also in conjunction with Nobel Biocare, John runs the Esthetic Alliance Program (EAP), which is an implant restorative course.



Mr Rob Leggett

RDT Dip CDT RCS Ed

Clinical Dental Technician

Rob is co-founder of New Life Teeth with Dr Stuart Lutton. His focus is on the creation of dentures and dental implant solutions, including full arch dental implants, which he constructs from zirconia using groundbreaking technology from Zirkonzahn. After qualifying as a dental technician from Edinburgh's Telford College, Rob worked in both the private and public sector, spending 10 years in the NHS including Glasgow Dental Hospital and Edinburgh's Dental Institute. He has been elected on to the council for the Dental Technicians Association. In 2009 Rob qualified as a clinical dental technician from the first CDT course to be run in the UK. In January 2013 Rob began Scottish Denture Clinic in Edinburgh, and now practises at New Life Teeth, where he works with both NLT and referral patients.



Dr Daniel Benson

DMD, MOM, MSc Implantology and Dental Surgery

Dental Implant Surgeon (Practice limited to implant treatments)

Daniel qualified in 2006 from Semmelweis University. His first registration with the GDC is 2007. Daniel completed a Masters degree in implantology and dental surgery in 2013 at Muenster University. Daniel is a widely experienced implant surgeon providing single, multiple and full arch implant treatments, soft tissue and hard tissue augmentations. He is a member and registered implant mentor of the Association of Dental Implantology. He regularly lectures nationally and internationally. Attention to detail and where possible minimal invasiveness characterises his work. In 2018, Daniel provided over 30 full arch rehabilitations. Daniel accepts referrals in Edinburgh for any type of implant work. He treats patients needing complex GBR procedures, block grafts or sinus augmentations.



Dr Arvind Sharma

BDS, MSc (Endodontology), MJDF RCS, MFDS RCPS

Dental Surgeon (Practice limited to endodontics)

Arvind qualified in 1996 from the University of Dundee. He completed a Masters degree in Endodontology at the University of Central Lancashire, passing with merit and has gained membership through examination of the Royal College of Surgeons of England in 2012 and Glasgow in 2016. Having worked many years in general practice he has now limited his work to endodontics providing his services in Edinburgh. Using contemporary equipment, (including a microscope), materials and techniques. Arvind accepts referrals for all aspects of non-surgical endodontic treatments from first primary treatments to re-treatments and includes management of cases with complex anatomy, sclerosis, open apices, perforation repair and removal/retrieval of fractured posts and separated instruments.



Louise Grant

Partner

Tel: 01382 312 100

Email: louise.grant@eqaccountants.co.uk

LOUISE is a Partner in our Dundee office, having been with EQ for more than 14 years. She heads up EQ Healthcare, our dedicated team for healthcare professionals. With a wealth of knowledge within the dentistry sector, Louise and her team can offer specific accountancy, taxation and business advisory services to dentistry professionals. She can also advise of operational issues and assist accordingly to ensure the optimum outcome is achieved. Specialising in corporate finance, Louise has helped many dentistry professionals raise funding to achieve their dream of buying a practice, or assisted dentistry professionals in selling their practice by guiding them through steps such as business valuation, wealth management and tax planning. For Louise, offering the correct support and advice is crucial to achieving long-lasting relationships with her clients. Therefore she spends the time getting to know your business inside and out in order to suggest the best plan moving forward.

She currently acts on behalf of many dentistry professionals, who see her as instrumental to their businesses, helping turn their dreams and aspirations into reality.



Anna Coff

Tel: 01307 474274 (Forfar)

Email: anna.coff@eqaccountants.co.uk

ANNA is a member of EQ Healthcare, based in our Forfar office. She assists Louise by providing dedicated accountancy, taxation and business advisory support to dental professionals.

Anna attends various dental trade shows, and also delivers various presentations to dental school students throughout Scotland, on topical issues affecting those coming into the profession.

She enjoys working with clients who view us as part of their team, assisting their practices to grow and develop, to realise their ambitions and to make a real difference.

Contact Louise or Anna to discuss your business ambitions, and see how EQ Healthcare can assist you in turning those dreams into reality.



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Suzanne Casey

South Glasgow and the East

Tel: 07774 105 402

Email: suzanne.casey@kulzer-dental.com

SUZANNE has worked in the dental industry her whole working life, since leaving school in 1995 and joining Tom Lamont's practice in East Kilbride as a trainee dental nurse. After 13 years in practice working between NHS, private, implant and orthodontic practice, she was ready for a new challenge and joined Kulzer Dental in June 2008.

Kulzer (formally Heraeus Kulzer) is one of the world's leading dental companies with many brands the market leaders in their relative segments. In the highly competitive composite sector, Kulzer brands, such as Venus Pearl and Venus Diamond, are increasingly seen as the most aesthetic and strongest composite materials available to UK dentists today.

Other well-known products in the Kulzer portfolio are Xantasil, iBond Universal, Provil, Flexitime, Dynamix and Charisma ABC.



Donna Morrison

North Glasgow, West Coast
and Northern Ireland

Tel: 07825 343 920

Email: donna.morrison@kulzer-dental.com

DONNA started as a dental nurse in 1988 straight from school and nursed for 15 years in three different practices. At her last practice, she was there for nine years before returning as practice manager. She started her dental sales career with Heraeus Kulzer, where she worked for four years before briefly working in practice and then returning to the trade on the dealer side. She has recently returned to Kulzer and is excited about her new challenge. Kulzer (formally Heraeus Kulzer) is one of the world's leading dental companies with many brands the market leaders in their relative segments. In the highly competitive composite sector, Kulzer brands, such as Venus Pearl and Venus Diamond, are increasingly seen as the most aesthetic and strongest composite materials available to UK dentists today. Other well-known products in the Kulzer portfolio are Xantasil, iBond Universal, Provil, Flexitime, Dynamix and Charisma ABC.



www.kulzer.com

For more
information
visit www.braemarfinance.co.uk or call
01563 897545.

WITH an increasing range of finance options available to dental practitioners, the choice of lender becomes ever more critical. Braemar Finance, a direct lender established over 25 years ago, offers not only competitive rates but industry-leading customer service.

"We know the importance of providing a quick and simple finance application and approvals process, allowing dentists to focus on patient care," said Gail Cormack, Area Sales Manager at Braemar Finance. "Our clients really do value the personalised service they receive from us, which is tailored to their individual needs and circumstances."

THROUGH THE CYCLE

Braemar Finance continues to lend through all economic cycles; for example, during the financial crisis of 2008, when many lenders exited the market, Braemar Finance carried on supporting its clients.

"We know that businesses can feel

the strain at times," said Gail. "Often through no fault of their own, business owners can find themselves in need of a supportive lender who can work with them through these tough times. It's our policy to do everything we can to support our customers through both good and bad times, working as a trusted partner."

Gail also reiterates the importance of providing clients with suitable and varied options.

"One size definitely does not fit all," she said. "With advancements in technology now meaning that the useful economic life of dental equipment is far longer, something we offer that many others can't is funding terms of up to seven years on both equipment and loans."

Finance products:

- Equipment Finance
- Business and Tax Loans
- Personal Loans
- Patient Finance



Gail Cormack
Area Sales Manager for Scotland
and Northern Ireland.



Finance solutions to grow your practice

Our tailored finance solutions provide you with a range of loans to assist your practice*.

Whether it's a practice refurbishment, purchasing the latest equipment or a loan to meet your tax demand, we are on hand for a speedy response, allowing you to focus on patient care.

For more information:



01563 897 545



info@braemarfinance.co.uk



www.braemarfinance.co.uk/dental

*Finance approval is subject to status

Braemar Finance is a trading style of Close Brothers Limited. Close Brothers Limited is registered in England and Wales (Company Number 00195626) and its registered office is 10 Crown Place, London, EC2A 4FT.



Part of  Close Brothers Group

DENTAL PRODUCTS AND EQUIPMENT



WITH a career spanning more than 25 years in the dental industry, Helen's experience includes working as a dental nurse, in both general practice and community services.

Moving into the sales arena in 2011, and currently working as territory manager for Scotland and NI, Helen has a passion for customer service; showcasing products and up-skilling staff through "lunch and learn" events and providing after-sales care.

Helen's technical background, coupled with her previous experience of owning her own beauty business, ensures she is vitally aware of the need to source and provide quality products and support.



Helen Wilson
Territory Manager for Scotland

07788 146 109

helen.wilson@coltene.com

www.coltene.com

SURGICAL AND SPECIALIST SUPPLIES

I WORK closely with dentists throughout Scotland to help them make an informed decision on the purchase of their next piece of equipment. More than a dental chair, a treatment centre is the centrepiece of your surgery and your choice sets the tone for the whole practice.

With nearly five years' experience working with the world's leading brands, such as Adtec, Dentsply Sirona, Anthos and Belmont, I can help to guide your decision so that the investment you make is one you'll never regret.

From single chair replacements right through to full surgery refurbishments and new developments, I work closely with architects to produce the necessary drawings, and work alongside your builders creating layouts bespoke to your requirements.

Project management is always key so I work with your contractors to ensure all runs smoothly, then give you and the team a thorough handover to ensure you understand exactly how everything works.

The Henry Schein team here in Scotland are some of the industry's leading engineers with more than 35 years' experience installing and maintaining dental equipment, they are involved from your project's inception through to its seamless installation.

I would welcome the opportunity to work with you in the future.



Kelly Paterson,
Equipment Specialist, Henry
Schein Dental, Scotland

DIGITAL SOLUTIONS



Ian Wilson

Director, IWT Dental + Services
0845 200 2219
www.iwtdental.co.uk

IAN Wilson, Director of IWT Dental + Services has been supporting dental practices throughout Scotland for more than 15 years, providing expert IT knowledge and advice. Ian works closely with practices to understand and discover their current and future needs to align with the long-term ambitions and goals of the practice.

As Director of IWT, Ian has worked on a variety of projects – specialising in technology services, including complete networks, digital imaging, installation of practice management software and much more. Before starting IWT Ian gained years

of valuable experience working with some of the leading software and hardware companies in the industry, making his knowledge second-to-none in the field of digital and dental IT solutions. IWT have gained the reputation of being the leading provider of specialist dental IT solutions in Scotland with a service that goes the extra mile. With a dedicated team including fellow Director Bruce Deane, Ian and IWT offer a comprehensive support service which goes far beyond the installation.



Bruce Deane

Director, IWT Dental + Services
0845 200 2219
www.iwtdental.co.uk

BRUCE Deane is joint Director of IWT Dental + Services and has worked in the dental industry for the past two decades overseeing the sales, implementation and on-going customer support process for hundreds of dental practices, giving him a detailed understanding of dental practices and the dental sector in general.

Bruce and his team at IWT are fully committed to every task they undertake and thanks to the IWT 'Partnership' method of working are perfectly placed to advise and support you with a range of solutions including: IT management, dental chair supply and service,

digital X-rays systems, phone systems and AV solutions.

Working with both NHS and private practices Bruce and the team at IWT bring enthusiasm, dedication and experience to every single project. Bruce works closely with his fellow Director Ian to steer IWT forward and continue to build on the excellent working relationships with industry-leading suppliers and manufacturers, so they can bring you the best possible products while ensuring the service and support you receive is exceptional at every stage.



07854 725 544
rachelm@dmg-dental.co.uk
uk.dmg-dental.com

THE DMG brand is recognised in more than 80 countries and is marked by several innovative milestones, including Luxatemp, now celebrating more than 20 years of international success – quite a remarkable achievement for a temporary crown and bridge material. Constick self-etching and adhesive flowable composite is a new three-in-one flowable composite that combines etching gel, bonding agent and flowable composite in one single product; and Icon, DMG's revolutionary treatment for incipient caries and carious white spot lesions, represents a breakthrough in micro-invasive technology.



Rachel Moreland

HEALTHCARE SPECIALISTS

MacRoberts' experienced commercial team offers innovative and practical solutions for the dental sector



Michael Kelly

Partner

Corporate Finance

michael.kelly@macroberts.com

0141 303 1318

MACROBERTS is one of Scotland's leading law firms with a history and heritage tracing back over 150 years. Through the delivery of high-quality, innovative and practical solutions for clients, along with an impressive ability to adapt to the contemporary commercial landscape, we have maintained a position of leadership and prestige in the Scottish legal sector and beyond. Our strength comes from our collaborative relationships and connections – we have an extensive network of clients and contacts throughout Scotland, as well as strong links to the wider UK and international markets.

The MacRoberts corporate team have an unrivalled commercial experience, encompassing all sectors of the Scottish economy and we are recognised as one of Scotland's leading corporate practices. We have a clear focus on the Scottish marketplace and enjoy excellent relationships with the wider corporate finance community in Scotland. We advise and assist on a broad spectrum of our clients' business transactions, covering their day-to-day corporate needs through to major transactions.

Led by partner Michael Kelly, the team are key players in the healthcare and life sciences sector. The team have advised on many new hospital and healthcare projects under private finance initiative (PFI), public-private partnership (PPP), non-profit distributing (NPD) and hub schemes. Beyond that, they have helped clients ranging from international pharmaceutical companies and life science technology businesses to independent care home operators, pharmacists, and doctors. More recently, the team have become leaders in the dental market, with particular expertise in buying and selling dental practices.

An industry once dominated by independent owners, the dental industry is undergoing a period of great change, offering increased opportunity for consolidation. Having been instructed in numerous dental transactions throughout Scotland, Michael and

his team, consisting of Victoria McMurray and Gary Baines, are accustomed to working through the complex legal issues that go hand-in-hand with dental deals.

Michael is one of the brightest corporate partners emerging in the Scottish market and can bring an exceptional level of commercial insight to any transaction. As observed by a client, "Michael is the most insightful and commercial advisor I have ever encountered."

Alongside Michael, Victoria has been acknowledged as "an intelligence and unflappable young lawyer" whilst clients have commented that "Gary's communication is exceptional, he is understanding and patient while providing a professional but personal service."

The team specialise in providing a bespoke service to current and prospective practice owners, with particular expertise relating to management buy-outs, group expansion and corporate consolidation. The team are well placed to provide not only expertise advice, but also work alongside banks, financiers, and other investors who help fund the organisations they provide their expertise to. They have extensive experience in each step of a transaction, and can offer pragmatic support and advice from start to finish.

Dealing with both NHS and privately run practices, Michael and his team have learned to understand not only the legal issues that arise but practical and personal issues that crop up in both share and asset deals. These issues range from the clinical freedom you wish to have as a practitioner, to the remuneration rate you expect to pay or receive. Such understanding and knowledge of the market places MacRoberts in a unique position for advising on mergers and acquisitions of dental practices, whether you are a vendor looking to sell your sole practice or a corporate consolidator looking to build your portfolio. With such a vast dental portfolio, MacRoberts' first-class team can provide advice every step of the way.



EXPERT SUPPORT IS KEY WHEN SELLING IN SCOTLAND

THE challenges of selling a dental practice can often be minimised with good preparation and support.

Dr John Moore had initial concerns before selling a practice in Scotland. He explained who he worked with to overcome them.

"Selling a dental practice has become a very complicated and stressful process. My main concerns were getting through the process itself and finding the time to deal with elements such as due diligence.

"I approached Dental Elite upon the recommendation of a colleague and worked primarily with Ted Johnston. He kept me up-to-date with progress in all aspects he was involved with and was easy to contact at all hours."

Dr Nat Chamberlain, who recently sold a practice near Glasgow, faced a different type of challenge.

"I was most concerned about whether I was doing the right thing," he said. "I wanted to alleviate some of the responsibilities I had but I certainly wasn't ready to retire. I originally looked at going into partnership with an associate but that didn't work out. I was a bit lost as to what to do next."

At this point, Nat contacted Ted from Dental Elite for advice and support. About the service he received and the outcome achieved, he said: "Ted Johnston was amazing. He was very professional but his support went much further than this. He understood what I wanted to achieve and pointed me in the right direction. He provided reassurance and helped me make sure I was doing the right thing for me. I couldn't have asked for more.

"The offer being above the valuation was a huge factor for me. I also found the arrangement offered by the buyer to be very attractive. My practice joined the group and they paid 80 per cent upfront. The final 20 per cent was invested into the group itself, so I effectively became a partner in the entire business.

"I didn't realise that this kind of model existed in dentistry. My advice for others, therefore, would be that if you know what you're looking for, don't be afraid to ask for exactly that. If you don't know what to do, speak to an expert like Ted. Once I found the right type of sale for me, I knew I was doing the right

thing. So far, I think this has been the best thing I could possibly have done, both in terms of my professional and personal life."

John Moore offered some additional advice for other dentists looking to sell: "I would strongly advise getting a good lawyer with experience in the dental sector! You do also need an agent to steady you through the process. It's important to know what you're getting into with the Heads of Terms and to make sure you can work with them early on – this will help to avoid significant changes as the transaction progresses.

"In addition, I would recommend allowing more time and money for the transaction than you initially think. Selling a dental practice can be an enormously complicated business and the due diligence requires a lot of time outside of normal working hours."



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ERGONOMICS AND MAGNIFICATION

Orasoptic Senior Sales Representative Jane Kilgour is focused on helping dentists and dental students to solve and improve their daily dentistry



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JANE KILGOUR is Senior Sales Representative for the North of England & Scotland and has more than 10 years' experience working with Orasoptic.

Jane has become a specialist in ergonomics and magnification in dentistry.

Before joining Orasoptic, Jane spent her career working as dental nurse under Professor Paul Tipton, so she knows a lot about dentistry and how to best serve her customers with the right Loupe Illumination system for them.

Jane is willing to go above and beyond a sale, she is focused on helping dentists and dental students solve and improve their daily dentistry, taking a customer service approach to all her sales, having a detailed understanding of her customers' needs.

Jane focuses on educating all customers and then focusing on the right product according to the dentist's needs.



BANKING AND FINANCIAL SOLUTIONS

Royal Bank of Scotland provides the country's healthcare sector with a comprehensive range of services for businesses of all sizes



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OUR teams cover the whole of Scotland from a network of offices across the country including Edinburgh, Glasgow, Aberdeen, Dundee and Inverness.

We provide a comprehensive range of banking and financial services to meet the needs of all sizes of businesses, in a wide range of sectors.

The Royal Bank of Scotland has its headquarters in Edinburgh and is a major provider of financial solutions to companies across Scotland and the rest of the UK. Our staff cover all parts of Scotland and are dedicated to delivering efficient, high-quality solutions – from standard financing right through to complex transactions. Service underpins all that we do, and we remain committed to providing a high level of service to all our customers.

